Notice of Meeting

Health Scrutiny Committee

SURREY COUNTY COUNCIL

Date & time	Place	Contact	Chief Executive
Thursday, 14 March 2013 at **10.00 am**	Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN	Leah O'Donovan or Victoria Lower Room 122, County Hall Tel 020 8541 7030 or 020 8213 2733 leah.odonovan@surreycc.gov.uk or victoria.lower@surreycc.gov.uk	David McNulty

If you would like a copy of this agenda or the attached papers in another format, eg large print or braille, or another language please either call 020 8541 9068, write to Democratic Services, Room 122, County Hall, Penrhyn Road, Kingston upon Thames, Surrey KT1 2DN, Minicom 020 8541 8914, fax 020 8541 9009, or email leah.odonovan@surreycc.gov.uk or victoria.lower@surreycc.gov.uk.

This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Leah O'Donovan or Victoria Lower on 020 8541 7030 or 020 8213 2733.

Members

Mr Nick Skellett CBE (Chairman), Dr Zully Grant-Duff (Vice-Chairman), John V C Butcher, Bill Chapman, Dr Lynne Hack, Mr Peter Hickman, Mrs Caroline Nichols, Mr Colin Taylor, Mr Richard Walsh and Mr Alan Young

Co-opted Members

Dr Nicky Lee, Rachel Turner, Hugh Meares

Substitute Members

Ben Carasco, Tony Elias, Carol Coleman, Marsha Moseley, Denise Saliagopoulos, Geoff Marlow, Mohammed Amin, Will Forster, Peter Lambell, Pauline Searle, Fiona White, Nigel Cooper, Chris Frost, Nick Harrison.

Ex Officio Members:

TERMS OF REFERENCE

The Health Scrutiny Committee may review and scrutinise health services commissioned or delivered in the authority's area within the framework set out below:

- arrangements made by local NHS bodies to secure hospital and community health services to the inhabitants of the authority's area;
- the provision of such services to those inhabitants;
- the provision of family health services (primary care trusts), personal medical services, personal dental services, pharmacy and NHS ophthalmic services;
- the public health arrangements in the area, e.g. arrangements by NHS bodies for the surveillance of, and response to, outbreaks of communicable disease or the provision of specialist health promotion services;
- the planning of health services by NHS bodies, including plans made in co-operation with local authorities, setting out a strategy for improving both the health of the local population, and the provision of health care to that population;
- the arrangements made by NHS bodies for consulting and involving patients and the public under the duty placed on them by Sections 242 and 244 of the NHS Act 2006;
- any matter referred to the Committee by Surrey Local Involvement Network under the Local Government & Public Involvement in Health Act 2007;
- social care services and other related services delivered by the authority.

PART 1
IN PUBLIC

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

2 MINUTES OF THE PREVIOUS MEETING: 24 JANUARY 2013 (Pages 1 - 10)

To agree the minutes as a true record of the meeting.

3 DECLARATIONS OF INTEREST

To receive any declarations of disclosable pecuniary interests from Members in respect of any item to be considered at the meeting.

Notes:

- In line with the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, declarations may relate to the interest of the member, or the member's spouse or civil partner, or a person with whom the member is living as husband or wife, or a person with whom the member is living as if they were civil partners and the member is aware they have the interest.
- Members need only disclose interests not currently listed on the Register of Disclosable Pecuniary Interests.
- Members must notify the Monitoring Officer of any interests disclosed at the meeting so they may be added to the Register.
- Members are reminded that they must not participate in any item where they have a disclosable pecuniary interest.

4 QUESTIONS AND PETITIONS

To receive any questions or petitions.

Notes:

1. The deadline for Members' questions is 12.00pm four working days before the meeting (Friday 8 March 2013).
2. The deadline for public questions is seven days before the meeting (Thursday 7 March 2013).
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 CHAIRMAN'S ORAL REPORT

The Chairman will provide the Committee with an update on recent meetings he has attended and other matters affecting the Committee.

6 SOUTH EAST COAST AMBULANCE (SECAMB) PERFORMANCE DEEP DIVE (Pages 11 - 32)

Purpose of report: Scrutiny of Services

The Committee will scrutinise South East Coast Ambulance (SECAmb) on its performance in the Guildford and Waverley areas, comparing urban and rural response times.

7 PATIENT TRANSPORT SERVICES (Pages

33 - 52)

Purpose of report: Scrutiny of Services

The Committee will scrutinise South East Coast Ambulance (SECAmb) and Surrey County Council on the delivery of the patient transport contract.

8 LINK STROKE REHABILITATION PROJECT FINAL REPORT (Pages 53 - 112)

Purpose of report: Scrutiny of Services/Policy Development

The Committee will receive the final report of an investigation by LINk and scrutinise post-stroke rehabilitation services across the County.

9 PERFORMANCE AND QIPP UPDATE (Pages 113 - 132)

Purpose of report: Scrutiny of Services

The Committee will scrutinise performance against QIPP savings targets and national performance indicators.

10 REVISED HEALTH SCRUTINY REGULATIONS (Pages 133 - 138)

Purpose of report: Policy Development and Review

The Committee will be updated on the revised Regulations governing Health Scrutiny

11 RECOMMENDATION TRACKER AND FORWARD WORK PROGRAMME (Pages 139 - 152)

Purpose of report: Scrutiny of Services/Policy Development

The Committee is asked to monitor progress on the implementation of recommendations from previous meetings, and to review its Forward Work Programme.

12 DATE OF NEXT MEETING

The next meeting of the Committee will be held on 4 July 2013.

David McNulty
Chief Executive
Published: Wednesday, 6 March 2013

MOBILE TECHNOLOGY – ACCEPTABLE USE

Use of mobile technology (mobiles, BlackBerries, etc.) in meetings can:

- Interfere with the PA and Induction Loop systems
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MINUTES of the meeting of the **HEALTH SCRUTINY COMMITTEE** held at 10.00 am on 24 January 2013 at Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting on 14 March 2013.

Elected Members:

Mr Nick Skellett CBE (Chairman)
Dr Zully Grant-Duff (Vice-Chairman)
John V C Butcher
Bill Chapman
Dr Lynne Hack
Mr Peter Hickman
Mrs Caroline Nichols
Mr Colin Taylor
Mr Richard Walsh

Independent Members

Borough Councillor Hugh Meares
Borough Councillor Mrs Rachel Turner

Apologies:

Mr Alan Young
Borough Councillor Nicky Lee

In Attendance

62/13 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Alan Young and Nicky Lee.

63/13 MINUTES OF THE PREVIOUS MEETING: [Item 2]

The minutes were agreed as an accurate record of the meeting.

64/13 DECLARATIONS OF INTEREST [Item 3]

No declarations

65/13 QUESTIONS AND PETITIONS [Item 4]

None received

66/13 CHAIRMAN'S ORAL REPORT [Item 5]

Southwest London JHOSC
The Southwest London joint Health Overview & Scrutiny Committee met on 12 December to discuss the inclusion of Epsom Hospital into the Better Services, Better Value review following the halting of the merger that we will be looking at in-depth today. NHS southwest London is looking again at all options and will report back to the JHOSC in due course with its preferred option. The aim was to begin consultation after Easter but as this will be during the purdah period it may have to be pushed back to after the election. I will keep you updated on the timetable.

BSBV Stakeholder Event
On 15 January I attended a stakeholder consultation event for BSBV at Epsom Downs. The proposals still include only three A&Es across now five hospital sites, with one site without an A&E hosting a planned care centre. I, along with other key stakeholders, provided important feedback to the BSBV programme on the concerns we have for the residents of Surrey should the option to remove the A&E from St Helier and Epsom be the preferred one. Colin and I will continue to voice these concerns during the upcoming JHOSC meetings.

Visits to SECAmb Headquarters
On 4 and 15 February there are visits scheduled to SECAmb's headquarters in Banstead. The purpose of these visits is to show those that have not seen how vehicles are managed and dispatched or for those that have, to have a refresh. This is to ensure that we are well-informed when they attend our March meeting to discuss their performance in more detail. I would encourage you to attend one of these visits if you have not been to their HQ before.

CQC Inspections
In November, two of the Council's own residential homes for older people were inspected by the Care Quality Commission. They did not receive favourable reports and an enforcement notice was served at Cobgates, Farnham, in relation to keeping accurate care records. I sought assurances from the Strategic Director of Adult Social Care about the matter and she has responded. There is a management plan in action to resolve these issues and the Directorate continues to strive for excellent services. Another

unannounced CQC inspection took place in the beginning of January and Cobgates was deemed compliant.

67/13 REVIEW OF EPSOM HOSPITAL MERGER [Item 6]

Declarations of Interest:

None.

Witnesses:

Matthew Hopkins, Chief Executive, Epsom & St Helier University Hospitals NHS Trust

Jan Sawkins, Independent Chair, Epsom & St Helier Transaction Board

Peter Cook, Programme Director, Epsom & St Helier Transaction Board

Bob Peet, Director of Special Projects, Ashford & St Peter's Hospitals NHS Foundation Trust

Miles Freeman, Chief Officer, Surrey Downs CCG

Karen Parsons, Chief Operating Officer, Surrey Downs CCG

Diane Hedges, Better Services Better Value lead for Surrey Downs CCG

Rachel Tyndall, Senior Responsible Officer, Better Services Better Value Programme

Key Points Raised During the Discussion:

1. The Chairman began by setting out the concern of the Committee about the failed merger between Epsom Hospital ("Epsom") and Ashford & St Peter's Hospitals ("ASPH") and its wish to understand why this had happened.

2. The Independent Chairman of the Transaction Board reported that it had not anticipated when the Transaction Board last updated the Committee that the merger would fail.. In outlining the history of the transaction it was explained that obtaining Cooperation and Competition Panel (CCP) approval at stage 1 on 12 September 2012 had been a very significant achievement. After this Deloitte had continued their investigations and concluded their work on the merger. It was emphasised that stakeholder support for the proposed merger especially that of Surrey residents could not have been stronger.

3. Subsequent to stage 1 approval ASPH had also engaged in further financial work. This work resulted in a reduction in their proposed synergies downwards at year 5 from £14.0m to £10m (£8.8m at the five year point) and a projected increase in on–costs from £1.2m at year 5 to £5.m (due mainly to the inclusion of capital costs). At around this time there was also uncertainty concerning Surrey Downs CCG and its commissioning intentions whilst the Better Service Better Value (BSBV) preferred option made public in August 2012 included the repatriation of south west London orthopaedics from the Elective Orthopaedic Centre at Epsom Hospital ("EOC") to St Helier Hospital.

.It was noted that the impact of this BSBV option on Surrey residents was a concern for Members.

4. In conclusion four factors were identified as having led to the failure to agree a credible financial case for approval of the merger, the size of the deficit at Epsom which was £5.4m at the five year point after transitional funding, the reduction in ASPH synergies and increased costs, uncertainty over Surrey Downs CCG commissioning intentions and the potential impact of BSBV. It was explained that NHS South of England (NHSSoE) had considered the requirement for transitional funding too great whilst BSBV was now delayed pending further discussion between NHS South West London (NHSSWL) and Surrey CCG's These factors had together led to the decision of NHS London on 25 October 2012 to halt the merger with urgent discussions to follow to progress matters.

5. Members raised questions concerning the allocation of the deficit between Epsom and St Helier Hospital and whether the Trust felt that the Deloitte's figures were accurate in this regard and were satisfied that they were not biased in favour of St Helier. Hospital .It was explained by the Chief Executive that NHS finance is especially complicated as each year it is necessary to make a number of assumptions and judgments on income and costs of patient care and other risks such as inflation and level of savings possible to produce an operating plan. This plan predicted a total deficit of £19.4 million which was then split between the two sites which had been operating as a single organisation for the last 13 years. This split was complicated by factors such as the level and type of activity at each site (for example Epsom has some services with a richer skill mix) and the respective running costs. It was noted that the healthcare market around Epsom had a range of other healthcare providers which meant that some patient care which would normally be provided in an acute hospital, was provided elsewhere. It was explained that the Transaction Board were satisfied that there was consistency between the financial analysis done by the Trust in this regard and that done by Deloitte and that there will always be movement over a financial year as costs, cost savings and income move . For this reason Deloitte had prepared three scenarios, the best, most likely and worst case with, for example, the worst case scenario including the potential £5.7m fine. It was refuted on this basis that there was a mismatch between the Deloitte figures and the Trust Management Accounts and reported that any discrepancies were the result of movement in items such as planned commissioned activity which had been greater than anticipated.

6. An increase in commissioned activity at Epsom was "a good news story" for the Trust as it had attracted work from other parts of south west London due to an increased need for healthcare and the good standards available at the Trust's hospitals Hence the Trust was moving towards the Deloitte best case scenario and any decrease in deficit should be applauded.

7. Questions were then addressed by members to ASPH concerning the reduction in proposed synergies, the level of transitional funding available from NHS South of England, the impact of BSBV on the

merger plan and the impact of the potential £5.7 m fine for breaching infection control rates. On the decision to halt the merger, The Director of Special Projects explained that following the announcement of Preferred Bidder Status, further financial investigatory work had been undertaken with Epsom managers and clinicians and a more prudent view of the level of savings that could be obtained had been reached. In the intervening period, significant improvements in efficiency at Epsom meant that there was far less scope for further savings in subsequent years. Much work had been done on improving infection control at Epsom & St Helier but prudent financial assumptions had to be made concerning the potential significant fine and this had been done. As far as Transitional funding was concerned it was reported that there was support from NHS London and NHS South of England and that the issue had not been the amount of transitional funding that would be provided but the length of time it became apparent it would be required. A viable business case that transitional funding would not be required after five years could not be established.

8. Concern was raised by members that the interests of Surrey residents had not been represented or addressed by BSBV and this needed to be addressed. It was conceded that the emergence of the BSBV plan had been one of the factors that contributed to the failure of the merger. In particular the plan to move the EOC from Epsom to St Helier was identified as having had a major impact on the viability of the Epsom site and ASPH's view of Epsom.

9. Another factor leading to the halting of the merger was uncertainty over the commissioning intentions of Surrey Downs CCG and Members enquired as to the level of dialogue that had taken place between the CCG and the Trust. It was reported to Members that despite a constructive meeting as to commissioning intentions the potential gap that would be caused by the move of the EOC could not be closed to ensure viability at Epsom. Members were told that for some years it had been a feature of the local health economy that it had been in deficit .There needed to be cooperation within the whole health system to reach a balanced position as with the current static funding arrangements savings had to be made. Judgements therefore had to be made as to how to get to a place where services are sustainable in the area and a balanced financial position achieved for the providers and commissioners.. It was reported to members that although the EOC is significant for Epsom it is run on a profit share basis so that the impact of its loss is not as grave as it might appear whilst it had been anticipated that additional work would come to Epsom from the BSBV plan.

10. Members then asked about the level of representation for Surrey on BSBV and the extent that impact of the BSBV plan on surrey residents was considered. The SRO for BSBV Rachel Tyndall explained that the expectation had been that the merger between Epsom and ASPHs would proceed and services be maintained at Epsom. There was representation from Surrey as the Chief Executive of NHS Surrey or her Deputy were involved as were members of Surrey Link. In the more detailed groups such as Finance, Surrey representation was there in the form of Consultants from Epsom and St Helier though they were there for the St Helier part of the business. It was stated BSBV

was interested in Surrey residents who used Kingston Hospital and St Helier Hospital in addition to those who used Epsom Hospital. In terms of future proposals the needs of Surrey residents who use St Helier (especially for surgical emergencies as Epsom does not provide this) were being considered as were the needs for the Renal service which Surrey residents use .All these factors are taken into account in modelling. It was stated that now that the transaction is halted BSBV are embracing Epsom and looking at the needs of the Surrey population and their usage.

11. Members asked what involvement the CCG had with BSBV or the Epsom merger process and why NHSSoE required clarification of the CCG's commissioning intentions for Epsom and if this request had impacted on the halting of the merger. The SRO for BSBV reported to members that until the merger was halted the principal contact for BSBV had been NHS Surrey though in August 2012 a meeting had taken place with Surrey Downs CCG to obtain their involvement and it was acknowledged that if the process was being repeated they would be involved earlier. It was reported that all Surrey Downs GPs wished to reduce avoidable hospital admissions and commissioning intentions were dependent on how much budget had to be saved though it was noted that income had increased at Epsom more than originally anticipated which was the "good news story referred to above.

12. It was stated that the CCG have no firm commissioning plans yet and therefore for the purposes of the merger projected need had to be calculated on the basis of information available.. There was concern from members that the decision of BSBV to move the EOC from Epsom had harmed the merger process and will result in increased capital costs. Members also raised concerns that boundary issues were adversely affecting strategic decisions which from a Surrey perspective was difficult to understand.. It was accepted by BSBV that the impact of the EOCs contribution to running costs was a contributory factor to the halting of the merger but it was only one of a number of factors.. Members were informed that the merger had failed for a number of reasons and that uncertainty around commissioning intentions was also certainly one of these factors as there was uncertainty here. Another factor had been the decision to move the EOC. It was acknowledged that boundary issues can get in the way in decision making and that the situation should improve from April 2013 .It was considered these were only factors contributing to the reasons why the merger failed and were not any more important than other factors.

13. Members expressed their concern that the decision to move the EOC from Epsom and the halting of the merger had meant that NHS London could take control of Epsom and that it could then be sacrificed for other objectives. The SRO for BSBV assured Members that BSBV were motivated to provided good sustainable services for residents but that more had been spent than was available and that all had to live within their income. All organisations involved were working for the benefit of the community to achieve this.

14. Members expressed their concern over continued uncertainty and a strong desire to ensure the best interests of Surrey residents are

protected. Members of the Transaction Board explained to Members that the reason why the merger had been launched was to meet the deadline to become a Foundation Trust. In essence, this enables a Trust to hold a licence to operate rather than it being seen as the sole vision for delivering high quality care that meets healthcare need. In order to obtain Foundation Trust status it is necessary to have good quality services, appropriate governance and a credible 5 year financial plan forecast to have a 1% surplus. It is this last requirement that that the Trust has struggled to meet as a deficit organisation. A solution is being sought and work is taking place with BSBV as the current situation cannot continue and a sustainable future has to be achieved. Until it is clear what the impact of BSBV will be and commissioning intentions are known as to which services are required no further action can be taken by Epsom Hospital to establish if it should be or be part of a Foundation Trust..

15. The SRO for BSBV reported that plans for a planned care centre at St Helier had been put aside with the halting of the merger and that it was hoped that BSBV would have credible service options ready by March 2013 .In this respect BSBV were mindful of the need to engage with Surrey residents and have financial plans in place for their proposals. It was said that this may mean if necessary the March deadline will have to be extended later than anticipated balancing the need for certainty with the need for time to consult and prepare thorough plans. On behalf of ASPH it was explained to members that support remained for Epsom with an overall aim for a joined up system with community providers.

16. Members expressed concern as to the costs of the failed merger which were stated to be £2.7m plus ASPH's own costs (subsequently reported as £0.51m). Members were assured that the funds came from a Special Projects Fund not used for services and that part of work done for this process was useful work and had to be done in any event.

17. A request was made that the Deloitte report be made available to Members and this will be passed on.

18. The Transaction Team expressed their deep disappointment that the proposed merger had failed and thanked staff and Members for their support

Recommendations:

1. The witnesses are thanked for their attendance today and for contributing to the frank discussion about the future of Epsom Hospital.

2. The Committee expresses its strong disappointment at the cancellation of the merger process between Epsom Hospital and Ashford & St Peter's Hospitals and its concerns about the process leading to that decision.

3. The Committee formally calls on Epsom Hospital and Ashford & St Peter's Hospitals and other health organisations in Surrey to re – open

discussions on joint arrangements seeking improvements in care and organised efficiencies either through management steering or eventual merger: and

4. The Committee is concerned that boundary issues appear to have been a factor affecting the roll out of Better Services Better Value(BSBV) and calls for a wider and more independent review of acute provision in the sub-region.

68/13 PERFORMANCE AND QIPP UPDATE [Item 7]

Declarations of Interest:

None.

Witnesses:

Justin Dix, Acting Director of Governance, Transition and Corporate Reporting, NHS Surrey

Malachy McNally, Director of Finance, NHS Surrey

Key Points Raised During the Discussion:

1. The Acting Director of Governance, Transition and Corporate Reporting apologised to Members that no recent performance Report was available due to staffing problems and stated that information would be sent to the Scrutiny Officer for circulation. A brief outline was given at the meeting and it was reported that performance is good against QIPP and performance targets. There were some difficult issues to deal with such as Norovirus (East Surrey Hospital in particular has had problems with this which were being addressed) and the recent snow but transport arrangements had been good and very well supported with the assistance of the volunteer 4x4 drivers.

