MINUTES of the meeting of the **HEALTH SCRUTINY COMMITTEE** held at 10.00 am on 30 May 2014 at Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting.

Elected Members:

Mr Bill Chapman (Chairman)
Mr Ben Carasco (Vice-Chairman)
Mr W D Barker OBE
Mr Bob Gardner
Mr Tim Hall
Mr Peter Hickman
Mrs Tina Mountain
Mrs Pauline Searle
Mrs Helena Windsor

Independent Members

Borough Councillor Mrs Rachel Turner

Apologies:

Mr Tim Evans
Rachael I. Lake
Mr Chris Pitt
Borough Councillor Karen Randolph

23/14 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Tim Evans, Rachel I Lake, Chris Pitt and Karen Randolph.

24/14 MINUTES OF THE PREVIOUS MEETING: 19 MARCH 2014 [Item 2]

The minutes of the meeting on 19 March 2014 were agreed as a true record of the meeting.

25/14 DECLARATIONS OF INTEREST [Item 3]

None received.

26/14 QUESTIONS AND PETITIONS [Item 4]

None received.

27/14 CHAIRMAN'S ORAL REPORT [Item 5]

Item 6 was taken before Item 5.

Declarations of interest: None.

Witnesses: None.

Key points raised during the discussion:

1. The Chairman provided the following oral report:

Proposed Merger of Frimley Park with Heatherwood and Wexham Park
The catchment area of Frimley Park Hospital is largely contained within the geography covered by Surrey County Council, Hampshire County Council and Bracknell Forest Unitary Authority.

I have therefore been in informal discussions with the Chairmen of the Health Scrutiny Committees for Hampshire, that is Pat West, and for Bracknell Forest, Tony Virgo. I am pleased to welcome Tony Virgo to our Meeting here today.

Ashford and St Peter's Merger with Royal Surrey Hospital
Since our last Meeting the 2 Management Boards have agreed to a merger. We intend to hear from Royal Surrey and Ashford and St Peter's at our next Meeting on 3 July.

Health Accountability Forum
Ross and I attended this event hosted by the Centre for Public Scrutiny. The event was attended by about 60 Officers and Members from around England.

The high point was a presentation by Mark Browne who is the Senior Civil Servant leading on the development of the role of Scrutiny in the changing Health Environment. Mark will be producing the long promised Government Guidance for Health Scrutiny, which understandably has

been delayed because of the rapidly changing Health Service environment.

I brought away the following 3 messages for us:

- The Health Service needs to change dramatically in the next few years. For example, the Keogh Report pointed the way ahead for Emergency Care. Generally Acute Health units need to become bigger and have Consultant level cover extending towards 168 hours a week. This will mean more major service reconfigurations that would be classed as 'significant' in our Terms of Reference. We have two such changes going forward in Surrey at the moment where Acute Hospital Trusts are merging and I mentioned those earlier.

  Some reconfigurations may be highly controversial. The provisions of Clause 119 of the new Care Bill will make it possible, under certain circumstances, for changes to a local Health Economy to be dictated by a Government appointed Inspector. The impact of Clause 119 will be radical if it goes ahead as currently intended.

- Our role in scrutinising possible reconfigurations will change. The process of examination of such proposals will be expected to broaden to include more emphasis on local partnership. For us that will continue to include active engagement with residents. There will be a better defined resolution process with reference to the Secretary of State only as a very last resort.

- The move towards further integration of Health and Social Services is a key activity in meeting the challenges facing the Health Service. We have an important role to play in insuring that good value for money is obtained from the Surrey Better Care Fund.

Planning Our Work Programme
All Members of the Committee will have the opportunity to become involved in planning our work –programme.

Ross has been organising a half-day Health Scrutiny Event for 19 June at Guildford Borough Council Offices. 8 Members of the Committee have signed up to attend, I believe. Other attendees will be leading people from the Surrey Health Service Commissioners, Acute Hospitals, Community Care providers and County Council Social Care Commissioners.

The objectives will be to understand what is going well and not so well in the Surrey Health Economy, and what should be the role of the Health Scrutiny Committee. The findings from this Event will then feed into a short Planning Event following our next Committee Meeting of 3 July.