2. The Performance function was now passing to CCG's and they were becoming engaged and were establishing good relations with acute services. It was reported that there did not seem to be any impact on performance during the transitional period.

3. Members were informed that it was anticipated that The Francis Report which was due to be published on 5 February 2013 would be very important to the future management and expectations as far as care quality is concerned. The implications of this Report would be discussed at the final NHS Board meeting in March 2013.

4. Members asked whether there were any financial issues they should be aware of which may affect the ability to meet savings targets and if they were not met what the impact of this would be. It was reported that there was some slippage and concern in some areas (for example at the Ashford & St Peter's A $ E) but that it was hoped the CCG's would deliver and it was considered that they have developed clear, robust plans to do so. It was explained that the CCG's have had a 2.3% uplift to their budgets but levels of inflation and growth meant that this is sometimes seen to be a reduction in budgets. Members

were concerned as to the impact on services that may arise from meeting savings targets. It was stated that each plan had implications and choices would have to be made with budget allocations but that CCG's were collaborating together as a Surrey wide group which was encouraging for Surrey residents.

Recommendations:

1. The witnesses were thanked for their attendance today and their assistance to Members.

2. Members were supportive of all efforts made to seek to meet QIPP targets and performance objectives but were keen to ensure services to Surrey residents were appropriately. maintained during the transitional period and beyond and that all efforts were sustained to meet challenging objectives.

3. Members to be provided with a guide to the measures on infection control required by hospitals and noted that there is much agreement on best practice.

69/13 RECOMMENDATION TRACKER AND FORWARD WORK PROGRAMME [Item 8]

Declarations of Interest:

None.

Witnesses:

Leah O'Donovan, Scrutiny Officer, Democratic Services

Key Points Raised During the Discussion:

1. The implications and issues arising from The Francis Report to be included in the Work programme for future consideration.

2. A series of meetings has been arranged with the new CCGs. The intention is for the Chairman or Vice Chairman to attend in each case with Members attending the meeting of the CCG for their division

3. Members should make any other comments on the Work programme or recommendation tracker to the Scrutiny Officer by email.

70/13 DATE OF NEXT MEETING [Item 9]

Noted that the next meeting of the Committee would be held on 14 March 2013.

Meeting ended at: 12.53 pm

Chairman

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SURREY
COUNTY COUNCIL

Health Scrutiny Committee
14 March 2013

SECAMB Performance Deep Dive

Purpose of the report: Scrutiny of Services

The Committee will explore in detail the performance of South East Coast Ambulance NHS Foundation Trust (SECAmb) in the Guildford and Waverely areas.

Introduction:

1. South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is the ambulance service for the south east coast region. The Trust responds to 999 calls from the public and urgent calls from healthcare professionals in Kent, Surrey and Sussex, and areas within North East Hampshire and Berkshire. Across the region the Trust provides specialist neonatal transfer services, in Kent and Sussex it also provides non-emergency patient transport services.

Ambulance performance

2. The patients the Trust cares for range from the critically ill and injured, to those with minor healthcare needs that can be treated at home or in the community. Calls are received in Emergency Dispatch Centres via the 999 system, and triaged in accordance with the NHS Pathways to determine the most appropriate response based on clinical need.

3. SECAmb last attended the Health Scrutiny Committee to discuss performance in July 2012. Across Surrey, SECAmb regularly meets the 75% target for responding to calls within the 8 or 19-minute targets; however, members were concerned about their performance in more rural areas.

4. The Committee agreed to invite SECAmb back to undergo a deep-dive of their performance on a locality-based level, rather than County-wide. The areas in which concern had been expressed were Cranleigh and

Haslemere; therefore, the area of Waverley has been chosen to discuss in detail.

5. SECAmb has provided the attached report (**Annex 1**) on their performance in these areas.

Recommendations:

6. The Committee is requested to scrutinise SECAmb on its performance in the Guildford and Waverley areas.

Report contact: Leah O'Donovan, Scrutiny Officer, Democratic Services

Contact details: 020 8541 7030; leah.odonovan@surreycc.gov.uk

Sources/background papers: None

South East Coast Ambulance Service NHS
NHS Foundation Trust

HOSC Update

South East Coast Ambulance Service NHS
NHS Foundation Trust

Aim

- To provide the HOSC with an overview:
- SECAmb performance deep dive
- Performance review of Surrey PTS contract

Your service, your call

Planning Assumptions – Centre Locations May 12

South East Coast Ambulance Service NHS
NHS Foundation Trust

Surrey

- 3 MRCs – Chertsey (opened Jan 08), Tongham Station, Merstham.
- 18 old stations replaced by 29 patient led ACRPs.

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Performance Ytd (Jan13)

SECamb

Ytd planned activity (January 13)	527,617
Ytd actual activity	556,508
Ytd over performance	5.5%
Ytd Cat A performance	76.4%

Surrey

Ytd planned activity (January 13)	113,643
Ytd actual activity	121,994
Ytd over performance	7.3%
Ytd Cat A performance	74.9%

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Conveyance rates (excl HCP)

- SECAmb Ytd (Jan 13) 55.9%
- Surrey Ytd (Jan 13) 54.5%
- Numbers of A&E patients conveyed to Hosp in Surrey Ytd (Jan 13) 74,512

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Changes to ambulance response time categories

- From 1 June 2012 the A8 measure (immediately life threatening) was split into two parts, Red 1 and Red 2

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Red 1 Calls

- Red 1 calls are the most time critical and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions. For Red 1 calls, the existing call connect clock start will remain, ensuring that patients who require immediate emergency ambulance care will continue to receive the most rapid response

South East Coast Ambulance Service NHS
NHS Foundation Trust

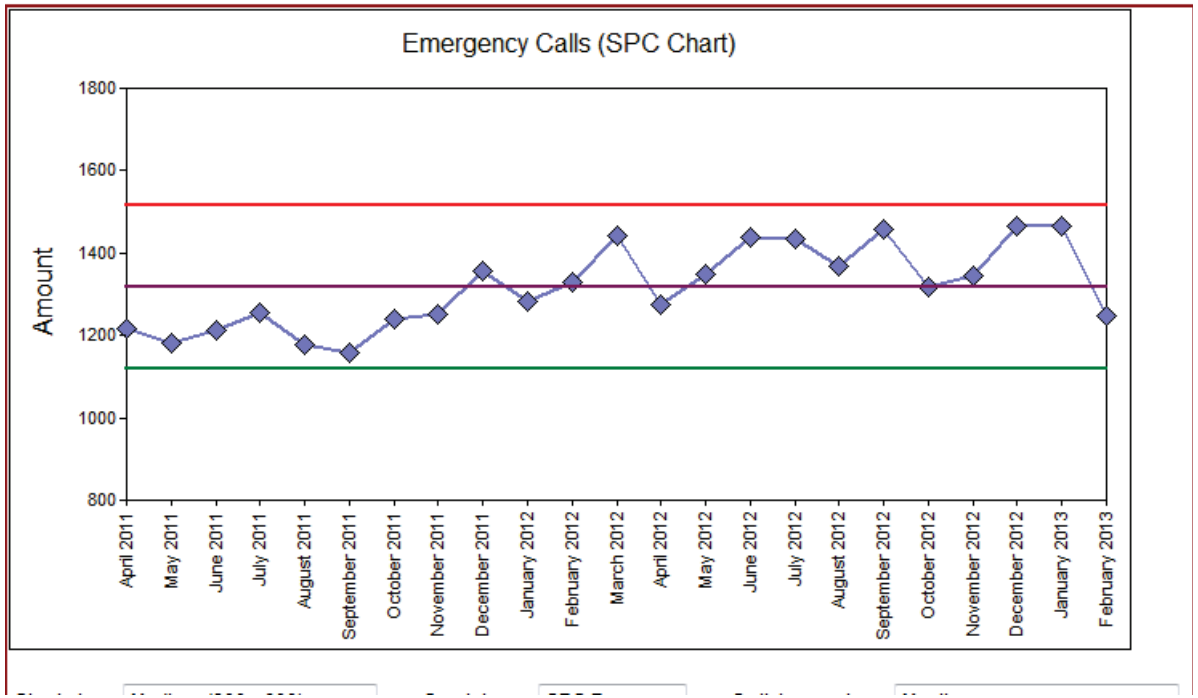
Red 2 Calls

- Red 2 calls are serious but less immediately time critical and cover conditions such as stroke and fits, a new clock start will allow call handlers to get more information about patients so that they receive the most appropriate ambulance resource based on their specific clinical needs

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

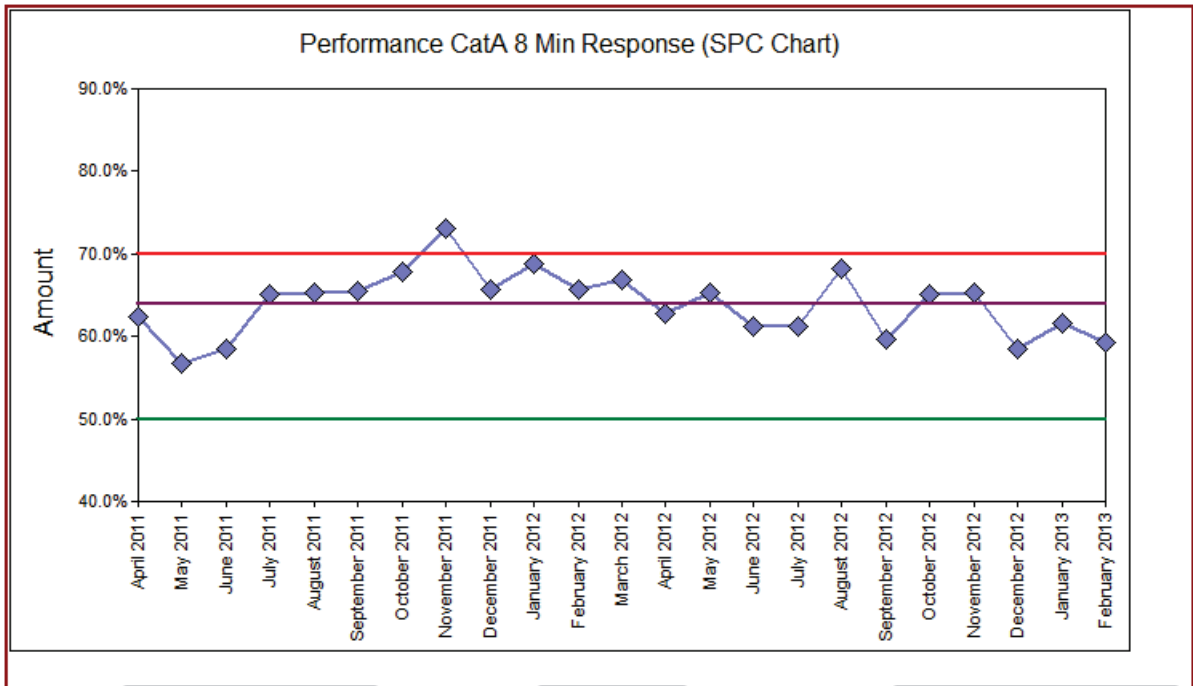
Waverley Number of R1 and R2 calls in total from 1st April 2011 to date



Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

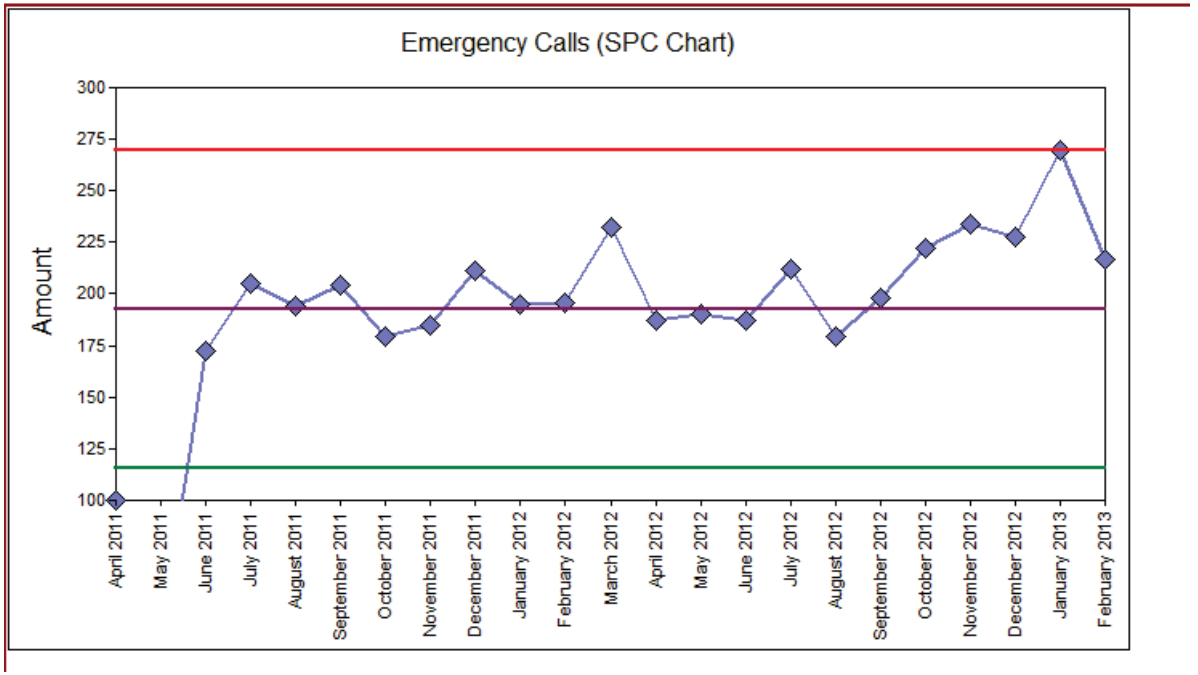
Waverley R1 and R2 (Cat A) performance 1st April to date



Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Waverley HCP Calls April 2011 to February 2013



Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Update on 111

- Planned service go live for March 2013
- Public Marketing will be towards end of March 2013 although communications have gone out to all local GPs and Service Providers
- Surrey Clinical Governance Group will oversee all clinical aspects of the local service

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

PTS update

- SECAmb awarded Surrey PTS contract 1st April 2012 go live 1st October 2012
- Contract covers Surrey, North Hampshire and Berkshire
- Secondary work cross border with Hounslow, Richmond & Twickenham, Sutton and Merton, Kingston for Surrey Patients

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

PTS Update

- Where are we now 6 month's post go live?
  - What's working;
    - New fleet (60 vehicles) rolled out across surrey mid February 13
    - Delivering 18,000 transports a month (Surrey)
    - 85% of patient transports on time
    - 91% of patients on vehicle for less than an hour
    - Good working relationship with SCC

South East Coast Ambulance Service NHS
NHS Foundation Trust

PTS Update

- What's working continued
  - Working with patient groups to agree the application of the eligibility criteria
  - Plan for roll out of the technical solution for booking service with SCC developed
  - Plan for roll out of ebooking solution to Hospital Trusts in development
  - Workshop with Acute Trusts to work through issues held 6th March
  - Contract meetings in place

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

PTS Update

- What's going less well;
  - Underpinning contracts for PTS not agreed (as at 20th Feb) with NHS Surrey
  - Underpinning contract for Booking Solution not agreed(as at 20th Feb) with NHS Surrey
  - Roll out of technical solution for eligibility criteria delayed to September 13
  - Delays to or missed appointments still happening (<0.5%)

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

PTS Update

- Solutions
  - Short term
    - All team leader posts and operational manager posts fully recruited to
    - Monthly meeting with Trusts and Commissioners to resolve issues
  - Longer term
    - New rotas in place 1st April – right resource right time right location
    - Technical solutions for CBS and ebookings in place

South East Coast Ambulance Service NHS
NHS Foundation Trust

CFRS

- CFRS 13
- Members 167
- Staff responders 26
- Co responder schemes 10

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Q&A Session

Your service, your call

Health Scrutiny Committee
14 March 2013

Patient Transport Services

Purpose of the report: Scrutiny of Services

The Committee will scrutinise South East Coast Ambulance (SECAmb) and Surrey County Council on the delivery of the patient transport contract.

Summary:

1. A report detailing the non – emergency centralised call booking service, provided by SCC on behalf of NHS Surrey, can be found as **Annex 1**.

2. An update report on the Patient Transport Service from South East Coast Ambulance Service can be found as **Annex 2**.

3. A report from Surrey Coalition for the Disabled offering a patient perspective can be found as **Annex 3**.

Recommendations:

4. The Committee is asked to scrutinise Surrey County Council and South East Coast Ambulance Service on the delivery of Patient Transport Services.

Report contact: Victoria Lower, Committee Assistant, Democratic Services

Contact details: 020 8213 2733; victoria.lower@surreycc.gov.uk

Sources/background papers: None

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South East Coast Ambulance Service NHS
NHS Foundation Trust

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Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

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South East Coast Ambulance Service NHS
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South East Coast Ambulance Service NHS
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Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

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Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Q&A Session

Your service, your call

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SURREY
COUNTY COUNCIL

Health Select Committee
14 March 2013

Non-Emergency Patient Transport – Centralised Booking Service

Purpose of the report: Scrutiny of Services

The Select Committee is examining the patient transport service, looking at its operation since contract start (1 October 2012). This report details the centralised call booking service, provided by SCC on behalf of NHS Surrey.

Introduction and background

1. In 2010/11, the Health and Social Care Bill (now enacted) promoted a multi-agency approach to social care and health services provision. At the same time, the Public Value Review of SCC's Transport Co-ordination Centre (TCC) advocated the benefits from joint working with NHS Surrey. Patient user groups had also expressed concerns with the former service provision.

2. The former patient transport contract ended on 30 September 2012 and, having reviewed the service, Surrey PCT decided to split out the eligibility assessment and journey booking element of the service from the transport provision element. The PCT invited SCC to deliver a centralised booking service on their behalf (and funded by them); and the service commenced 1 October 2012.

What is the service provided by SCC?

3. The SCC centralised booking service (CBS) is for Surrey residents registered with a Surrey GP requiring transport to and from home to attend outpatient appointments. The service operates Monday to Friday 8am to 6 pm currently. The CBS provides a "one stop shop" for patients dealing with:

    - The eligibility assessment
    - The booking of patient transport, if eligible
    - Signposting to alternative transport solutions, if not eligible

4. The CBS assesses a patient's eligibility for transport against the South East Coast wide eligibility criteria, which state that only patients with a genuine medical need that prevents them from travelling by public transport, community transport, taxi or private vehicle are entitled to NHS funded patient transport.

5. If eligible, the CBS will book transport for a patient's planned outpatient appointments up to 5pm of the day prior to an appointment (on the day transport must be booked direct with the transport provider – South East Coast Ambulance).

6. For patients that are not eligible, the CBS will offer alternative suggestions for making the journey; for example, providing information on public transport routes and community or voluntary schemes that may operate in their area.

Service Activity and Contract Monitoring

7. The CBS currently handles around 500-600 calls per week. The service was originally set up to book transport for first appointments only, but a decision has been made that the CBS should take all planned appointment bookings from 4 March 2013, so the volume of calls is expected to rise.

8. NHS Surrey has recently appointed a Contracts Manager for the CBS and South East Coast Ambulance contracts. A number of KPIs are being developed that will be used for monitoring performance. Monthly contract review meetings have also been put in place.

Issues

9. There are good working relationships with South East Coast Ambulance (SECAmb) and NHS Surrey, with a shared commitment to high quality, cost effective service provision. There have been concerns expressed previously at the lack of resource NHS Surrey has put into the project, and consequently slow progress has been made on certain issues, including contract sign off. However, the resource issue is now resolved with the appointment of a Contracts Manager, and significant progress has been made in the weeks since her appointment. The CBS specification is now close to agreement and it is expected the contract will be signed within the next few weeks.

Next Steps

Permanent CBS Team

10. The intention is to recruit a full permanent team as soon as a final structure is agreed with NHS Surrey. The number of staff employed will largely depend on projected call activity, agreed expansion of service scope and the level of service expected from NHS Surrey e.g. in respect to call answering times etc.

Further Development

11. Further IT development is planned jointly with NHS Surrey and SECAmb to provide a new front-end to the booking system to allow the capture of the outcomes of the eligibility assessments, for example.

12. The scope of service for the CBS may be expanded if further PCTs wish to use the service. Any such expansion would be subject to a separate contract with each PCT.

13. NHS Surrey, SCC and SECAmb are currently working with patient user groups to review how the eligibility of patients should be assessed, to make the process effective, fair and transparent.

Department for Transport

14. The Department for Transport has expressed interest in the partnership working on this project and has indicated a possible ministerial visit in that respect.

Financial and value for money implications

15. None

Equalities Implications

16. A key aim of the CBS is to deliver a service that is fair and personalised, providing equitable access to the patient transport service for eligible patients.

Risk Management Implications

17. None

Implications for the Council's Priorities or Community Strategy

18. This project helps deliver the Council's commitment to strategic partnership working.

Recommendations:

19. This report is for information only.

Report contact: Tracey Coventry, Transport Co-ordination Centre Team Manager, Travel and Transport Group, Environment and Infrastructure

Contact details: 0208 541 9592 / tracey.coventry@surreycc.gov.uk

Sources/background papers: not applicable

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Annex 3

Surrey Coalition of Disabled People

Evidence submitted to Health Scrutiny Committee on NHS Patient Transport Services

14th March 2013

1. INTRODUCTION

Surrey Coalition members have represented the interests of patients with long term conditions on NHS Surrey's Patient Transport User Group for many years. Patient representatives monitored the performance of the former PTS provider, G4S and sought improvements in service delivery through quarterly meetings of the PTS User Group.

When the PTS contract was due for retender in 2010/11, patient representatives were involved in designing a new specification which sought to ensure an improved service for patients, and were then involved in the procurement process and tender evaluation which resulted in SECAmb being awarded the contract from 1st October 2011. The PTS User Group has continued to meet frequently with managers from NHS Surrey, SECAmb and Surrey County Council since then, to monitor implementation of the new contract.

We had very high hopes of seeing a significantly improved Patient Transport Service, both with a new provider, SECAmb, and with the introduction of a Central Booking Service provided by Surrey County Council which would enable patients not eligible for PTS to be offered alternative forms of community transport. We have however been extremely disappointed by the service delivered to date by all parts of the Patient Transport Service, as outlined below :-

2. PROBLEMS FACED BY PATIENTS

This Report is submitted to the Health Scrutiny Committee to provide a brief overview of the problems which have been faced by patients,

which we understand to have been due to failure to finalise the contractual arrangements and to delays in implementing processes for assessing patient eligibility and making bookings. Examples of the problems are as follows :-

2.1. Some patients have been refused patient transport, although they were eligible and had received patient transport previously.

- This, we knew, was due to a failure by NHS Surrey to develop a clear protocol for assessing patient eligibility. We have been pressing for this vital work to be completed, both prior to 1st October last year, and since.

2.2. Some patients have reported travelling in vehicles without suitable clamps or fixings for wheelchairs.

- This, we have been advised by SECAmb was due to delays in the delivery of their new fleet of high standard vehicles, and also because many drivers transferred from the previous provider were not trained to drive such vehicles. SECAmb therefore had to source alternative vehicles for the interim period.

2.3. Patients have also reported concerns about driver attitudes and behaviour,

- Which were reported to and investigated by SECAmb and we have been told of the significant amount of driver training which has now been given to the transferred staff.

- We would also like to mention that we have received reports more recently of excellent service from many drivers.

2.4. Many patients have experienced problems and delays in getting through to both the Central Booking Service run by SCC and to SECAmb's Ambulance Control, and there has inevitably been confusion caused by having two phone numbers for bookings and enquiries.

- This we know is due to failure to implement and publicise a clear process for booking transport by patients themselves and by hospital reception staff.

2.5. Some patients have experienced failure of Patient Transport to arrive on time or not at all.

- This was due it seems to confusion and complexity of the current booking process, and patients therefore not knowing if a booking has been made and for what time.

- Although not what we originally agreed, a process has 'developed' since October last year, whereby patients can only book their first appointment and follow up's are booked by the hospital.

- This is another very unsatisfactory situation, exacerbated because the patients could not book transport themselves.

3. SOLUTIONS

The Patient Transport User Group has continued to meet frequently over recent months to ensure patient involvement in designing the solutions to the problems. The current situation, as we know it, is that :-

3.1. A new protocol for assessing patient eligibility for transport against the NHS criteria, is nearly finalised. This should improve assessment by the SCC Central Booking Service, and provide for

new technology to be developed to implement an electronic rather than a paper assessment process.

3.2. It has been agreed that patients will be allowed to book both their first and follow up appointments, unless they need or want the hospital to do it for them. This will give patients more control over the process and reassurance that a booking has been made.

3.3. It has also just been agreed that patients/ hospitals will use only one phone number (at SCC's CBS) for all bookings and enquiries, which will remove the current confusion.

3.4. SECAmb have progressed in their plans to train all staff, and to introduce their new fleet of vehicles, so the quality of service provided should improve.

3.5. What remains to be done is to provide clear guidance to patients, GP's and hospital staff on the new process, so that everyone knows the eligibility criteria, how to book and make enquiries, and the other services or assistance which are available if a patient is not eligible for NHS Patient Transport. We hope this will be done soon.

4. RECOMMENDATION

Members of the Health Scrutiny Committee are asked to note this report from patient representatives on the Patient Transport Service.

Carol Pearson
Chief Executive
Surrey Coalition of Disabled People 5th March 2013

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SURREY
COUNTY COUNCIL

Health Scrutiny Committee
14 March 2013

LINk Post-Stroke Rehabilitation Care Final Report

Purpose of the report: Scrutiny of Services/Policy Development

LINk will present its final report of an investigation into post-stroke rehabilitation services in the County.

Background:

1. In September 2012, the Committee looked at Stroke Services across the County. As part of the item, LINk had brought a patient perspective to the meeting to present his wife's trouble in accessing post-stroke rehabilitation services.

2. LINk proposed, and the Committee agreed, to undertake a research project into the availability and quality of post-stroke rehabilitation care across the County. Attached at **Annex 1** is the final report of this project.

Recommendations:

3. The Committee is asked to note the report from LINk, thanking them for their work on this project and to scrutinise post-stroke rehabilitation care in Surrey.

Next steps:

Identify future actions and dates.

Report contact: Leah O'Donovan, Scrutiny Officer, Democratic Services

Contact details: 020 8541 7030; leah.odonovan@surreycc.gov.uk

Sources/background papers: None

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A report of evidence gathered on the stroke pathway for Surrey residents after discharge from acute hospital. It is a simulation of how Local Healthwatch might give appropriate support to enable the Health Scrutiny Committee to carry out their scrutiny role from 1st April 2013

Surrey LINk/Shadow Healthwatch
STROKE PATHWAY PROJECT REPORT

For Health Scrutiny Committee

Jane Shipp. James Stewart.

CONTENTS

Executive Summary

Possible deficiencies in stroke services for the residents of Surrey detected by Surrey LINk and the Health Scrutiny Committee prompted this report. It was also prompted by the need to develop an effective Local Healthwatch in Surrey from 1st April that could gather evidence and communicate the views of patients, relatives and carers.

An effective Local Healthwatch will gather views, with trained volunteers who reach out and collect experience stories and carry out Enter & View visits; these will be underpinned with Freedom of Information Requests, to inform the HSC.

The Francis report 2013 has stated that Health Scrutiny Committees will need reports with comment and recommendations for actions, with local involvement in the development and maintenance of the healthcare system.

There has been an improvement in the quality of stroke care since 2008 but Surrey residents are still facing challenges in 2013. Improvements in Acute Care are not yet matched by progress in delivering more effective post-hospital support for stroke survivors and carers, progress needs to be accelerated.

Across Surrey stroke services varied in quality and accessibility, the challenge will be with the way the NHS is to be organised from 1st April maintaining and monitoring standards Surrey wide.

What did come across strongly was the importance for people of voluntary services such as The Stroke Association, Headway, TALK, Strokeability, Dyscover and local stroke clubs (not all named) in the stroke pathway.

The recommendations are made to raise the quality of stroke care, and to audit/ monitor progress and performance.

If the Local Healthwatch project approach and draft report meets with the Health Scrutiny Committee's approval then the next steps would be to produce a final report and action plan.

Introduction

There are many policy drivers for the improvement of stroke services, the National Stroke Strategy, Royal College of Physicians (RCP) National Clinical Guidelines for Stroke, National Institute for Clinical Excellence (NICE) quality standards for stroke and Care Quality Commission (CQC) report on stroke services.

The National Stroke Strategy published in 2007 by the Department of Health recognised that stroke was the country's third biggest killer. It was acknowledged that progress to ensure that lives are saved and disability reduced would take time to deliver but that there was no excuse for standing still. The strategy presented 20 quality markers to assist commissioners, stroke networks and service providers in judging the quality of their local services and a 10 point plan for action to guide those affected by stroke, their carers and the public in looking at the services available locally. This was the beginning of an ambitious agenda to deliver high quality stroke services from prevention right through to life-long support.

By 2010 the quality markers set out in the National Stroke Strategy were well established so during 2010 the Care Quality Commission used them to look at how services across the country helped people who have had a stroke after they leave hospital and how well services supported carers and family members, focussing on progress against the National strategy. In their 2011 Supporting life after stroke publication the data collected from the Surrey PCT area from the health and council services resulted in an overall assessment of performance of "Fair performing", with more areas of weakness than strength.

The 2010 NICE Quality Standards for stroke gave therapists a standard to work to deliver stroke rehabilitation, however, it was recognised by NHS Improvement that services were struggling to work out how to implement them. Their Mind the Gap report gave lots of ideas and methods to change and improve services in order to make the standards a reality with examples of how nine project sites across the country had redesigned services and the stroke pathway.

During 2012 people in Surrey who had had a stroke and their carers told Surrey LINk that their experience of care was confusing and uncoordinated; this is also reflected in the Stroke Association's 2012 report, Struggling to Recover. Individual service users and carers were not experiencing a seamless transfer of care as stated in quality marker 12 of the National Strategy and that local service commissioners did not have an understanding of the NICE standards. It was agreed that Surrey LINk working in partnership with Surrey County Council Health Scrutiny Committee would find a way of gathering evidence on the health and social care experiences of Surrey residents so they could be heard and understood.

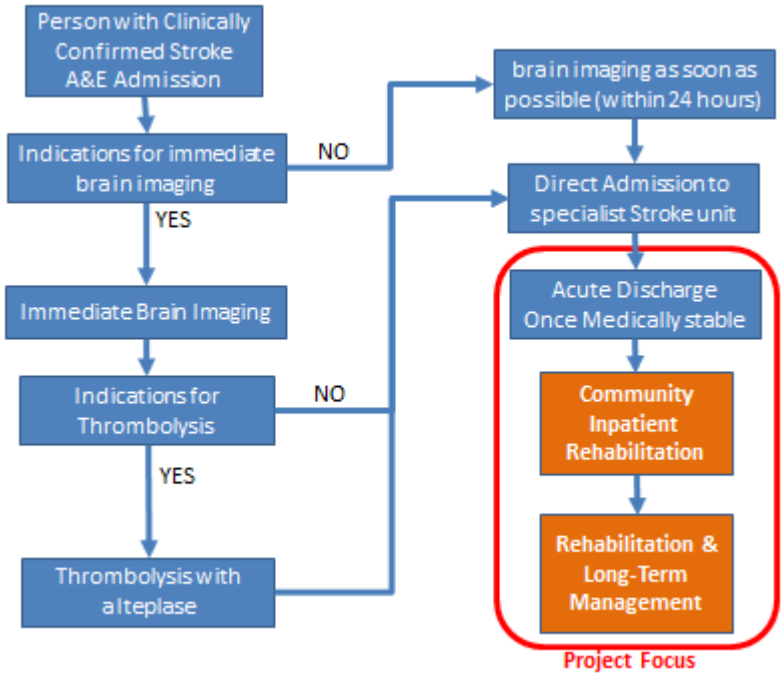
Project Process

At the September 2012 Health Scrutiny Committee meeting the committee heard the experience of a Surrey stroke carer presented with the support of Surrey LINk. A proposal by Surrey LINk to work on a project that would both look at the quality of stroke health and social care services in Surrey and simulate how Surrey LINk might work with the committee following the changes introduced by the Health and Social Care Act 2012 was agreed. The 2012 Act is to bring about structural reforms to end LINk and introduce Local Health watch from 1st April 2013.

The stroke project was introduced to explore a real experience that Local Health watch and the health and social care system might face in Surrey. A simulation to develop and establish an open and transparent Health watch process, gathering evidence of the stroke pathway drawn from Surrey residents experiences to influence and monitor the quality of stroke health and social care services in future.

A project gathering evidence for the whole stroke pathway beginning to end with all 20 quality markers would have been too large and take too long to report. The particular part of the pathway relevant to the carers experience story that the HSC had heard was quality marker 12 the seamless transfer of care, so this was the focus for the project. The carer's experience of the stroke pathway had been poor due to the lack of smooth transitions and transparent decisions.

Stroke Pathway



To build a picture of the stroke pathway starting at hospital discharge and the community in patient rehabilitation provided afterwards the project gathered evidence from four different sources.

- The individual
- Enter & View visits
- Patient stories
- Carers stories

A significant part of the project involved actively reaching out across Surrey to collect experience stories from people who had recovered from a stroke and find out their personal experiences of services. This entailed LINk volunteers and staff attending different stroke clubs and carers groups in the boroughs meeting with individuals who stepped forward to tell their story. Enter and view visits were carried out to the six community units commissioned by NHS Surrey to provide in patient stroke rehabilitation in Surrey. LINk volunteers took part in visits to Crawley Hospital, Ewell Cottage Hospital (NEECH), Milford Hospital, Haslemere Hospital (Godwin Unit), Woking Hospital (Bradley Unit) and Farnham Hospital. These visits looked at hospital facilities and found out how stroke rehabilitation was experienced by patients and service units. The findings and recommendations from these visits were reported to each service provider and will be made publicly available on the Surrey LINk website

The LINk volunteers were the authorised representatives of Surrey LINk, they were CRB checked, had ID and had undergone training. The twenty people who shared their experience stories told us that that they were keen to talk to LINk volunteers because they were independent. The experience stories covered eight areas of experience; with these eight quality elements present the stroke pathway would be seamless with smooth transitions and transparent decisions. These was then used to evaluate the evidence in the stories.

During the early stages of the project a press release was sent out to the local media to raise awareness and inform patients, service users and carers and the wider public. This gained publicity in newspapers and on the radio with articles in the Surrey Comet, Elmbridge Guardian and This is Local London. An interview with a stroke carer for Eagle Radio was broadcast to listeners across Surrey and Hampshire helped to raise awareness of stroke, its effects on people and the project.

Freedom of information requests were made to gather evidence of number of patients receiving in patient stroke rehabilitation, how many were under 65 years old, how many were over 65 years old, where they had been referred from, where they were discharged to, the average length of stay, bed occupancy and the number of stroke registers held by GPs.

Stroke Pathway Activity in Rehabilitation Units

Activity 2011-2012	NEECH Epsom/Ewell	Farnham	Godwin Unit Haslemere	Bradley Unit Woking	Milford	**Total**
Number of patients	23	49	10	66	32	**180**
Patients over 65 years	14	25	7	32	30	**108**
Patients under 65 years	9	24	3	34	2	**72**
Referred from acute hospital	All	All	All	All	All	**180**
Discharged home	18	36	5	48	16	**123**
Discharged to Nursing Home	3	8	2	11	10	**31**
Discharged to acute care	1	4	1	6	2	**14**
Unrecorded	1	1	2	1	4	**9**
Number of stroke/neuro beds	4	6	10	12	12	**44**
Average length of stay	47.3 days	35 days	36 days	47 days	47 days	Average 42.3 days

No information was made available from Crawley Hospital for Surrey residents

In a year (2011-2012) 180 Surrey stroke patients received community in patient stroke rehabilitation in 44 beds.

Stroke rehabilitation for Surrey residents who are under 65 years of age mainly takes place in the Bradley (Woking) and Farnham units with some at NEECH.

Stroke rehabilitation for Surrey residents over 65 years of age takes place at all the units.

Enter and View Visit to Crawley Hospital Stroke Unit Draft

Name and address of unit visited

Crawley Hospital
West Green Drive
Crawley
RH11 7DH

Day, Date and time of visit

Monday 29th October 2012 at 10.30am

People undertaking visits

Colin Slatter – Chair FPH LINk Group
Jane Shipp – Stroke Project

Details of service provider

NHS West Sussex – Julia Dutchman-Bailey

Type of service/unit

In patient Stroke Rehabilitation - NHS Surrey has advised Surrey LINk/Shadow Healthwatch that Crawley Hospital is one of the six providers that they commission a service from for Surrey residents

Reason for the visit to the Stroke Unit

The Surrey LINk/Shadow Healthwatch Stroke Project for Surrey County

Council Health Scrutiny Committee.

Pathway Information

Activity - April 2010 to March 2011 and April 2011 to March 2012, Surrey residents.

- The number of in patients who have received stroke rehabilitation.
- How many over 65 years?
- How many under 65 years?
- Where patients are referred from and the numbers
- Where patients are referred onto and the numbers
- Number of beds?
- Average length of stay?
- % bed occupancy

Information requested none received.

First Impressions of premises

Parking was limited

Reception was welcoming, staff were aware that a visit was to be made and had instructions of who to call. Good sign in, identity and authorisation processes. Met by Nicky Dowdswell the Admissions/Discharge Sister as the Matron was on annual leave.

Visiting times are 2- 4.30pm and 6.30 – 8pm

The Unit

Access to the unit on the 1st floor is by stairs and lift.

Ward has a conservatory and day room, there were no patients in these areas upon arrival. In this area there was a comprehensive range of patient and carer stroke information available

There are 18 beds that are used flexibly, three 5 bedded bays and three side rooms, the side rooms do not have ensuite facilities.

The ward has its own OT kitchen and Physio gym

There was suitable space and sufficient equipment including hoists Boards at each bed indicated patient's therapy plan but did not have the name of the patient

The Pathway
Surrey and Sussex patients are admitted to the ward from East Surrey Hospital. Patients below and above 65 years of age are admitted to the unit.

Therapy is available 5 days per week. There is a hairdresser and access to an interpreter
There is no psychology service, it was funded short term and has now stopped.
There is an MDT meeting weekly and the aim is that within 2 weeks of admission the patients have their treatment goals agreed. Patients hold a copy of their care plan and they are up dated weekly
Patients are referred to a Stroke Association Stroke Support Worker from East Surrey Hospital.

Observations
There was one patient observed in the gym practising the stairs with a physiotherapist and another later.
By the time of leaving at noon there were many patients all sat at tables for lunch, others had the choice of remaining by their bed. There were red trays and red jugs on the food trolley.

Conversations with staff and patients
Female patient – awaiting discharge that day her stay had been a good one she had achieved her rehab goals and was to have lunch first and then go on transport. She told us she had had an OT home visit and was expecting a visit at home later that day from a carer to see if she was OK.
Female patient – was making slow progress she felt this was not because of the rehab but because she is elderly and “these things take time”

There is pressure to reduce length of stay but this expectation is difficult because many of the patients on the unit had complex needs and were older especially since the introduction of Early Supported Discharge for Stroke.
There is no neuro community service at the weekends and packages of care do not start at the weekend
Continence is an issue when discharging patients, if not safe to toilet at night then a care home is the only option. Younger patients to have a rehab specific to them can go to a brain injury unit at Horsham but this would only be for the Sussex patients not Surrey patients.
Sussex PCT and Surrey PCT have different processes to follow, an example of

this is Continuing Care, Sussex require a checklist only and respond quickly coming to see the patient whereas Surrey there is a 2 week wait, more paperwork and they don't come to see the patient. Delayed discharge data does not show Surrey patients

Action Points

What to address, by whom and by when

Item	Action	By whom	By when
No Psychology	Put service in place	Sussex PCT	1/4/13
No FOA Information supplied for Surrey residents	Make information available when a FOA request is received	Sussex PCT	ASAP
Be able to address patients with limited speech by name	If agreed with patient put their name on board by the bed	Sussex PCT	1/4/13

Enter and View Visit to New Epsom & Ewell Cottage Hospital (NEECH) Stroke Ward

Name and address of unit visited

NEECH
West Park, Horton Lane
Epsom, Surrey

Day, Date and time of visit

Monday 29th October 2012 at 2pm

People undertaking visits

Colin Slatter – Chair FPH LINk Group
Jane Shipp – Stroke Project

Details of service provider
Central Surrey Health

Type of service/unit

In patient Stroke Rehabilitation - NHS Surrey has advised Surrey LINk/Shadow Healthwatch that NEECH is one of the six providers that they commission a service from for Surrey residents

Reason for the visit to the Stroke Unit

The Surrey LINk/Shadow Healthwatch Stroke Project for Surrey County Council Health Scrutiny Committee.
Pathway Information

Activity - April 2011 to March 2012, Surrey residents.

- 23 patients received stroke rehabilitation, in a year
- 14 patients were over 65 years
- 9 patients were under 65 years
- 5 patients were admitted from Epsom hospital, 1 from East Surrey hospital, 1 from Kingston Hospital and 2 from home
- 18 patients went home, 3 went to a nursing home, 1 to an acute hospital and 1 unrecorded
- The average length of stay was 47.3 days
- 100 % bed occupancy

Note- CSH responded to the information request promptly and accurately

First Impressions of premises

Parking was good
Ward reception was welcoming. Met by Mary Weller the Ward Sister.
Visiting times are all the time except meal times which are 12.30 – 13.30pm and 17.30 – 18.30pm.
Public transport for visitors could be difficult but as more houses are being built in the area more demand will be triggered for a bus service.

The Unit

The ward is on the ground floor.
There is a large dining/ day room with a view, it is a lovely setting. There are 4 beds for stroke/neuro rehab, the overall bed capacity is 21beds consisting of 3 six bedded bays and 3 single rooms, only 15 of the 21 bed capacity is commissioned.
There is a quiet room and suitable space and sufficient equipment on the ward.

There is an OT kitchen, the physio gym is an excellent facility well equipped with In patient and OP activity

The unit may have to move to Epsom Hospital because of subsidence

Observations

On the day of the visit 19 beds were open as there were 4 beds closed at Molesey Hospital for flooring to be replaced
The day room had tables set ready for patients to take meals together

There were several patients and therapists in the gym

Conversations with patients and staff

Female stroke patient and her husband – she had had a home visit this week and with the OT she and her husband were making plans for her discharge with the adaptations needed. Rehab had been hard work and her speech was difficult still, SALT would continue post discharge. She and her husband were having a good experience of rehab on the unit and praised it highly.

Male patient – had not had a stroke but was having neuro rehab for a long term condition he also reported that his rehab on the unit was excellent, the food was good too.

MDTs are not always attended by social services
6 days per week therapy would be better
There is a 1 year funded post for vocational rehab and return to work (funded by the network, whole system?)
Commissioning is still for historic pathway and this will be reviewed so that commissioning catches up with the integrated health and social care pathways that are being developed with a model for the whole of Surrey.
A positive aspect of a move to Epsom would be the location next to the stroke ward and co-location with the community team.

Action Points

What to address, by whom and by when

Item	Action	By whom	By when
Awaiting NHS Surrey and CCG decision to support move to Epsom Hospital due to subsidence	Ensure the good patient experience, especially the excellent gym is maintained when decision is made to move to another site. CSH have ensured there are contingency arrangements in place if condition of buildings worsens	Central Surrey Health	During 2013
Accessible Stroke patient/carer information	Currently under review to be made available in areas	CSH	Completed available in Poplars

Enter and View Visit to Milford Hospital Stroke Ward

Name and address of unit visited

Milford Hospital
Tuesley Lane
Milford
Surrey

Day, Date and time of visit

Thursday 1st November 2012 at 10.30am

People undertaking visits

Margaret Jago – West LINk Group
Jane Shipp – Stroke Project

Details of service provider

Surrey Community Health

Type of service/unit

In patient Stroke Rehabilitation - NHS Surrey has advised Surrey LINk/Shadow Healthwatch that Milford Hospital is one of the six providers that they commission a service from for Surrey residents

Reason for the visit to the Stroke Unit

The Surrey LINk/Shadow Healthwatch Stroke Project for Surrey County Council Health Scrutiny Committee.

Pathway information

Activity - April 2011 to March 2012, Surrey residents.

- 32 patients received stroke rehabilitation, in a year
- 30 patients were over 65 years
- 2 patients were under 65 years
- All patients were admitted from RSCH
- 16 patients went home, 10 went to a nursing home, 2 to an acute hospital and 4 unrecorded
- The average length of stay is 47 days
- 13 % of total bed occupancy

First Impressions of premises

Parking was good. Public transport for visitors is difficult.
Met on Holly Ward by Angela Williamson the sister in charge who was very helpful.

The Unit

Holly Ward has 17 beds is on the ground floor with a dining room and a lovely view. There is a physio gym and OT kitchen.
The corridor in the ward had boxes etc requiring storage

The Pathway

Surrey patients are admitted to the ward from RSCH. Patients are usually above 65 years. The minimum wait for a bed to become available is about a week.
There were 6 patients receiving stroke/neuro rehabilitation on the day of the visit, these were located amongst the rest of the patients on the ward, not as a unit, there can be up to 12 stroke patients.
There is an MDT meeting/ and a consultant ward round weekly
Therapy is available 5 days per week
There is psychology, aromatherapy and a hairdresser available
Weekend medical cover is by GPs so transfers are avoided
Rehab period offered is 42 days this may be longer or shorter
Clinics to provide a 6 weeks follow up review have just started to be available at Milford.

STED team (early supported discharge for stroke patients) located at Milford Hospital. Team staffed with part time SALT, 1.5 WTE OT, part time Physio, 1 Nurse, 3 rehab assistants and admin. At the time of the visit there was a nurse and physio vacancy. Service is provided 8-5 M-F with some visits at weekends, the maximum caseload for the service is 20 patients. The service is available for a maximum of 12 weeks and patients are then referred to social care
STED do the 6 month post stroke review of patients who are theirs, rest are dealt with by the Stroke Coordinator
Patients are referred onto the Stroke Association Support Worker.

Observations
There were boards above the beds with the patient's therapy programme but no Estimated date of discharges (EDD) completed.
Cedar Ward is closed.
The physio gym was busy with several therapists and patients
Some patients having lunch together in the dining room at the end of the visit

Conversations with patients and staff
Female patient – she was from Cranleigh, she was able to choose her food from a menu and enjoyed the food. She said her therapy was making her busy which she needs in order to get better as she had been very unwell. She needed to drink often because of her kidney condition and the water was sometimes out of reach
Male patient – his rehab morning had been to get up and dressed and go to physio

Care Managers are now co-located part time to pick up social care referrals which is an improvement but still not really part of the team a designated case manger would improve continuity – this is now in place
Section 2 referrals have now stopped
The OTs and physios work well together
The gym is not big enough for 12 therapists and a room for the OTs to work with individuals and groups is needed that is quieter.
The Day Unit is not integrated with the rest of the unit and the gym was empty at the time of the visit – therapists to be made aware that this space can be used also

Action Points

What to address, by whom and by when

Item	Action	By whom	By when
Review use of space available in Cedar Ward, as well as space available in the Day Unit	More space is required to provide rehab therapy for in patients there is need for an area quieter than the gym. Make the 6 bedded bay in Cedar Ward available for OT rather than storage. Therapists to be made aware that Day Unit space can be used also.	Virgin Care	1/5/13
Tidy Holly Ward corridor	Remove and store boxes regularly	Virgin Care	1/4/13
Estimated Date of discharge (EDDs)	To be filled in on boards by patient's beds.	Virgin Care	1/4/13

Enter and View Visit to Godwin Unit, Haslemere Hospital

Name and address of unit visited

Haslemere Hospital
Surrey

Day, Date and time of visit

Thursday 1st November 2012 at 2pm

People undertaking visits

Margaret Jago – West Surrey LINk Group
Peter Hughes – ASPH LINk Group
Jane Shipp – Stroke Project

Details of service provider
Surrey Community Health

Type of service/unit

In patient Stroke Rehabilitation - NHS Surrey has advised Surrey LINk/Shadow Healthwatch that Haslemere Hospital is one of the six providers that they commission a service from for Surrey residents

Reason for the visit to the Stroke Unit

The Surrey LINk/Shadow Healthwatch Stroke Project for Surrey County Council Health Scrutiny Committee.
Pathway Information

Activity - April 2011 to March 2012, Surrey residents.

- 10 patients received stroke rehabilitation, in a year
- 7 patients were over 65 years
- 3 patients were under 65 years
- All patients were admitted from RSCH and FPH
- 5 patients went home, 2 went to a nursing home, 1 to an acute hospital and 2 unrecorded
- The average length of stay is 36 days
- 7% of bed capacity bed is for stroke patients

First Impressions of premises

Parking was reduced due to roofing works.
Reception was welcoming with good sign in, identity and authorisation processes.
Visiting Times 2- 4.30pm and 6.30 – 8pm
We met Chris Papworth, Matron.

The Unit

The Godwin Unit has 10 beds and is split between the male and female wards which are on the ground floor with access to a garden.
Physio gym, OT Dept. There were 6 neuro/stroke patients on the day of the visit. Patient and carer stroke information was available

There is suitable space and equipment. Boards by each of the beds indicate the patient's therapy plan with estimated dates of discharge (EDDs)

The Pathway

Patients come from Hants and W Sussex as well as Surrey.
Surrey patients are admitted to the ward from RSCH. Patients are above 65 years and below 65 years.
There was 1 male bed available on the day of the visit.
Rehab is offered for 42 days, therapy is available 5 days per week
A psychologist and psychology student are available
MDT meetings are weekly with a Care Manager present
There has been no Consultant for the neuro rehab patients for over a year, all the patients are looked after by the Haslemere GPs

The unit admits patients 7 days per week but cannot discharge at the weekends in the same way.

Observations
There were several patients and therapists in the gym during the visit

Conversations with patients and staff
Female patient – not a stroke patient, had come from St Georges Hospital described her rehab programme and the improvement she had made because of the expert therapy, she was looking forward to discharge but had encountered problems with wheelchair provision because of a Surrey/Hants border issue, provided by Hants but they would not deliver as her address was Surrey. Group exercise classes were especially good and she had done visualisation and relaxation. Had to rush off to OT.
Male patient- not a stroke patient, he praised the clinical expertise of the therapists in treating his long term condition. Together in a unit with the other neuro rehab males had been beneficial as they compared notes and encouraged one another. He said the food was good and enough too as doing rehab increases appetite he did not approve of powdered potato.
Male patient – not a stroke patient, he praised both the rehab for his long term condition and the food and being able to sit together at mealtimes.
The experience is good for patients at the unit they expressed sorrow that it was to be moved
Social Services have begun to return to being based at Haslemere so there will be practitioners in place.
There are some nursing vacancies with staff deciding where they might work when the unit closes and moves to Woking Hospital
The bed number was 16 but there have been up to 24 in the past

Action Points
What to address, by whom and by when

Item	Action	By whom	By when
Unit move to Woking Hospital	Maintain good patient experience and staff neuro expertise	Virgin care	2013?

Enter and View Visit to the Bradley Unit Woking Hospital

Name and address of unit visited

Bradley Unit
Woking Hospital
Surrey

Day, Date and time of visit

Monday 5th November 2012 at 11am

People undertaking visits
Gareth Jones – West Surrey LINk
Margaret Jago - West Surrey LINk
Jane Shipp – Stroke Project

Details of service provider
Surrey Community Health – to be branded Virgin Care from 10th December 2012.

Type of service/unit

In patient Stroke Rehabilitation - NHS Surrey has advised Surrey LINk/Shadow Healthwatch that the Bradley Unit is one of the six providers that they commission a service from for Surrey residents

Reason for the visit to the Stroke Unit

The Surrey LINk/Shadow Healthwatch Stroke Project for Surrey County Council Health Scrutiny Committee.

Pathway Information

Activity - April 2011 to March 2012, Surrey residents.

- 66 patients received stroke rehabilitation, in a year
- 32 patients were over 65 years
- 34 patients were under 65 years
- patients were admitted from ASPH, RSCH
- 48 patients went home, 11 went to a nursing home, 6 to an acute hospital and 1 unrecorded
- The average length of stay was 47 days
- 17% of total number of beds are for stroke
- % bed occupancy not supplied

First Impressions of premises

Parking was good. Public transport good, railway station and buses. Reception was welcoming with good sign in, identity and authorisation processes. There was an information board with carer's information and "recommend to a relative or friend" questionnaires available.
Met by Annie Christie the Matron.

The Unit

The ward is on the first ground floor it is secure, security is required for the more cognitively impaired patients.
There are 12 beds, 4 double rooms and the rest are single there are ceiling hoists in all the rooms.

Co-located there is a quiet room with computers, a physio gym and OT kitchen, a group day room and a new wet room.

The clocks in the unit were excellent for orientation, with date and time and very visible

The Pathway

Surrey patients are admitted to the unit from ASPH, RSCH and FPH hospitals both under and over 65 years of age
There is a waiting list

Admissions are planned and at the time of the visit there were 5 patients on the waiting list for admission, each patient is assessed for suitability before admission and there is a detailed referral form
There is an MDT meeting weekly with social services present, there is a care manager linked to the unit from the two at the Woking Hospital site. The aim is that within 2 weeks of admission the patients have their treatment goals agreed. Patients hold a copy of their care plan updated weekly, to update more frequently is difficult. Patients have a key worker who is a therapist. EDDs are patient specific
Therapy is available 5 days per week. The unit is Consultant led.
Psychology is available and a Disability Councillor
The rehab period target is 42 days it may be longer or shorter
The community rehab team is co-located at Woking Hospital providing 6 weeks rehab at home post discharge gives continuity.
There is a patient information meeting to which carers are invited.
A carers support group is available half an hour before visiting time at 2.30pm.
Families are encouraged to be around the unit
There is vocational therapy for return to employment
The pathway is due to change when the Godwin Unit is closed and all patients will go to the Bradley Unit instead

Observations
At lunchtime the patients were sat together at a table in the dining room for lunch
Wheelchair users were able to move around the unit independently
There was a comprehensive range of patient and carer stroke information available

Conversations with patients and staff
Male patient – his experience of rehab in the unit was very good especially the therapy programme and the food
The unit is fully staffed, a recruitment drive was held to fill nursing vacancies, morning
shift has 4 nurses 1 trained and 3 untrained, there are 2 nurses at night
It is not clear yet if nurses will move from the Godwin Unit
The unit would be capable of admitting a mother for rehab, with baby and for husband to stay
LINk had been informed that the unit did not admit smokers but this is not true,

smoking cessation is encouraged during admission The move to Victoria Ward to accommodate more patients when the Godwin Unit closes will require such things as security and ceiling hoist to be put in Place. There will be 20 beds. The Bradley Unit name is to remain so all the patient information does not have to be changed

Action Points

What to address, by whom and by when

Item	Action	By whom	By when
Project to change service to accommodate Godwin Unit patients	Ensure rehab service is replicated to same standard with involvement of users and carers in the project	Virgin Care	During 2113

NOTE : On 7th December 2012 the Godwin Unit moved from Haslemere Hospital to the Bradley Unit at Woking Hospital.

The action now will be to carry out an Enter & View visit to the larger Bradley Unit during March 2013.

Enter and View Visit to the Stroke Ward Farnham Hospital

Name and address of unit visited

Farnham Hospital
Farnham
Surrey

Day, Date and time of visit

Thursday 8th November 2012 at 2pm

People undertaking visits
Gareth Jones – West Surrey LINk
Peter Hughes - ASPH LINk
Jane Shipp – Stroke Project

Details of service provider
Surrey Community Health

Type of service/unit

In patient Stroke Rehabilitation - NHS Surrey has advised Surrey LINk/Shadow Healthwatch that Farnham Hospital is one of the six providers that they commission a service from for Surrey residents

Reason for the visit to the Stroke Unit

The Surrey LINk/Shadow Healthwatch Stroke Project for Surrey County Council Health Scrutiny Committee.

Pathway Information

Activity - April 2011 to March 2012, Surrey residents.

- 49 patients received stroke rehabilitation, in a year
- 25 patients were over 65 years
- 24 patients were under 65 years
- patients were admitted from FPH and RSCH
- 36 patients went home, 8 went to a nursing home, 4 to an acute hospital and 1 unrecorded
- The average length of stay is 35 days
- 11% of bed capacity is for stroke patients

First Impressions of premises

Parking was good, a modern building.
Reception was welcoming and efficient, good sign in, identity and authorisation processes.
Visiting times 2pm – 4.30pm and 6.30pm – 8pm
Runfold ward was well signposted on the 1st floor.
We met Daphne Denhayi the ward sister, Amanda Edwards and Ruth Whiting

The Unit

The stroke unit is on Runfold Ward, all single rooms.
There are 6-10 beds available for stroke patients, there were 10 on the unit when we visited.

There is a sitting room with a phone for patients to use it is shared with SALT

The OT kitchen and a second physio gym are located on another floor where there is a garden

There is space and sufficient equipment

Observations

The therapy gym was well used with several therapists and patients
There was one patient using the sitting room

Conversations with patients and staff

Female patient – she had a stroke post cardiac care at FPH, was just starting rehab and felt she was doing well and that the rehab she was experiencing was good she had a rehab timetable and was to have an OT home visit soon

Breakfast club and coffee morning are held in the sitting room it is important for patients to come together as they are in single rooms

At discharge better organisation between Hants and Surrey Social Services would smooth the pathway if Surrey could act as co-ordinator for Hants who are not present in the hospital

There is much confusion about how many beds are commissioned at Farnham, by whom and what they are designated for.

Not all the beds are commissioned.

Action Points

What to address, by whom and by when

Item	Action	By whom	By when
What beds are commissioned and for what	Review and provide clarity	Virgin Care	1/4/2013
Social services coordination	Agree a process whereby Surrey can coordinate for Hants	Surrey and Hants SS	1/4/13

Quality Marker 12 – Seamless Care

For a seamless stroke pathway of care a workable plan with the full involvement of the individual, (carer and family where appropriate) that is responsive to the individual's particular circumstances and needs should be developed by health and social care services together with other services such as transport and housing.

Evaluation of the experience stories

1. How smooth the discharge from acute hospital was

Experiences of discharge were mostly good and well organised; five poor experiences were from East Surrey Hospital.

2. The specialist rehabilitation provided

The experience of rehabilitation was good at the Bradley and Farnham units. Provision of therapy is only 5 days per week at all units. Rehab provision has improved over the last 5 years. Some experiences were that of "fighting" for rehab in the community, two people in east of the county had their rehab stopped at 6 weeks when they felt that needed more. Five people were purchasing rehab privately. Psychology provision is provided across the county except the Crawley area, this is an issue.

3. Help for family and carers

The experiences of being offered help in a timely way were poor; some had had no help and had found it for themselves over time. The Stroke Association Care Support Workers were praised as the "only help" that had been offered. Carers experiences have been difficult to collect and we will continue to try for more.

4. Care of individual needs

The experience was that voluntary organisations such as Strokeability and the Stroke Association Care Support Workers were doing good work with individuals. Two people were experiencing problems with advocacy for return to work. There is a need for more psychological support for people and their carers and more group activities.

5. Help to return to family life

The experience was that more help is needed, the main issue was transport, one person used Dial a Ride, some people had Blue Badges and it was the Stroke Association Support Workers that had helped with this.

6. Reviews weeks/months after the stroke

The experience of 6 week/month reviews taking place was poor.

7. Information given

The experiences of being given information in a timely way were poor. People were missing out on vital sources of (free) support and information they wanted to be given stroke information right from the beginning of the pathway in hospital and for it to include voluntary organisations. Most information had been provided by the Stroke Association Care Support Workers.

8. Choices given

The experiences of being given choice were very poor; most felt they had had no choice.

Although it was acknowledged that improvements in stroke services have been made over the last 5 years the overall experience was of a group of people who due to lack of information, a named person, a care plan and reviews did not know what support they could expect as stroke survivors and carers. Once discharged from acute care the reduction in the level of therapy causing a gap in their rehabilitation programme and progress. For all of them returning home was by no means the end of the journey.

Stroke Registers

GP Practice	Locality	Over 65 years	Under 65 years
Ashford Health Centre	Ashford	11	7
Stanwell Road Surgery	Ashford	72	20
Studholme Medical Centre	Ashford	216	54
Park House Surgery	Bagshot	88	22
Ahmad M & Partners	Banstead	177	34
Longcroft Surgery	Banstead	222	37
Gordon Road Surgery	Camberley	161	33
Heatherside Surgery	Camberley	47	12
Caterham Valley Medical Practice	Caterham	103	26
Townhill Medical Practice	Caterham	232	66
Cranleigh Medical Practice	Cranleigh	271	15
Dorking Medical Practice	Dorking	179	26
Medwyn Surgery	Dorking	137	24
Riverbank Surgery	Dorking	32	7
Ashley Centre Surgery	Epsom	109	23
Derby Medical Centre	Epsom	184	31
Old Cottage Hospital Surgery	Epsom	401	87
Lantern Surgery	Esher	38	9
Farnham Centre For Health	Farnham	58	14
Farnham Dene Medical Practice	Farnham	115	36
Ferns Medical Practice	Farnham	155	17
Holly Tree Surgery	Farnham	90	10
Frimley Green Medical Centre	Frimley Green	176	26
Binscombe Medical Centre	Godalming	146	25
Mill Medical Practice	Godalming	174	32
Pond Tail Surgery	Godstone	23	12
Fairfield Medical Centre	Great Bookham	221	27
Austen Road Surgery	Guildford	59	13
Dapdune House	Guildford	110	24
Guildowns Group Practice	Guildford	197	43
Merrow Park Surgery	Guildford	119	24
Shere Surgery and Dispensary	Guildford	78	27
Wonersh Surgery	Guildford	179	28
Stoneleigh Surgery	Epsom	13	4
Smallfield Surgery	Horley	94	27
Wayside Surgery	Horley	48	7
Horsley Medical Practice	Leatherhead	136	14

Greystone House Practice	Redhill	137	31
Hawthorns Surgery	Redhill	161	26
Holmhurst Medical Centre	Redhill	112	83
Moat House Surgery	Redhill	138	37
Woodlands Surgery	Redhill	89	33
Wall House Surgery	Reigate	184	21
Hythe Medical Centre	Staines	50	21
Knowle Green Surgery	Staines	67	16
St Davids Family Practice	Stanwell	129	51
Thorkhill Surgery	Thames Ditton	72	19
Elizabeth House Medical Practice	Warlingham	93	16
Parishes Bridge Medical Practice	West Byfleet	184	32
Whyteleafe Surgery	Whyteleafe	53	11
Witley Surgery	Witley	100	18
Heathcot Medical Practice	Woking	169	37
Sheerwater Health Centre	Woking	22	9
Villages Medical Centre	Woking	81	20
Westfield Surgery	Woking	128	35
Auriol Medical Centre	Worcester Park	42	7
Shadbolt Park Surgery	Worcester Park	51	17

The Freedom of Information request to GP Surgeries met with a response of over 40%

There are 6,690 stroke patients over 65 years on a stroke register

There are 1,739 stroke patients under 65 years on a stroke register

Male under 65 years. Stroke in July 2012

1. How smooth the discharge from hospital was

He was in East Surrey hospital for 2 weeks. Discharged at 7pm in the evening and because the wait for drugs from Pharmacy was so long he had to return to the hospital the next day to collect them and this required him to catch 2 buses which was very difficult.

2. The provision of specialist rehabilitation

This was provided in the hospital by therapists, physiotherapy and OT. The kitchen where he made a cup of tea was the staff room and it was not clean and tidy, a poor facility for assessment.

A physiotherapist was due to visit him at home (from Oxsted) but this did not happen.

Available 5 days per week

3. Help for family members and carers

Lives alone

4. Care of individual needs

Return to work most important to resolve, has financial problems with mortgage payments. He has been to Access for Work advocacy help at the council and the Job Centre and is on statutory sick pay only.

5. Help to return to family life and leisure

From the Stroke Association Support Worker East Surrey

6. Reviews weeks/months after stroke

No review at 6 weeks. 6months review would be due in Jan 2013

7. Information given

None, promised but not received from E Surrey and CAB

8. Choices given

No choice has to return to work due to financial issues cannot live on £81 per week.

None, feels that nothing is getting done for return to work.

Patient Experience Story – Stroke Pathway Project

Male under 65 years. Second stroke in 2012

1. How smooth the discharge from hospital was

Two admissions to two different hospitals

In East Surrey hospital, Chaldon Ward is a much better stroke ward than the previous one, an improvement, discharged to Crawley Hospital.

St Peter's Hospital was good, discharged to Bradley Unit, Woking.

2. The provision of specialist rehabilitation

Ist stroke, rehab at Woking, Bradley Unit, excellent all rehab should be like this, especially for the younger stroke victims.

2nd stroke, rehab at Crawley Hospital. It was too big and with too many ages, old as well as young. Not enough staff often patients had to wait a long time for bell to be answered.

Available 5 days per week?

3. Help for family members and carers

Care for 6 weeks was not enough, then there is nothing or you pay for it.

4. Care of individual needs

He has employed his own personal trainer at the Redhill stroke gym.

Has speech problems as was not told about DISCOVERY found out later.

5. Help to return to family life and leisure

He was able to return to work after 1st stroke for 3 days per week then became sick again. Has been to the CAB but needs an advocate to help with work issues and his rights as they are trying to get rid of him.

6. Reviews weeks/months after stroke

6 week review when carers stopped.

7. Information given

From the Stroke Association Support Worker.

About the YMCA in Redhill has a stroke gym and Pilates

8. Choices given

None and there is no join up of what provided

Male over 65 years. Stroke in Sept 2010 and July 2012

1. How smooth the discharge from hospital was

From East Surrey Hospital to Crawley Hospital and then home was good.

2. The provision of specialist rehabilitation

Physiotherapy at home and then this stopped at 6 weeks, still has poor balance and uses a stick.

The Stroke Association Support Worker visited at home

Provided 5 per week

3. Help for family members and carers

Lives with wife, no help offered.

4. Care of individual needs

Once you are out of hospital you are on your own

GP has been useless

Worries about another stroke

5. Help to return to family life and leisure

He has been depressed. The Stroke Group (organised by the Stroke Association Support Worker) are the only ones who understand.

6. Reviews weeks/months after stroke

6 weeks attended out patients clinic at the hospital and had to wait 2 hours.

7. Information given

At the outpatient appointment they promised to send literature but this never arrived.

8. Choices given

None. Strokes are life changing; there is a big adjustment to make

Male under 65 years. Stroke in August 2012

1. How smooth the discharge from hospital was

Was blue lighted from East Surrey Hospital to St Peters Hospital because there were no ITU beds and then transferred back to East Surrey. Was on Chaldon Ward for 3 weeks.

Fell at home on the first day home, carers came next day after discharge but they were not needed as he has a wife and they had coped alone on the first day.

2. The provision of specialist rehabilitation

Physiotherapy at home was good but this stopped at 6 weeks, he still needs another stick and a wheelchair for long distances.

Achieved his goal of being able to do the stairs

Available 5 days per week

3. Help for family members and carers

Help to fill in forms, for example benefits. He is on incapacity benefit at the moment.

4. Care of individual needs

He wants to be able to drive.

Purchased a urine bottle for himself, it was promised but didn't happen

5. Help to return to family life and leisure

Would like a wheelchair to go out with the family further distances

6. Reviews weeks/months after stroke

6 weeks review then rehab at home stopped

7. Information given

Physiotherapist supplied information on the Stroke Association Support Worker

8. Choices given

No choice about having carers at home when they managed without, what was really needed was more rehab at home.

Female under 65 years. Stroke caused by heart condition

1. How smooth the discharge from hospital was

No problems whatsoever, all good.

Was at the Royal Surrey County Hospital – Stroke Ward, had stroke consultant and cardiologist support.

Physiotherapy and psychology sessions offered.

Excellent provision.

2. The provision of specialist rehabilitation

Excellent. Home stroke team (Stroke Early Supported Discharge) available constantly, the service offered was excellent.

Rehabilitation offered and sessions taken, all excellent.

Available 5days per week

3. Help for family members and carers

Other help offered and appreciated but not needed as Stroke Early Supported Discharge Team helping. Had Surrey Help in Home, walking children to school, getting running and (exercise) again

4. Care of individual needs

Good. Offered help in home and with personal hygiene

5. Help to return to family life and leisure

Good, although not needed

6. Reviews weeks/months after stroke

6 weeks review main question remaining is why the stroke happened. No answers as yet, understandably.

7. Information given

Personal experience is the mental side of my stroke – affected me mentally more than physically. Psychology offered.

8. Choices given

Yes, given as many choices for situation

Patient Experience Story – Stroke Pathway Project

Male over 65 years. Stroke March 2012

1. How smooth the discharge from hospital was

East Surrey Hospital, perception of staff at hospital was that NHS care is 'free so what do you expect'. Had to fight to get therapy as often as they did, he received therapy everyday whilst at hospital and this was very disciplined.

First time he has accessed NHS and the stroke was very sudden and unexpected.

Patient was told discharge had been arranged 2 weeks prior to discharge date.

The patient had been fitted with peg for feeding & medication administration as swallowing difficult. When he arrived home food had not been organised, no key safe installed, and discharge was very disorganised.

MDT team meeting was held with all involved soon after discharge, community team quickly resolved these issues and therapy started.

No discharge letter given whilst at hospital, the patient was told it had been sent to his GP and to request copy from his GP. The patient had to phone the GP to get a copy.

2. The provision of specialist rehabilitation

Physiotherapy, OT & SALT was provided for 12 weeks 5 days a week, this then stopped with no on-going therapy provided and no Dietician oversight.

Available 5 per week

3. Help for family members and carers

Wife has suffered a stroke and now in hospital, she has had a history of TIA since 2009, aspirin was prescribed.

She was due to be discharged from hospital to a care home on 29/11/12, choices have been given of care homes and the husband is due to visit to review choices.

The Stroke Association have been excellent in providing support, not aware of any other support being provided.

4. Care of individual needs

A Care support worker is still providing help 2 times a day but service is poor, they can turn up at any time and he has to get up early in morning in anticipation of their arrival. They are very quick and are in and out in few minutes, they blend the food and state they have feed the patient but he feeds himself and administers medication. There is no provision of household support, housework, laundry etc

Issues have been raised with carers manager but no action taken.

Stroke Association have given lots of help and support to organise benefits and disability badge etc.

5. Help to return to family life and leisure

No transport provision for community access, friend drives him on Mondays to stroke club. No access to community or help with transport to hospital appointments.

Patient takes taxi to hospital to visit wife.

6. Reviews weeks/months after stroke

None

7. Information given

None

8. Choices given

None

Any other notes or comments

GP is very difficult to book appointments with and can take weeks, also problems with blood test machine patient has to get taxi (£30 return) to GP surgery to have test with machine and papers.

Male under 65 years. Stroke in October 2011

1. How smooth the discharge from hospital was

He was admitted to FPH, stayed for 10 days making good progress. Discharged to Farnham hospital all went well.

2. The provision of specialist rehabilitation

At Farnham he had physiotherapy and speech therapy. Currently attends as an outpatient 3 weekly, making good progress speech now normal.

OT home visit equipment and adaptations done.

Available 5 days per week

3. Help for family members and carers

None required

4. Care of individual needs

Attends Woking Strokeability, gym and hydrotherapy weekly

Has had private physiotherapy

5. Help to return to family life and leisure

Driving, assessed at Queen Elizabeth Foundation (QEF). Not eligible for a Blue Badge which is a major problem as he needs to open the car door fully to get out. He requires a wheelchair for long distances.

6. Reviews weeks/months after stroke

At Farnham Hospital when he attends as an outpatient.

7. Information given

Feels that in hospital he should have been given details of voluntary or other organisations in the area, there should be a list. Recommended ARNI a private charity for stroke

8. Choices given

Was able to make choices himself as he is “well off”

Male 65 years. Stroke in January 2011

As told by carer

1. How smooth the discharge from hospital was

He was in FPH, stayed there for a month. Discharged to the Bradley Unit, Woking Hospital, his stroke was very severe.

2. The provision of specialist rehabilitation

Had 5 months rehabilitation at the Bradley Unit, physiotherapy and OT, Speech Therapy began but was stopped. OT did a home visit and environment made suitable for wheelchair and shower equipment loaned.

Available 5 days per week?

3. Help for family members and carers

Wife has Disability allowance to help with car costs, she has Multiple Sclerosis

4. Care of individual needs

Also has a long term condition Multiple Sclerosis. Has had a 10 days at Bagshot park private rehabilitation centre at a cost of £2,300, to have physiotherapy at home is not safe.

5. Help to return to family life and leisure

Wheelchair provision has been a big problem. Loaned basic wheelchair is unsuitable it has poor back support and wife had to remove right hand propelling wheel to get through downstairs bedroom door. Wheelchair service in Guildford have taken over 4 months to provide an adequate wheelchair, it is due soon.

Transport is difficult as wife cannot transfer him into a car, neighbours do help. Dial a ride comes 3 times per week to take him to Disability Initiative in Camberley.

6. Reviews weeks/months after stroke

Has an appointment with the Psychologist at FPH

7. Information given

Yes.

8. Choices given

Yes

Female under 65 years Stroke in 2005

1. How smooth the discharge from hospital was

She was in RSCH for 2 weeks. 4 days in ITU. Really cannot remember very much has poor memory due to the stroke

Her balance was very affected and has vertigo so when she was sent home her husband wheeled her out of the hospital in a wheelchair that he had borrowed

2. The provision of specialist rehabilitation

None.

It was assumed that her husband would take care of her even though he had a full time job

She needed care as she was tired, had poor memory and could hardly walk

3. Help for family members and carers

Her husband did not have help, when he returned to work he would make the lunch before he left and then ring her to remind her to eat it, her memory was so bad she would forget otherwise

4. Care of individual needs

Has had hearing tested as her right ear and hearing have been affected

5. Help to return to family life and leisure

After 4 months off work she returned and could not cope. She requested early retirement but this was refused. Occupational Health said she should not drive so she had a taxi for a while and then 8 months later she was allowed to retire

6. Reviews weeks/months after stroke

Has not had any review, her GP is not good

A six week review and a 6 month review?

7. Information given

Found Headway in Guildford herself in 2010

Going to the drop in at Headway gets her out of the house

8. Choices given

Does not think that she has had any choice

Male under 65 years. Stroke in November 2011 and January 2012

1. How smooth the discharge from hospital was

He was discharged from FPH followed by an admission of 5/6 weeks to the Bradley Unit, Woking for rehabilitation, no problems mentioned.

2. The provision of specialist rehabilitation

Was at the Bradley Unit for 6 weeks, the experience was good

Had a home visit with therapists prior to discharge

The speech therapy he received was good

Available 5 days per week

3. Help for family members and carers

No, was he supposed to ask for this?

His partner visited him constantly when he was at the Bradley Unit.

4. Care of individual needs

Currently he has home visits from a physiotherapist and a District nurse.

Attends hospital to see a neuropsychologist

5. Help to return to family life and leisure

Was at home for 24 hours every day when first discharged which he did not like, he has now progressed to driving himself to shop more or less daily, the car is essential as he can only walk 50 yds. Not clear if there was help with this and for example if there had been some advocacy to obtain a blue badge.

6. Reviews weeks/months after stroke

Not clear in the report

A six week review and a 6 month review?

7. Information given

May be too soon for information on employment, not clear what other information he might have been received to date

8. Choices given

Chose to be discharged home as soon as possible from rehabilitation

Female over 65 years Stroke in 2009 and 2010

1. How smooth the discharge from hospital was

She had a TIA and was admitted to Frimley Park Hospital for 5 days and later returned for further checks for 4 weeks and had a stroke during that period. Another 3 weeks in hospital. In 2010 she had another stroke. The second stroke also left her with epilepsy. Had Physiotherapy\Occupational Therapy following her first stroke at Frimley Park Hospital but after her second stroke “they didn’t want to know” and she “felt like a leper”. Transferred to Farnham Hospital for rehab

2. The provision of specialist rehabilitation

She went to Farnham for assessment though this focussed on her speech, which is fine, and not on mobility which was not good.

She did not want to stay in Farnham so went home.

Nothing special, the OT visited and made recommendations e.g. a stairlift which her husband installed.

Provided 5 days per week

3. Help for family members and carers

Her husband is retired and acts as carer.

Limited help there was a wide selection of stroke related leaflets in Frimley Park Hospital but it relied on relatives to sort them. Not much information was given by the physiotherapist. Husband was not aware of the need for him to register as a carer with his GP. He picked up from the Stroke Association information on the Surrey Heath Carers Association which has been very helpful they should have information in the hospital.

4. Care of individual needs

Her needs were like those of many stroke victims – lack of movement is particularly difficult and she cannot now read or cook.

5. Help to return to family life and leisure

This was mainly in terms of adaptation of the house (helped by having a husband experienced in building)

9. Reviews weeks/months after stroke

The last contact she had regarding her stroke was when she was copied a letter from FPH to the GP a year ago. She attends GP surgery to have dressing changed.

A six week review and a 6 month review? No

10. Information given

They found this; discussion on what services would be available to a single person (widow) in these circumstances, with no local family and how to find things.

This is a well educate family able to use services when they are aware of their existence.

11. Choices given

The only choice was whether to recuperate at Farnham or go home.

Patient Experience Story – Stroke Pathway Project
Male under 65 years. Stroke in 2009

12. How smooth the discharge from hospital was

Was admitted to East Surrey Hospital and had major stroke whilst kept overnight for observation. Was later told that I had had suffered 3 strokes in succession. Whilst in hospital both he and his wife were very confused and nobody was sharing information about the situation and felt very isolated. Once medically stable he was then transferred from East Surrey to Crawley for inpatient rehabilitation, still not given much information or sat down and the situation explained. 'We were just told it was time to go and felt we just had to go along with it' we both felt very shocked and confused and nobody seemed to be giving us any information or explaining what would happen.

2. The provision of specialist rehabilitation

At Crawley Hospital he had approximately 4 weeks intense inpatient rehabilitation.

Then told going home and next day we found ourselves at home and told the Oxsted community team would call. No information given and again we felt very isolated and lost.

Received 12 weeks rehabilitation at home, physio, OT & SLT 5 days a week.

After 12 weeks I was then told that they had done everything they could for me and that it was now up to me. If I needed any equipment to continue my exercises they suggested we buy those online. I had the same physiotherapist but people would come and go all the time and always different people. I was not offered physiological support at this time.

3. Help for family members and carers

It seems if you need anything you have to be very demanding and persisted, no help offered we were alone. My wife has had to organise everything for me from a Blue Badge to carers.

We finally found SILC and they helped us organise a Carer for me, initially we had issues with SILC and with many different people dealing with our case until we were assigned a case worker. Then 2 full time carers were found who look after me from 9 -5 Monday to Friday using self-directed payments. This had taken 12 months as my carer started on 1st Jan 2010. I had been having fits up to this point so it was important for us I have full time carer.

4. Care of individual needs

Felt I was abandoned and no information. No key worker was identified,

My wife had to return to work to support both of us and pay the mortgage, she also became my carer. We had no visit from Social services. My Wife had to arrange for a carer who then visited me 2 times a day for 30 mins to help shower me and feed me for the first year.

Group activities are most important for me and we need more organised group activities.

3.Help to return to family life and leisure

No help I have been totally reliant on my wife. I attend the stroke club once a month. Go to gym and go swimming / water aerobics that wife had arranged with carers.

4. Reviews weeks/months after stroke

No reviews received to date

GP has recently referred me for psychological support, not NHS I believe private.

5. Information given

Information from the NHS providers was extremely poor / non-existent both whilst there and also at discharge. Wife went to CAB and also did not have much information just directed us to Stroke Association and gave us the number.

Information has been one of the biggest challenges.

6. Choices given

No choices ever given or discussed

Patient Experience Story – Stroke Pathway Project

Female under 65 years. Stroke in 2009.

1. How smooth the discharge from hospital was

Admitted to hospital whilst on holiday, returned to stay with brother, once home went to see GP, had Scan taken at a London hospital.

2. The provision of specialist rehabilitation

Community team provided some Physio OT & SLT whilst at sisters but only for short time, she cannot remember exactly but for few months.

She feels she has memory problems but never been assessed, feel if had assessment 3 years ago this would have helped. 3 years ago I was not interested in physio, now I have been coming to the stroke club and am paying for the great physio here. Once a week I see him and I have seen progress. I had a knee operation recently and am receiving physio 2 days a week from the community team for that and it is great.

Her brother now pays for a private physio few times a week has helped to get her outside walking and building up confidence.

Would be great to get to be able to cook simple things myself and not be dependant.

Is great news about the new gym at the Walton Stroke club and she is very motivated to make progress.

3. Help for family members and carers

I had no help initially and had to rely on sisters and brother. She lived with sister for 2 years in Walton; she works so was difficult for both of them.

No intervention initially by social services has since had to fight for long time for assisted housing and care.

4. Care of individual needs

I was not and am not aware of what is available or what I am entitled to. Her sister cared for her for 2 years, had no carers until last year. Have fought for long time but she is now in assisted housing in Hersham (3 Wardens), has 2 carers a day who visit to help.

5. Help to return to family life and leisure

None except I have community transport to bring me to the stroke club once a week.

6. Reviews weeks/months after stroke

Had no reviews for 3 years until recently and the community team visited and carried out an assessment.

7. Information given

None apart from sharing information at stroke club

8. Choices given – None

Patient Experience Story – Stroke Pathway Project

Female under 65 years. Stroke in July 2012

1. How smooth the discharge from hospital was

Admitted to East Surrey Hospital was feeling sick and dizzy, and had seen GP few days before, she spoke to NHS Direct as symptoms had got worse. They called 999 and ambulance arrived, arrived at A&E and also did not know what the issue was. The hospital then recommended a CT scan that day and found a small bleed and thought the cause was a clot which had disappeared; she had become worse by this stage with paralysis of left side. Could not walk, talk or move arm. She was admitted onto Stroke Ward for 3 weeks receiving rehabilitation, Physio, OT & SLT.Sister came up from Devon met her at hospital and stayed a few weeks after discharge with her. At discharge she was walking assisted and speech coming back, her son had come over from Spain to stay for 2 months. No care plan or provision was made within the community, no visit by Social services. Bungalow did have rails at front door and in bathroom as fitted for late husband who had recently died of cancer.

2. The provision of specialist rehabilitation

No Inpatient rehabilitation was deemed necessary by the hospital team.

Oxted community team phoned and after explaining that she continued to do her exercises and how her son had been caring for her, they confirmed her son was doing everything correctly and there was no more the community team could do. At this point she feels that due to no ongoing physiotherapy she may not have progressed as far as potentially she might.

3. Help for family members and carers

Only help received is from Stroke association representative who called and gave lots of information, was the only help available post discharge.

4. Care of individual needs

Hospital care I was very good but no other care provision or discussion regarding needs. No Social services call or assessment.

5. Help to return to family life and leisure

Help from the Stroke Association and connection with Stroke club, this has been a life line. Family not close by but friends have helped and drive her to places she needs to be.

6. Reviews weeks/months after stroke

She had 3 month review at East Surrey hospital and recently had a 6 month review with a Stroke Nurse. She has written to her GP asking for a community team referral for Physiotherapy and felt as she is still young she would benefit from some level of Physiotherapy. Forgets things and has not received any cognitive or memory assessment.

7. Information given

Only information given by the hospital was a discharge letter that stated she needed to see GP for further blood tests for high cholesterol & follow up liver function tests as results were not clear.

Has no idea long term prognosis and kept being told it was just early days and found this very frustrating. No information given other than stroke association. Patient felt that without them they would not have been able to cope, the Stroke Support Worker was excellent and spent a lot of time explaining how to get help. Disabled parking badge etc.

8. Choices given

No choices and no community support given so no choices.

Patient Experience Story – Stroke Pathway Project

Female over 65 years. Stroke in 2008.

1. How smooth the discharge from hospital was

Was admitted to RSCH, the consultant said that I was fit to leave hospital. After that I had a very long wait. I went home in a taxi organised by a neighbour (I live alone). I was told that I would need to go back for a scan sometime of the carotid.

2. The provision of specialist rehabilitation

None. I was able to walk but was not told about exercises or care I needed to take.

3. Help for family members and carers

None, but it was really not needed.

4. Care of individual needs

None. I realise that I could have done with help at the time. I have reduced resilience, I tire easily and my balance is less good. No one has ever helped me with overcoming these problems. I suppose I simply accepted that fact that the differences were inevitable.

5. Help to return to family life and leisure

I had nothing extra, except a little bit of extra help with house work.

6. Reviews weeks/months after stroke

No review, my GP was not even informed that I had had a stroke. It came out in conversation when I went to see him about something else.

7. Information given

None.

8. Choices given

None were given. I guess they were not needed

Patient Experience Story – Stroke Pathway Project

Female under 65 years. Stroke April 2008

1.How smooth the discharge from hospital was

I had a severe headache at work and a fit, an ambulance was called and I was taken to East Surrey Hospital A&E I believe I was put to sleep for several days.

When I awoke I was not aware of what had happened and nobody explained to me that I had suffered a stroke, although I knew my left side was not working properly. I was moved from one ward to another over a period of 4 weeks at East Surrey Hospital. I did not receive any therapy although I was assessed at some point at my bed on the ward. Then suddenly one day I was taken on a trolley by ambulance and transferred to Crawley Hospital, nobody had discussed this with me prior to being moved.

2. The provision of specialist rehabilitation

The staff at Crawley were wonderful, Physios, OT & SLT and progress was great. I was there for 4-5 weeks but after 4 weeks I caught MRSA and was on a drip for a week or so and was not able to have any therapy. I remained in a bay of 6 beds but when I had visitors they had to wear yellow aprons. I was on anti-epileptic medication but still suffering some fits. I had an OT who arranged my discharge and visited me on my day of discharge. They arranged for equipment, a commode, wheelchair, walking Stick, hand rails, bath board and for the council to fit the rails. Unfortunately I had a fit later that day and was admitted back to East Surrey Hospital. I was put on new medication and have not had a fit for 3 years.

For 4 weeks I had the same Physio from the Oxsted community team once a week, and for another 2 weeks an assistant Physio came. I was then transferred to the Crawley team for a few weeks until finally being transferred to Caterham Dean Team to receive Physiotherapy for 4 weeks. I was told after this that they had done all they could for me and I should go to Stafford School and ask for Jackie to get more Physio at £3.50 per session. I continue to go there and having Physio still helps and I see progress, just a slower improvement now, swimming is also available here.

I have had no Psychological support or therapy.

Access to community is biggest issue and it would be great to have group Physio sessions for example.

3. Help for family members and carers

No help was provided for my family; my sister in law does washing and I rely on brothers and family to support me.

4. Care of individual needs

The council visited me last year to do an assessment but said I was not eligible for any help. I just get DLA and incapacity benefit.

5.Help to return to family life and leisure

Only help I get is from my family, brothers and sister. Have to do everything for myself, I have made friends at the stoke club arranged by the Stroke Association and we help each other.

6.Reviews weeks/months after stroke

No reviews over past 4/5 years.

7. Information given

The family picked up leaflets from Crawley Hospital and most information and help came from the Stroke Association and other people I have met at stroke club.

I volunteer at East Surrey Hospital and we have a new communication point which I host with the Stroke Association.

8.Choices given

No Choices given and most of the time no information.

Patient/Carer Experience Story – Stroke Pathway Project

Male over 65 years and female carer over 65 years. Stroke in September 2012.

1.How smooth the discharge from hospital was

First TIA in 2009, admitted to ASPH, had scan and then confirmed stroke but told it was too late for thrombolysis. Was on Cedar Ward, this was very good and staff very helpful & supportive; he received Physio, OT & SLT. He was then discharged to Ashford Hospital for further stroke rehabilitation.

2. The provision of specialist rehabilitation

At Ashford Hospital for a number of weeks, unable to recall how many, discharged home and received call from community team. No intervention by Social Services.

Was recommended White Lodge and given lots of information from them. Paid for and received Physio & SLT for 12 weeks twice a week at home and went out for walks with Physio and this started to give him confidence. Has continued SLT by paying for it from White Lodge but he is now 3rd on the list for SLT from the community. Physically now OK just SLT & memory are the main concerns and that no psychological support has been received.

3. Help for family members and carers

None, friends help to drive them to stroke club and shopping. Can only use buses, has bus pass, only gets to the stroke club with the help of friends.

4. Care of individual needs

No immediate care needs but with no psychological support for either him or his carer she felt she needed help to come to terms with what had happened.

5.Help to return to family life and leisure

None. Carer, when alone was trying to put on a brave face worried about ability to cope and the need for psychological support.

6.Reviews weeks/months after stroke

Had review after 3 weeks with GP, no other reviews so far.

7.Information given

Only information given was by the White Lodge

8.Choices given

No Choices

Carer Experience Story – Stroke Pathway Project

Wife. Carer for 5 years

1. How smooth the discharge from hospital was

East Surrey Hospital acute stroke ward was horrid experience, received some therapy.

Could not wait to get him home

Had to co-ordinate everything themselves, if you shouted and made a fuss you got some level of care provision.

2. The provision of specialist rehabilitation

Had to fight for rehab but once received progress was great.

Few times a week rehab provided but husband wanted more, not able to be offered at the time.

Has seen some improvement in last 5 years in the provision of services.

Available 5 days per week

3. Help for family members and carers

No help at the time was 5 years ago though

4. Care of individual needs

None

5. Help to return to family life and leisure

None

6. Reviews weeks/months after stroke

None

7. Information given

Have picked up information and contacts over the years, had to seek it.

8. Choices given - None

Carer Experience Story – Stroke Pathway Project

Wife. Carer for 2 years

1. How smooth the discharge from hospital was

Discharge from ASPH was smooth after 3 months there. She had to request speech therapy for his aphasia. The OT and District Nurse visited and recommended a special bed.

2. The provision of specialist rehabilitation

She had him admitted, with difficulty, to Woking, having been informed that it was full (it wasn't). He was in Woking for 16 weeks; following the inpatient stay she took him in for breakfast each day and collected him in the evening. This period was prolonged, he was able to help around the ward and this contributed to husband's recovery.

They both spoke highly of treatment at Woking. Speech therapy was good.

Available 5 days per week

3. Help for family members and carers

Social services did visit but, once it was discovered that savings were available, no help was forthcoming.

No particular help was provided (other than the bed) but it was difficult to see what could be provided other than help with aphasia – the role of the speech therapist. No modifications to the bungalow were needed.

The GP does not appear to have been very helpful

4. Care of individual needs

These relate mainly to aphasia, for speech therapy at home there was a 3 month wait and the quality was not as good.

5. Help to return to family life and leisure

This was via his daily attendance at Woking

6. Reviews weeks/months after stroke

Has had a review with consultant.

7. Information given

She felt that there was a substantial lack of information on facilities available. The Stroke Association was helpful but most avenues were found by her.

These included Woking Strokeabilty, Headway (charity in Guildford at £75 a day), Dyscover and Talk charities .Apart from SLT treatment the main worry was the lack of easily available information on sources of help – specialist in this case. There was some material on noticeboards in Woking Hospital but no tailored "pack" to be given out on discharge. Much then depends on the enthusiasm and persistence of the carer, preferably one who is prepared to "pester" 8. Choice - None

Recommendations

Royal College of Physicians SSNAP audit that audits patient care in acute hospitals to be implemented to audit patient care in the community hospitals, Woking, NEECH, Farnham, Milford and Crawley to participate in the audit.

Increase availability of community in patient therapy from 5 days per week to 6 days.

Provide a psychology service in the east of the county.

Conduct a review of the stroke rehab service to patients provided at the Bradley Unit, at Woking Hospital following the closure of the Godwin Unit.

Improve the access to reviews utilising the GP stroke registers and explore the possibility of the involvement of voluntary organisations such as the Stroke Association to increase review capacity.

Review and update the Stroke Service specification (this was due for review in November 2012 not sure if this has happened).

Improve the availability of information and a named contact (the recent new website will be an improvement).

Increase the number/hours of Stroke Association Care Support workers in the localities.

Commission stroke services using guidance from the Royal College of Physicians concise guide containing specific recommendations included in the National clinical guideline for stroke, fourth edition, 2012.

Thank you to all the people who shared their story and to the Surrey LINK volunteers

Health Scrutiny Committee
14 March 2013

Quality, Innovation, Productivity and Prevention Programme (QIPP) and Performance Monitoring

Purpose of the report: Scrutiny of Services

The Committee will scrutinise current NHS Surrey performance against QIPP plan savings and acute trust and NHS Surrey performance against national performance targets.

Introduction:

1. NHS Surrey has QIPP plans in place with a target to save £67million in 2012/13. The report at **Annex 1** shows current performance against this savings target.

2. NHS Surrey is responsible for the performance management of Surrey's five acute hospital trusts and the ambulance trust against nationally-set performance targets. The report at **Annex 2** sets out the Quality performance indicators and the performance against these for the last quarter. It provides a summary of the key areas of concern at the current time.

Recommendations:

3. The Committee is asked to scrutinise NHS Surrey on finance and overall performance and to make recommendations as appropriate.

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Sources/background papers:

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NHS Surrey

Agenda item XX

Quality & Performance Committee – 14th March 2013

QIPP Delivery/Monitoring Update 2012/13

Paper to Note
Prepared by: Ali Kalmis (Acting Director of QIPP & Contracts)
Presented by: Ali Kalmis (Acting Director of QIPP & Contracts)

EXECUTIVE SUMMARY

The 5th February 2013 submission to the SHA was the last required submission of the transformational tracker for the year of 2012/13. We continue to report Amber in terms of performance.

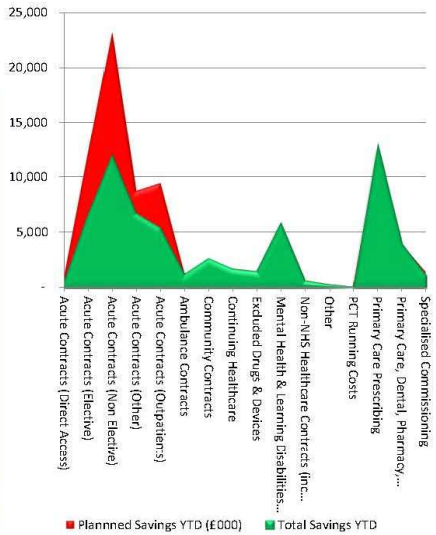
Original QIPP Schemes across Surrey have delivered £61m YTD at M10 against a YTD plan of £84M including planned savings associated to tariff and contract efficiencies. Financial recovery plans were put in place in October 2012 to mitigate the growing size of the saving requirement seen predominately through acute contracts. The PCT and CCGs continue to work closely to finalise year end deals with Acute providers. The report asks the Board to note the 2012/13 achievements made through the QIPP programme in Surrey and highlights key successes and lessons learnt by CCG's through 2012/13.

IMPLICATIONS

Health Impact	Improving quality and increasing prevention for the population.
Financial Implications	Cost savings requirement by CCG is paramount to delivering the control total in 2012/13
Legal Implications	Financial balance in a legal requirement driven through the achievement of QIPP
Equality impact	To ensure that all patients are able to access the best care in the most appropriate place regardless of demographics.
Reputational impact	Importance of having robust plans that deliver quality, innovation, productivity and prevention
Risk Register	Risk around failure to deliver and implications of workforce levels to deliver the required QIPP whilst transitioning to 5 CCG's.
Board Assurance Framework	Included

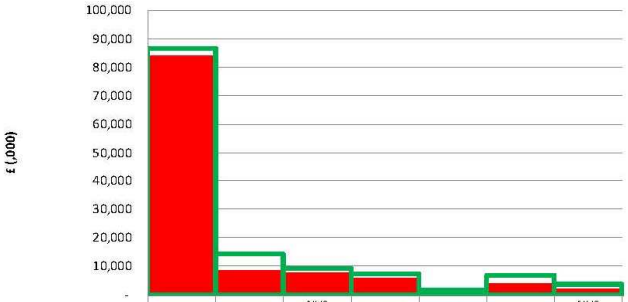
NHS Surrey QIPP Month 10 Financial Dashboard

	Surrey PCT			East Surrey			Farnham			G&W		
	Plannned Savings YTD (£000)	Total Savings YTD	VAR	Plan YTD (£000)	Total	VAR	Plan YTD (£000)	Total	VAR	Plan YTD (£000)	Total	VAR
Acute Contracts (Direct Access)	582	395	(186)	160	4	(156)	30	30	(0)	102	72	(31)
Acute Contracts (Elective)	11,918	6,530	(5,388)	25	(83)	(108)	102	110	8	207	207	-
Acute Contracts (Non Elective)	23,229	11,837	(11,391)	3,740	1,732	(2,008)	444	389	(54)	1,115	744	(371)
Acute Contracts (Other)	8,693	6,657	(2,037)	963	673	(290)	187	45	(142)	9	1	(8)
Acute Contracts (Outpatients)	9,398	5,333	(4,065)	263	6	(257)	4	1	(3)	380	261	(118)
Ambulance Contracts	1,154	1,154	(0)	6	5	(0)	1	1	0	3	3	-
Community Contracts	2,375	2,588	213	(1,115)	(1,135)	(21)	7	2	(5)	33	10	(22)
Continuing Healthcare	1,635	1,633	(1)	242	242	0	66	66	(0)	291	291	-
Excluded Drugs & Devices	1,396	1,395	(1)	69	69	-	22	22	(0)	145	145	-
Mental Health & Learning Disabilities Contracts	5,771	5,771	(0)	219	218	(1)	61	61	(0)	276	276	-
Non-NHS Healthcare Contracts (inc reablement)	560	560	-	-	-	-	-	-	-	-	-	-
Other	214	214	0	-	-	-	-	-	-	-	-	-
PCT Running Costs	-	-	-	-	-	-	-	-	-	-	-	-
Primary Care Prescribing	11,923	12,703	780	928	932	4	267	267	(0)	1,216	1,216	-
Primary Care, Dental, Pharmacy, Opthalmic	3,882	3,871	(11)	114	108	(6)	31	31	0	104	104	-
Specialised Commissioning	1,347	1,029	(318)	121	80	(41)	33	22	(11)	146	96	(50)
	84,077	61,671	(22,406)	5,733	2,850	(2,884)	1,256	1,049	(207)	4,028	3,428	(600)
Identified since Original Plans 11/12	-	25,042	25,042	-	4,398	4,398	-	640	640	-	3,375	3,375
Total	84,077	86,713	2,636	5,733	7,247	1,514	1,256	1,689	433	4,028	6,803	2,776



	NW Surrey			Surrey Downs			Surrey Heath		
	Plan YTD (£000)	Total	VAR	Plan YTD (£000)	Total	VAR	Plan YTD (£000)	Total	VAR
Acute Contracts (Direct Access)	209	209	0	12	12	(0)	68	68	0
Acute Contracts (Elective)	474	287	(187)	70	55	(16)	218	307	89
Acute Contracts (Non Elective)	1,256	658	(599)	2,957	868	(2,088)	450	525	75
Acute Contracts (Other)	2,122	2,290	168	1,304	329	(975)	3	20	17
Acute Contracts (Outpatients)	816	24	(792)	995	173	(822)	342	3	(339)
Ambulance Contracts	9	9	0	8	8	(0)	2	1	(0)
Community Contracts	69	18	(51)	(540)	(213)	326	15	-	(15)
Continuing Healthcare	507	506	(0)	399	400	0	130	129	(1)
Excluded Drugs & Devices	144	144	(0)	108	108	(0)	41	41	(0)
Mental Health & Learning Disabilities Contrac	393	394	1	319	319	(0)	108	109	0
Non-NHS Healthcare Contracts (inc reablem	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-
PCT Running Costs	-	-	-	-	-	-	-	-	-
Primary Care Prescribing	1,953	2,762	809	1,586	1,570	(17)	534	534	(0)
Primary Care, Dental, Pharmacy, Opthalmic	220	219	(1)	189	186	(3)	64	61	(2)
Specialised Commissioning	254	167	(87)	200	109	(91)	65	26	(39)
	8,425	7,687	(738)	7,608	3,922	(3,686)	2,040	1,825	(216)
Identified since Original Plans 11/12	-	6,528	6,528	-	5,276	5,276	-	1,839	1,839
	8,425	14,215	5,790	7,608	9,198	1,590	2,040	3,664	1,624

YTD against Total



	Surrey PCT	NHS NW Surrey CCG	NHS Surrey Down CCG	NHS East Surrey CCG	NHS NEH&F CCG	NHS G&W CCG	NHS Surrey Heath CCG
Plan Savings YTD (£000)	84,077	8,425	7,608	5,733	1,256	4,028	2,040
Total savings YTD	86,713	14,215	9,198	7,247	1,689	6,803	3,664

QIPP 2012/13 Reporting

The table above outlines the M10 YTD performance for Surrey and also by individual CCG's. As highlighted through the graph in the top right hand corner savings against plan have under-performed within those areas targeted at acute activity. Without caps and collar in place to share the risk with acute providers in 2012/13 that supported performance in 2011/12 the PCT and CCG's have struggles to maintain contracts within budget levels.

We are proud of the work that has gone into implementing systems to reform unplanned care through 111 the DOS and the implementation of virtual ward models into all areas of Surrey. These are significant building blocks that will support real change in clinical commissioning. The Tier 2 review commissioned by NHS Surrey has concluded and individual reports will be available to CCG's shortly to influence and advise commissioning of planned care services through 2013/14 and beyond.

Joint projects with SCC and Community providers have established and strengthened operational relationship to support the provision of best practice care for Surrey patients. We strongly hope that pilot sites for telehealth and care are proof of concept and continue to be supported by CCG's to ensure that patient can manage their care at home. 2012/13 has brought wide spread awareness of people living with Long Terms Conditions and CCG's have taken forward the mantel in planning for 2013/14 to ensure that resources are directed to those to enable self management and education.

CCG's have become better educated on those 'at risk' within their patient population and the desire is that progress is made to embed the utilisation of risk stratification tools and electronic registers.

Below are some highlight from CCG's on successes and lessons learnt:

Surrey Heath Clinical Commissioning Group

Achievements:

- Usable dashboards in place to support projects/reduce variation have been developed quickly where dedicated resource is identified e.g. Quality Observatory dashboards to SHCCG.
- Implementation of good practice/worked examples from elsewhere has given more confidence that savings will be realised e.g. medicines management nursing home prescription reviews.
- Partnership working with providers where there are win/wins are possible to find e.g. virtual ward project manager from Virgin, pathology information from Partnership Pathology for dashboard.

Lessons Learnt:

- Alignment of incentives (CQUIN & Local primary care incentives) & QIPP are really important for delivery.
- Better use could be made of contractual levers & there are development needs both for CCG's & CSU's in this area.
- The need to plan for more than 100% of target to allow for slippage.
- The need to have more than 1 year QIPP plans /rolling programme and start early.
- The need to have transformational workstreams going alongside more project based QIPP so that within time systems wide change can be achieved. Sharing project resource to support transformational planning supports buy-in from providers & commissioners.

NW Surrey Clinical Commissioning Group

During 2012/13, NW Surrey CCG has been working towards delivering a £14.636m QIPP savings programme. As of December 2012 our reported position was:

- 93% of the total QIPP programme had been delivered as planned for this stage in the year.
- 70% of the 62 programmes have delivered more than 97% of their plan. These programmes include medicine management /optimisation, reductions in hospital deaths, reducing excess bed days, reducing LOS for people with dementia, dental and learning disability repatriation. Our new Virtual ward programme has delivered on 79% of the planned savings
- 28% of the 62 programmes have not have delivered as planned. These programmes include reductions in referrals into ASPH and reduction in surgical interventions.

Surrey Downs Clinical Commissioning Group

Achievements:

- Clinical leadership of the Virtual Ward to enable the development of out-of-hospital care
- The development of longer term plans for system transformation such as dementia screening to meet the future health needs of our population

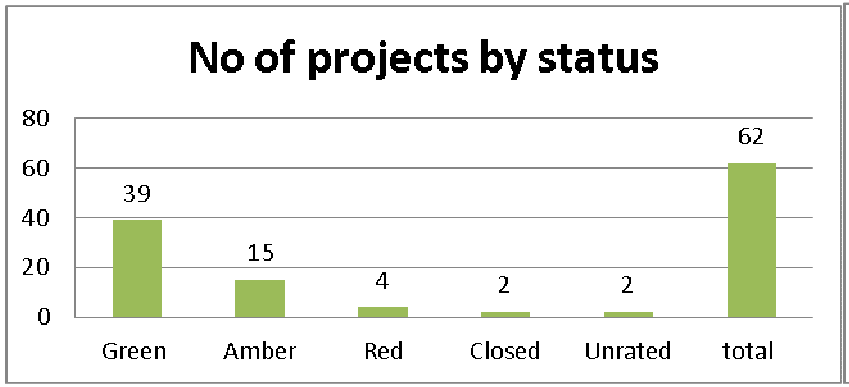
Learning:

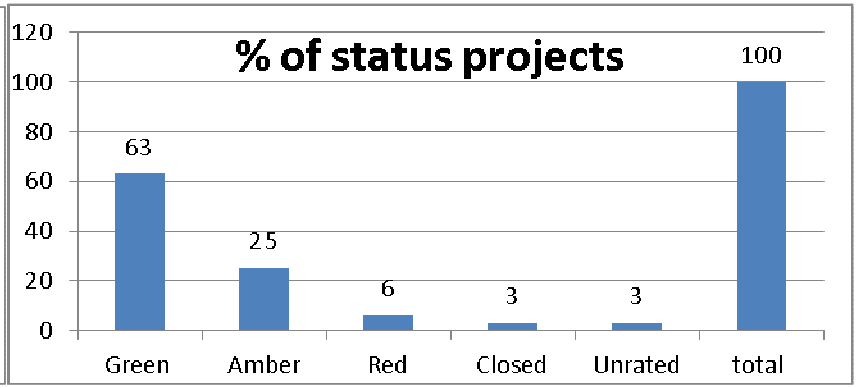
- Set realistic trajectories for project and financial delivery against the QIPP challenge at the start of the year

Guildford & Waverley Clinical Commissioning Group

There are at present 62 listed QIPP projects in the CCG programme of which:

- 39 are Green = 63% of total projects
- 15 are Amber = 25% of total projects
- 4 are Red = 6% of total projects
- 2 are closed = 3% of total projects
- 2 are ungraded = 3% of total projects





There are the following 7 Workstreams within the QIPP programme, with an allocated Commissioning Lead managing the programmes:

- Children's and Maternity – 1 project.
- Mental Health & LD – 5 projects all projected to deliver on financial target & Quality outcomes.
- Planned care – all live projects are on track to deliver 70% of original target.
- Unplanned care – all on track for delivery – forecasting over delivery on projects.

- Cancer care – all 12 projects on projected delivery.
- Medicine Management- delivered on all 4 projects.
- Primary Liaison - all projects are forecasting delivery against targets.

Lessons Learnt:

There has been no formal lessons learnt exercise, this is planned for end of March 2013 – but informally there are weekly meetings structured to afford each Workstream to share challenges and lessons learnt – to inform the QIPP programme for 2013-14.

The general theme- challenges from these are:

- Availability of timely data analysis- with associated business intelligence.
- Central shared risk identification of projects
- Resources – skills – project management- conflict with Business as usual demands – priorities.
- Acute- stakeholder ownership engagement

Final Thoughts

2012/13 has been a challenging year with many great successes large and small. Ground work has been done to create real change in the way that care is delivered for Surrey patient. Continued focus is required to get the right information to inform decision making and to utilise technology to support transformational change. Through a period of uncertain and transition staff have remain dedicated to project delivery supported by strong CCG clinical leads. CCG's will need to continue to ensure that they work collaboratively across larger areas that their population catchment through coming years to ensure that large scales transformational change can truly be delivered.

The Board is as to NOTE the following:

1. The M10 QIPP delivery position YTD
2. The successes delivered through the QIPP programme
3. The lessons learnt and captured here by CCG's
4. And give thanks to all the hard work of individuals through 2012/13

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Performance Summary for NHS Surrey - 2012/13

Areas of Concern

- Ambulance, Category A R2 Response Times
- Improved Access to Psychological Services
- Two Week Wait for Breast Symptoms
- Diagnostic Test Waiting Times
- A&E 4 Hour Waits
- Coverage of Health Checks
- Mixed Sex Accommodation

Performance Summary and expected year end position:

Ambulance Response Times

For Category A, Red 1, 8 minute response time, there were issues in December and January, for both the South East Coast Ambulance (SECAMB) total (provisional data for January shown in the table below) and Surrey PCT area. There are also expected to be issues in February, due to handover delays. NHS Surrey has worked with the Surrey Trusts to improve handovers/reduce delays, and an improvement in performance is expected again from March. Issues remain for SECAMB in Sussex and Kent.

There was an expectation that Trusts' follow a trajectory to reach 80% by the end of the year, which is expected to be the target for Red 1 calls for 2013/14. This was not achieved.

Category A, Red 2, 8 minute responses were not achieved for December or January, but are expected to be achieved for the year.

Category A, 19 minute responses have been achieved consistently and are expected to be achieved for the year.

Cancer

All Cancer 31 and 62 day waits were achieved against target for Q1 to Q3, and are expected to be achieved for the final quarter and overall for the year.

For the percentage of patients seen within two weeks of a referral for suspected cancer (all types), the target was achieved for Q1 to Q3 and is expected to be achieved for the Q4 and overall for the year.

For the two week wait for breast symptoms, the target was not achieved for Q1 to Q3. This was due to a capacity issue at the Jarvis Centre, where funding through a block contract did not allow for the volume to be increased to the level which would allow the service improvement required. Referrals to the Jarvis Centre have been stopped, now going to other providers, and the target is expected to be achieved for Q4. The target is not however expected to be achieved overall for the year.

Mental Health

The early intervention in psychosis measure, the number of new patients taken on by Early Intervention teams in the year, has been achieved for the year to date at January 2013, and has already met the target of 126 for the whole year.

The number of Crisis Resolution Home Treatment Episodes is above target January 2013 year to date, and is expected to be achieved for the year.

Improved access to psychological services, the proportion of people with depression receiving treatment, is at 2.4% at Q2 against a target or 15% to be achieved by the end of the year. This is due to a PCT decision to fund at 50%, and therefore limit capacity to a level where only around half of the required numbers will be treated. The target is therefore not expected to be achieved for 2012/13.

Improved access to psychological services was also below target, 43.8% in Q2, for the second part of the indicator, the number of people who complete treatment who are moving to recovery. The expectation is that this increases each Quarter towards a national target of 50%, which should then be maintained. This is not being performance managed, and the focus is now on moving to the new Any Qualified Provider (AQP) contracts for next year. The target is therefore not expected to be achieved for 2012/13.

Referral to Treatment Pathways

While the targets have been achieved at aggregate level for admitted patients, non-admitted patients and incomplete pathways, they were not achieved in each specialty by every organisation on a monthly basis as per the expectations set out in the Operating Framework.

Diagnostic Test Waiting Times

The 1% maximum limit will not be achieved for 2012/13, with 2.4% of patient waiting more than 6 weeks in January 2013.

Incomplete reporting earlier in the year was masking issues with Audiology Assessment breaches at First Community Health & Care. This is being resolved by NHS East Surrey Clinical Commissioning Group, who will be carrying out a review of

waiting lists to assess the impact of additional funding on reducing waiting times, as well as looking at options for addressing ongoing demand for the service.

The provider, First Community Health & Care, are also producing a business case around a cost per case option.

A&E 4 Hour Waits

4 Hour A&E waits remain and issue, with Ashford and St Peter's NHS Trust at 93.9% for Q3, and therefore not achieving the 95% target. Although the other trusts did achieve the target for Q3, weekly data to 24 February shows that all four Surrey Hospital Trusts had performance issues in Q4 to date. ASPH and RSCH are currently below target for the year to date.

Smoking Quitter

The target for the number of quitters was achieved for Q2. Data for Q3 is not yet available, but monthly data to November shows that performance is expected to be above target and to exceed the overall target for the year (3541 quitters) by the end of Q4.

Mixed Sex Accommodation Breaches

There were four mixed sex accommodation breaches reported for January. There were two at Epsom and St Helier Hospital NHS Trust (ESHH), one at Royal Surrey County Hospital NHS Foundation Trust (RSC), and one at St George's Healthcare NHS Trust. The numbers for Surrey patient have decreased steadily through the year, but should be at zero.

VTE Risk Assessments

Achieved in all trusts for Q1 to Q3, and expected to be achieved in Q4.

HCAI Measures

The number of MRSA breaches is expected to be within the limit for the year, with 14 breaches against a plan of 17 for April to December 2012. The PCT is not aware of any significant issues for Quarter 4 to date, although because the target numbers are so small, one or two per month, there is a degree of uncertainty around achieving this.

The number of Clostridium Difficile breaches is expected to be within the limit for the year, with 194 breaches against a plan of 204 for April to December 2012.

Health Checks

This target is unlikely to be met as funding has been withdrawn due to financial pressures within the PCT.

Mitigating actions are being taken as follows:

- All CCG leads are being contacted by the DPH with a view to working in partnership to continue to deliver health checks in 2012/13 without resource.
- A Health Checks Steering group has been developed that has representatives from the LMC, LPC, CCG's, public health and the county council to ensure a safe transfer of the health checks programme through transition.
- An enhanced service agreement is being developed with County Council colleagues, to be implemented with Primary Care colleagues as of April 2013

Performance 2012/13							
Code	**Indicator**	**Period**	**Performance**	**Target**	**Status**	**Forecast for Year**	**Comments:**
PHQ01	Ambulance Clinical Quality: Category A, RED 1, 8 Minute Response Time	Jan 2013	**73.9%**	**>75%**	**Red**	**Amber**	74.9% for the year to date. Some issues in Feb, but an improvement expected for March, with a chance of bringing overall performance back above 75%.
	Ambulance Clinical Quality: Category A, RED 2, 8 Minute Response Time	Jan 2013	**73.4%**	**>75%**	**Red**	**Green**	Currently at 76.5% for the year to date, and expected to be achieved for the year.
PHQ02	Ambulance Clinical Quality: Category A 19 Minute Transportation Time	Jan 2013	**96.8%**	**>95%**	**Green**	**Green**	Consistently achieved
PHQ03	Cancer 62 Day Waits: All Cancer	Q3	**91.3%**	**>85%**	**Green**	**Green**	All Cancer 31 and 62 day waits were achieved against target for Q1 to Q3, and are expected to be achieved for the final quarter and overall for the year.
PHQ04	Cancer 62 Day Waits: Referral from Screening Service	Q3	**95.3%**	**>90%**	**Green**	**Green**	
PHQ05	Cancer 62 Day Waits: Consultants Decision to Upgrade	Q3	**93.3%**	**N/A**	N/A	N/A	
PHQ06	Cancer 31 Waits: 1st Treatment	Q3	**98.7%**	**>96%**	**Green**	**Amber**	
PHQ07	Cancer 31 Waits: Subsequent Surgery	Q3	**97.5%**	**>94%**	**Green**	**Green**	
PHQ08	Cancer 31 Waits: Subsequent Drugs	Q3	**99.8%**	**>98%**	**Green**	**Green**	
PHQ09	Cancer 31 Waits: Subsequent Radiotherapy	Q3	**98.8%**	**>94%**	**Green**	**Green**	
PHQ10	Mental Health Measure: Early Intervention in Psychosis (YTD)	Jan 13	**129 YTD**	**105 YTD**	**Green**	**Green**	Achieved for the year to date, and has already met the target of 126 for the whole year.
PHQ11	Mental Health Measure: Crisis Resolution Home Treatment	Jan 13	**1397 YTD**	**1299 YTD**	**Green**	**Green**	Achieved for the year to date, and expected to be achieved for the whole year.

PHQ12	Mental Health Measure: Care Programme Approach (CPA)	Jan 13	**98%**	**95%**	**Green**	**Green**	Achieved for the year to date, and expected to be achieved for the whole year.
PHQ13	Improved access to psychological services: Proportion of people with depression receiving treatment	Q2	**2.4%**	**15% (by Q4)**	**Red**	**Red**	PCT decision to fund this service to a level to reach 8%, and therefore the 15% target will not be achieved.
	Improved access to psychological services: The proportion of people who complete treatment who are moving to recovery	Q2	**43.8%**	**50% (by Q4)**	**Red**	**Red**	Unlikely to be achieved
PHQ14	People with long-term conditions feeling independent and in control of their condition	Jan to Sept 2012	**70.9%**	N/A	N/A	N/A	
PHQ15	Unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 adult population	2011/12	**642**	N/A	N/A	N/A	
PHQ16	Unplanned hospitalisation for asthma, diabetes and epilepsy per 100,000 under 19 population (Directly Standardised Rates)	2011/12	**228**	N/A	N/A	N/A	
PHQ17	Emergency admissions for acute conditions that should not usually require hospital admission per 100,000 adult population	2011/12	**908**	N/A	N/A	N/A	
PHQ18	Patient Experience Survey	2011/12	RSCH: **74.4** KH: **74.3** FPH: **78.2** ASPH: **71.3** SaSH: **69.5** ESHH: **73.5**	N/A	N/A	N/A	

PHQ19	Referral to Treatment Pathways - Admitted	Dec 2012	**93.9%**	**>90%**	**Green**	**Amber**	Compliance expected to continue for Q4 at aggregate level, but some issues remain at Specialty level.
PHQ20	Referral to Treatment Pathways – Non-Admitted	Dec 2012	**97.6%**	**>95%**	**Green**	**Amber**	Compliance expected to continue for Q4 at aggregate level, but some issues remain at Specialty level.
PHQ21	Referral to Treatment Pathways - Incomplete	Dec 2012	**95.6%**	**>92%**	**Green**	**Amber**	Compliance expected to continue for Q4 at aggregate level, but some issues remain at Specialty level.
PHQ22	Diagnostic Test Waiting Times	Jan 2013	**3.4%**	**<1%**	**Red**	**Red**	Issues with capacity for Audiology assessments at First Community Health & Care, currently being resolved through contract negotiations for next year.
PHQ23	A&E waiting time- Total Time in the A&E Department	Q3	ASPH: **93.9%**	**>95%**	**Red**	**Red**	Poor performance in Q4 to date, and currently at 93.7% for the year to date (to 24 Feb 2013).
			ESHH: **95.7%**		**Green**	**Green**	Expected to be achieved for Q4 and for the year.
			FPH: **95.3%**		**Green**	**Amber**	Some issues in Q4 to date. Currently at 95.3% for the year to date (to 24 Feb 2013).
			KH: **96.1%**		**Green**	**Green**	Expected to be achieved for Q4 and for the year.
			RSCH: **95%**		**Green**	**Amber**	Some issues and unlikely to be achieved for Q4. Currently at 94.9% for the year to date (to 24 Feb 2013).
			SaSH: **96.3%**		**Green**	**Green**	Issues during some weeks in Q4 to date, but on track to achieve the target in Q4 and for the year to date.
PHQ24	Cancer 2 Week Waits - all	Q3	**96.6%**	**>93%**	**Green**	**Green**	Achieved for Q1 to Q3 and expected to

							be achieved for Q4 and the year.
PHQ25	Cancer 2 Week Waits – breast symptoms		Q3	**85.2%**	**>93%**	**Red**	**Red**	Not achieved for Q1 to Q3. Expected to be achieved for Q4, but not for the year.
PHQ26	MSA Breaches		Jan 2013	**4 breaches**	**0**	**Red**	**Red**	Numbers decreased during the year, but should be at zero.
PHQ27	HCAI measure (MRSA)		Dec 2012	**1**	**Plan**	**Green**	**Green**	On target to achieve for the year, with 14 breaches against a plan of 17 to December 2012.
PHQ28	HCAI measure (Clostridium Difficile infections)		Dec 2012	**19**	**Plan**	**Green**	**Green**	On target to achieve for the year, with 194 breaches against a plan of 204 to December 2012.
PHQ29	VTE Risk Assessment	ASPH	Q3	**93.7%**	**>90%**	**Green**	**Green**	Achieved for all Trusts in Q1 to Q3.
		ESHH		**95.3%**				
		FPH		**93.7%**				
		KH		**91%**				
		RSCH		**93.5%**				
		SaSH		**90.8%**				
PHQ30	Smoking Quitters		Q2	**1993**	**1908**	**Green**	**Green**	This is expected to be achieved for Q3 and to exceed the overall target for the year (3541 quitters) by the end of Q4.
PHQ31	Coverage of NHS Health Checks : Checks Offered		Q3	**1.48%**	**15%**	**RED**	**RED**	High risk of not delivering this target.
	Coverage of NHS Health Checks: Checks Received			**1.45%**	**7.5%**	**RED**	**RED**	

KEY

RSCH	Royal Surrey County Hospital NHS Foundation Trust
KH	Kingston Hospital NHS Trust

FPH	Frimley Park Hospital NHS Foundation Trust
ASPH	Ashford & St Peter's Hospitals NHS Foundation Trust
SaSH	Surrey and Sussex Healthcare NHS Trust
ESHH	Epsom & St Helier University Hospitals NHS Trust

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Health Scrutiny Committee
14 March 2013

Revised Health Scrutiny Regulations

Purpose of the report: Policy Development and Review

This report updates the Committee on the amended Department of Health Regulations governing Health Scrutiny Committees, which have been published recently.

Introduction:

1. Health Overview & Scrutiny Committees (HOSCs) were set up by the Health and Social Care Act 2001. They give local authorities the power to scrutinise the NHS through overview and scrutiny committees. They can review any matter relating to the planning, provision and operation of health services in their area, and make reports and recommendations to NHS bodies and local authorities.

2. HOSCs are governed by separate Regulations laid down by Parliament. The original Regulations were published in 2003, along with explanatory Guidance from the Department of Health.

3. The Health & Social Care Act 2012 changed the way in which health scrutiny functions are discharged as well as creating new commissioning bodies and provisions for health scrutiny. Therefore, the Regulations needed to be amended.

4. The Department of Health consulted on new Regulations in the summer of 2012. The final Regulations were subsequently published in February 2013 and are due to come into effect on 1 April 2013.

Changes

Health Scrutiny Function

5. The most important change is that the health scrutiny function is now conferred directly onto the local authority. This was previously conferred

directly onto the committee itself. This means that each local authority can decide how it discharges its health scrutiny functions.

6. A local authority can now decide to retain its statutory health scrutiny committee or to discharge its functions through

   a) An overview and scrutiny committee of the council

   b) A joint overview and scrutiny committee appointed by the Council and one or more other local authorities

   c) Another committee or sub-committee of the Council

   d) An overview and scrutiny committee of another local authority

The local authority cannot discharge its health scrutiny function through the Health and Wellbeing Board.

Witness attendance and information

7. HOSCs have always had the power to require information and attendance from commissioners and providers in respect of matters relating to the health service in the area.

8. The Health and Social Care Act 2012 has established several new bodies and added powers for a HOSC to call independent providers as well. The following bodies will be subject to scrutiny:

   a) NHS Commissioning Board (NCB)

   b) Clinical Commissioning Groups (CCGs)

   c) NHS trusts or NHS foundation trusts providing services to people residing in the area of the authority

   d) Other relevant health service providers, providing NHS services in the area (e.g. this may include voluntary, independent and private sector providers)

   e) Health and Wellbeing Board – it is expected that HOSCs will hold HWBs to account for the decisions they take and make reports to the Cabinet, similar to how our current Select Committees operate

   f) Public Health – commissioners who are now employees of the local authority; and providers.

Powers of referral

9. Proposals for substantial variation of the health service in the local authority's area can be referred to the Secretary of State for several reasons, such as if the Committee felt consultation was not adequate or if it believes the proposals are not in the best interest of the residents in that area.

10. As the health scrutiny function was conferred directly onto the committee previously, the power of referral was also conferred onto the committee. Now that the health scrutiny function is conferred onto the local authority, so is the power of referral. Where a local authority retains a health

scrutiny committee, it can delegate the power of referral to this committee but it cannot delegate it to any other committee or sub-committee.

11. The DH position is that, regardless of what arrangements local authorities establish for referral to the Secretary of State, the full Council should be aware of how the powers are being exercised, as it is ultimately accountable for them. It proposed that a health scrutiny committee might wish to notify its full Council that it is likely to refer a matter to the Secretary of State to give the Council the opportunity to debate the matter, if it so wishes.

Joint Health Overview & Scrutiny Committees

12. When proposals for major changes to health services cross local authority boundaries (e.g. Surrey and West Sussex or Surrey and south west London), under previous Regulations it was merely recommended that a Joint HOSC be set up. Under the new Regulations, in these circumstances the local authorities involved will be required to set up a JHOSC to scrutinise and respond to the proposals.

Additional changes

13. The NHS body consulting the HOSC (or JHOSC) will now be required to work with the HOSC to publish clear timescales for decision-making. The NHS body will notify the HOSC of when it intends to make its final decision and the HOSC will have to respond by this deadline. The Regulations do give flexibility to amend these timescales should there be a need to do so.

14. Financial considerations will now be need to be taken into account in any referral to the Secretary of State on a contested proposal for service change

15. The NHS Commissioning Board will have a supportive role with a focus on facilitating engagement and local agreement on contested proposals.

16. It is expected that any NHS service change proposal will support the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. If the Health and Wellbeing Board supports a service change proposal and the local authority decides to refer it to the Secretary of State for Health, it will have to set out clearly why it is referring something that the Health and Wellbeing Board supports.

17. It is suggested that the Health and Wellbeing Board could play a role in helping to resolve any local disagreements for service reconfiguration.

18. Healthwatch, the new health champion for local people and patients, will be able to formally refer a matter to a HOSC and it must respond within 20 working days. It must also keep Healthwatch informed of any further actions it plans to take.

Implications for the Health Scrutiny Committee

19. As of the date of publishing these papers, a draft report to full Council on 19 March 2013 is recommending that the Health Scrutiny Committee be retained, with the power of referral delegated to it. If this is agreed, there will be no major change to how the Committee works.

20. The Terms of Reference for the Committee are also being amended, to reflect the changes outlined above. These are also going to the 19 March 2013 full Council meeting for approval.

21. The Health and Wellbeing Board presents an excellent opportunity for partners to work together to commission a more integrated and joined-up health and social care service in Surrey. The Committee will want to stay abreast of decisions made by the HWB. It is likely that the HWB will be publishing a plan of its key decisions that can be monitored. This will also offer the Committee an opportunity to perform pre-decision scrutiny on any major decisions.

22. Working with Healthwatch will be an important relationship for the Committee to foster. Healthwatch will be able to provide patient experience information and feedback to the Committee and may be able to identify areas of concern that the Committee needs to investigate. It will be vital that Healthwatch is encouraged to share information with the Committee, and vice versa, and any formal referrals are responded to and actioned by the Committee in a timely manner.

23. The new ability to require information and attendance from independent providers will also be important, given the new Any Qualified Provider regime and the Government's push for competition in the NHS. There may be more independent providers in future and it will be vital that the Committee is able to scrutinise their performance and plans in the same manner as NHS providers.

Conclusions:

24. The changes to the Regulations Governing Health Scrutiny are important to note but they do not dramatically change the way in which the Committee operates at present. There is the potential for a future Council to reconsider the way in which it discharges its health scrutiny function but, for the time being, the Health Scrutiny Committee will remain.

25. The Committee will need to start building relationships with all of the new bodies that come into being on 1 April 2013: CCGs, HWB, Healthwatch, etc. The first year will very much represent a 'learning curve' for local authorities and the NHS in getting to grips with the new structures and ways of working. The Committee will need to be able to adapt to how it fits into the new health landscape and be ready to take on new challenges that this poses.

Financial and value for money implications

26. There are no financial or value for money implications arising from this report.

Equalities Implications

27. There are no equalities implications arising directly from this report; however, the Health Scrutiny Committee's remit is to ensure equity of health services across the County.

28. The Committee will continue to seek assurances from relevant NHS bodies and the local authority that the services provided do not unintentionally disadvantage any particular equalities group. It will also continue to work with partners to identify where health outcomes for a particular group need to be improved, services are put in place to do so.

Risk Management Implications

29. There are no risk management implications arising from this report.

Implications for the Council's Priorities

30. The Committee's continued scrutiny of health services in the County contribute to the Council's vision in three ways:

    a) Residents – the Committee offers residents the opportunity to hold commissioners and providers of NHS services to account for the decisions they make;

    b) Partnerships – the Committee works with partners to identify where there are gaps in service provision and where there is inequity in access to services; and

    c) People – the Committee is kept informed of changes to the Regulations and Members understand the role of the Committee in the overall health landscape.

Recommendations:

31. The Committee note the changes to the Regulations Governing Health Scrutiny and their implications for the Committee's work going forward.

Next steps:

The report to full Council on the changes needed to the Terms of Reference in the Constitution is on 19 March 2013.

The various bodies set up by the Health and Social Care Act 2012 will become statutory bodies on 1 April 2013.

Report contact: Leah O'Donovan, Scrutiny Officer, Democratic Services

Contact details: 020 8541 7030; leah.odonovan@surreycc.gov.uk

Sources/background papers: The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, Statutory Instrument 2013 No. 218

Health Scrutiny Committee
14 March 2013

Recommendations Tracker and Forward Work Programme

Purpose of the report: Scrutiny of Services and Budgets/Policy Development and Review

The Committee will review its Recommendation Tracker and draft Work Programme.

Summary:

1. A recommendations tracker recording actions and recommendations from previous meetings is attached as **Annex 1**, and the Committee is asked to review progress on the items listed.

2. A first draft of the Work Programme for 2013/14 is attached at **Annex 2**. This represents suggestions for topics for the next year and will be subject to consideration by the new Committee after elections in May.

Recommendations:

3. The Committee is asked to monitor progress on the implementation of recommendations from previous meetings and to review the draft Work Programme.

Report contact: Leah O'Donovan, Scrutiny Officer, Democratic Services

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Sources/background papers: None

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ANNEX 1

HEALTH SCRUTINY COMMITTEE
ACTIONS AND RECOMMENDATIONS TRACKER – UPDATED 5 MARCH 2013

The recommendations tracker allows Committee Members to monitor responses, actions and outcomes against their recommendations or requests for further actions. The tracker is updated following each Select Committee. Once an action has been completed, it will be shaded out to indicate that it will be removed from the tracker at the next meeting. The next progress check will highlight to members where actions have not been dealt with.

Select Committee Actions & Recommendations

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SC004	District and borough co-optee report [Item 10]	Protocol to be sent to HOSC Members.	Bryan Searle	Work is ongoing.	*None*
SC005	District and borough co-optee report [Item 10]	Protocol to be sent to all Leaders of Boroughs and Districts to determine their own local arrangements.	Bryan Searle	Work is ongoing.	*None*
SC006	Health Scrutiny Committee annual survey and report [Item 11]	That the HOSC consider producing an annual report to Council detailing performance.	Leah O'Donovan	This will be considered in future.	*None*
SC007	Surrey County Council Cabinet Members for Adult Social Care and Health priorities and performance update [Item 11]	The Public Health strategy comes to the next appropriate meeting, including financial aspects and outline spending plans.	Dr Akeem Ali	The Committee will consider the Public Health budget at an information workshop following	*March 2013*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
				the 14 March 2013 meeting.	
SC017	Sexual health services [Item 9]	The Committee looks forward to receiving further information and clarification in due course on future commissioning arrangements for all sexual health services and the new JSNA chapter	Director of Public Health/Scrutiny Officer	This will be circulated in due course	*None*
SC018	Review of Epsom Hospital Merger [Item 6]	The Committee formally calls on Epsom Hospital and Ashford & St Peter's Hospitals and other health organisations in Surrey to re – open discussions on joint arrangements seeking improvements in care and organised efficiencies either through management steering or eventual merger	Epsom & St Helier Hospials/Ashford & St Peter's Hospitals	This has been passed to the hospitals for action.	*None*
SC019	Review of Epsom Hospital Merger [Item 6]	The Committee is concerned that boundary issues appear to have been a factor affecting the roll out of Better Services Better Value(BSBV) and calls for a wider and more independent review of acute provision in the sub-region.	NHS South West London/NHS Surrey/CCGs from 1 April	This has been passed to these bodies for action	*None*
SC020	Performance and QIPP Update [Item 7]	Members to be provided with a guide to the measures on infection control required by hospitals and noted that there is much agreement on best practice	Acting Director of Governance, Transition and Corporate Reporting, NHS Surrey	To come to next meeting	*March 2013*
COMPLETED ITEMS					

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SC021	Recommendation Tracker and Forward Work Programme [Item 8]	The implications and issues arising from The Francis Report to be included in the Work programme for future consideration.	Scrutiny Officer	This has bee put on the work programme	

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DRAFT Health Scrutiny Committee Work Programme 2013-2014

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
July 2013				
	Better Services Better Value Consultation	Scrutiny of Services/Policy Development – The Committee will scrutinise the preferred option(s) of the Better Services Better Value programme out for consultation. Comments will make up the Committee's formal response to the consultation.	Rachel Tyndall, BSBV Surrey Downs CCG	
	Partnership working arrangements with Surrey & Borders Partnership NHS Foundation Trust (SABP)	Scrutiny of Services/Policy Development – The Mental Health Services Public Value Review of 2012 reviewed the partnership working arrangements of Surrey County Council and Surrey & Borders Partnership NHS Foundation Trust. The Committee will scrutinise the outcomes of this review.	Donal Hegarty/Jane Bremner	To be joint with ASC Select
	Surrey acute response to Francis	Scrutiny of Services – Following publication of the monumental Francis Report into failings at Mid-Staffordshire Hospital, all NHS organisations were encouraged to publish their response to and plans for implementing key recommendations made by the Inquiry. Surrey's acute hospitals will be invited to send their response to this. The Committee will discuss these and the wider implications of the report for the NHS.	Acute representative	
	Performance	Scrutiny of Services – The Committee will scrutinise performance across acute hospital providers on key national performance indicators.	TBC	
September 2013				
	Community Health Services	Scrutiny of Services – The Committee will scrutinise current community health provision across the County from the three community providers.	Virgin Care Central Surrey	

DRAFT Health Scrutiny Committee Work Programme 2013-2014

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
			Health First Community Health & Care ASC representation	
	Continuing Health Care (CHC)	Scrutiny of Services – Historically there was a backlog of CHC decisions to be made. The Committee will scrutinise the new lead CCG on arrangements for handling the backlog and moving forward.	Surrey Downs CCG Andy Butler, SCC ASC	
	Healthwatch Update Report	Scrutiny of Services – Healthwatch works with the Committee to identify areas of concern for investigation. Healthwatch will report on its work since April and the Committee can identify any future areas of work.	Healthwatch representative	
	Performance	Scrutiny of Services – The Committee will scrutinise performance across acute hospital providers on key national performance indicators.	TBC	
	NHS Finances	Scrutiny of Services – The Committee will scrutinise current CCG budget information.	CCG finance representatives	
November 2013				
	Development of Services for the Frail and Elderly	Scrutiny of Services/Policy Development – The Frail/Elderly pathway has been identified as a key priority County-wide. Issues include the unnecessary admission of care home residents into hospital. Hospitals and CCGs have been developing key workstreams around improving the pathway. It is important for the Committee to scrutinise current services and contribute to the development and commissioning of new services	SASH East Surrey CCG & other CCGs	To be joint with ASC Select

DRAFT Health Scrutiny Committee Work Programme 2013-2014

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
		and pathways.	Sarah Mitchell, Strategic Director for Adult Social Care	
	Virtual Wards	Scrutiny of Services – The Committee will scrutinise outcomes from this project, one year from implementation.	North West Surrey CCG and other CCGs Jean Boddy, Adult Social Care	
	Health & Wellbeing Board Update	Scrutiny of Services – The Health & Wellbeing Board will be invited to present a report identifying progress since April and any potential changes in service provision or commissioning for the next year.	Michael Gosling/ Joe McGilligan, Co-Chairs Health & Wellbeing Board Simon Laker, Assistant Director, Health & Wellbeing	
	Report of Quality Account Member Reference Groups	Scrutiny of Services – The Committee will receive mid-year update reports from each of the NHS Trust Quality Account Member Reference Groups (QA MRGs).	Leah O'Donovan, Scrutiny Officer	
	Performance	Scrutiny of Services – The Committee will scrutinise performance across acute hospital providers on key national performance indicators.	TBC	

DRAFT Health Scrutiny Committee Work Programme 2013-2014

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
January 2014				
	Sexual Health Services for Children and Young People	Scrutiny of Services – The Committee will scrutinise prevention work with children and young people in schools, colleges and the youth service.	Akeem Ali, Director of Public Health Caroline Budden, Children, Schools & Families	To be joint with C&F Select
	Childhood Obesity	Scrutiny of Services – There is a growing national problem of obesity in children and young people. The JSNA identifies that Surrey does not have an agreed weight management care pathway and services vary across the County, not meeting the needs of those at high risk. The Committee will scrutinise efforts of Public Health and the CCGs in addressing this issue.	Akeem Ali, Director of Public Health Guildford & Waverley CCG Children, Schools & Families representative	To be joint with C&F Select
	Surrey & Sussex Local Area Team	Scrutiny of Services – The Surrey & Sussex Local Area Team of the National Commissioning Board will be invited to report on their commission intentions for primary care and prisoner and offender health for the next year.	Amanda Fadero, Surrey & Sussex LAT	
	Performance	Scrutiny of Services – The Committee will scrutinise performance across	TBC	

DRAFT Health Scrutiny Committee Work Programme 2013-2014

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
		acute hospital providers on key national performance indicators.		
	NHS Finances	Scrutiny of Services – The Committee will scrutinise current CCG budget information.	CCG finance representatives	
March 2014				
	Mental Health Crisis Line Review	Scrutiny of Services – The Committee will scrutinise further work to improve the mental health crisis line provided by Surrey & Borders Partnership NHS Foundation Trust. The report will include outcomes of the carers meetings once they are complete; a review of the acute care pathway; and any further user surveys.	Mandy Stevens/ Rachel Hennessy, SABP NE Hants & Farnham CCG	
	End of Life Care	Scrutiny of Services – People approaching the end of their lives may have complex care needs. Their family also needs to be supported to cope with the relative's eventual death. The Committee will scrutinise current service provision in responding to a person's choices in end of life care.	CCGs Acute hospital representative Social care representative	
	Review of Quality Account Priorities	Policy Development – The Committee will receive progress reports from the QA MRGs for each NHS Trust and review the MRG's comments on priorities for the next year's QA for those Trusts that have submitted draft priorities.	Leah O'Donovan, Scrutiny Officer	
	Performance	Scrutiny of Services – The Committee will scrutinise performance across acute hospital providers on key national performance indicators.	TBC	
May 2014				

DRAFT Health Scrutiny Committee Work Programme 2013-2014

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
	Diabetes management	Scrutiny of Services – The prevention and management of diabetes was identified as a priority for the County in the Joint Health and Wellbeing Strategy. The Joint Strategic Needs Assessment has identified that not everyone who needs weight management and exercise programmes is accessing them. The Committee will scrutinise current service provision and identify any gaps.	CCGs Primary Care representative Community Health representative	
	Review of Quality Account Priorities	Policy Development – The Committee will review the MRG's comments on priorities for the next year's QA for those Trusts submitting priorities since the last meeting.	Leah O'Donovan, Scrutiny Officer	
	Performance	Scrutiny of Services – The Committee will scrutinise performance across acute hospital providers on key national performance indicators.	TBC	
	NHS Finances	Scrutiny of Services – The Committee will scrutinise current CCG budget information.	CCG finance representatives	
July 2014				
	Prisoner and Offender Health	Scrutiny of Services – There are five prisons in Surrey with approximately 2,700 prisoners. Prisoners have high health needs, often coupled with backgrounds characterised by inequalities. The Surrey Joint Strategic Needs Assessment (JSNA) sets out a number of gaps and areas of unmet need for the prisoner population in Surrey and it is therefore important that the Committee investigates options for addressing this issue.	Surrey & Sussex LAT Surrey & Borders Partnership NHS Foundation Trust	
To be scheduled				
	Renal Services	Scrutiny of Services/Policy Development – St Helier Hospital, which is	Epsom & St	

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
		based in the London Borough of Sutton, provides renal services to most Surrey residents. Following the outcome of the Better Services Better Value review that X should become a planned care centre, there is a need to review access to these services for residents of Surrey. The Committee will scrutinise current availability of renal services and the potential to move services back into Surrey.	Helier Hospitals CCG lead (TBC)	
	Cancer Services	Scrutiny of Services – The Committee will scrutinise current provision of cancer screening and treatment services across the County.	Acute hospital representatives Community health representatives	

Task and Working Groups

Group	Membership	Purpose	Reporting dates
Unplanned Care	TBC	There is a national and regional issue whereby people attend A&E for non-emergency care. The various reasons include inability to secure an appointment with a local GP or general lack of knowledge about other more appropriate services. It is hoped that with the roll-out of 111 as a non-emergency number and its comprehensive local services directory that this will	March 2014

		reduce the number of individuals attending A&E for non-emergency care. The purpose of a Task & Finish Group will be to investigate any 'acute blackspots' where there is a higher prevalence of unnecessary A&E attendances. It will also work with SECAmb, as the 111 provider, to monitor the effectiveness of the new system in reducing the number of A&E attendances.	
Prevention for 50-plus	TBC – To be joint with Adult Social Care Select Committee	Preventing the need for social care or health care in the future is paramount to reducing costs across the health and social care landscape as well as contributing to a healthier Surrey population. The Group will investigate the availability and provision of preventative services across the County for both physical and mental wellbeing for those over 50.	March 2014