Changes to our Committee Membership
Thanks are due to Cllr Richard Walsh who served for two years. I am sure that Members will join me in thanking Richard for his enthusiastic involvement. I look forward to welcoming Cllr Rachael Lake as Richard's replacement.

I would particularly like to thank Dr Nicky Lee who has come to the end of her 6 year stint with us. Nicky brought the distinct and special contribution of a practising GP to our discussions. Nicky also made a point of representing the particular needs of residents of the rural parts of Surrey, particularly with regard to the Ambulance Service.

The Leaders of the Surrey and District Councils will nominate a replacement for Nicky in due course.

Recommendations: None.

Actions/further information to be provided: None.

Committee next steps: None.

28/14 CARE QUALITY COMMISSION [Item 6]

Declarations of interest: None.

Witnesses:

Claire Martin, Inspection Manager GPs (Surrey and Sussex), CQC

Key points raised during the discussion:

1. The Care Quality Commission (CQC) Inspection Manager provided the Committee with a presentation on how the Committee and CQC should work together, copies of the slides can be found attached to the minutes.

2. The Chairman welcomed the invitation for the Health Scrutiny Committee to interact more with CQC and suggested quarterly meetings be held with representatives of CQC and himself and the Scrutiny Officer.

3. Members requested further details on the inspections, including the planning and monitoring of Get Well Plans. The Inspection Manager explained that during inspections specialists also took part to ensure there was clinical expertise. Inspections would focus on any specific concerns that had been raised and would involve a sufficient number of CQC staff and specialists in order to address the requirements of the new inspection methodology. The Wave One inspections for hospitals had involved teams of up to thirty people.

4. For Primary Care inspections there would be a smaller team and a percentage of surgeries would be inspected within a CCG area; these often took place at the same time as acute hospital inspections so as to enable to CQC to gain an understanding of the health environment in an area. The CQC worked closely with NHS England and wanted to work more with partners including Health Scrutiny Committees.

5. The CQC were currently considering how often they should inspect sites, though they would always inspect if there were particular issues.

6. The Chairman queried whether the Committees Member Reference Groups would be welcome to attend the Care Summits so to enable better engagement with the process.

7. The Vice-Chairman requested the CQC be involved in the Committees Primary Care Task Group. The Inspection Manager confirmed that the CQC was aware that there were issues regarding access to GPs and the organisation was looking at Out of Hospital care.

8. The Inspection Manager informed the Committee that the CQC gathered information from a range of sources and they utilised this information to inform the inspections which took place. The Inspection Manager requested Members to pass on specific concerns from residents so they could be assessed by specialists.

9. Members queried whether the financial position of services was considered during inspections and were informed that the CQC were required to determine whether regulations were being breached and could not consider whether there were financially issues involved. It was the role of Monitor to work with acutes in financial difficulties.

10. Members queried whether the specialists worked permanently for CQC and whether they were paid for their services. They were informed that the CQC had a bank of specialists as they all had day jobs as clinicians, and that they were paid for their services.

11. The CQC felt that they did have enough resources to carry out their duties as they had been given more by the government.

12. The Inspection Manager informed Members that the CQC aimed to inspect all GP surgeries by 2016, including those that were inspected last year under the previous inspection system.

13. The Out of Hospital centres had also been re-inspected where there were specific concerns and the Inspection Manager felt that the services had improved and hoped they would continue to improve.

14. Members were informed that services would be scored so as to enable best practice to be shared.

Recommendations:

1. The Committee requests that the Chairman and Scrutiny Officer agree with CQC how it will work in partnership.

2. The Committee will regularly share with CQC data that will inform consideration of issues, priorities and work plans. It will seek to involve the CQC in all relevant activities including task groups.

3. Invite CQC to return in the autumn to review progress on the work they have carried out in Surrey following this Committee.

Actions/further information to be provided: None.

Committee next steps: None.

29/14 FRIMLEY PARK HOSPITAL NHS FT MERGER WITH HEATHERWOOD & WEXHAM NHS FT [Item 7]

Declarations of interest: None.

Witnesses:

Andrew Morris, Chief Executive, Frimley Park NHS Foundation Trust
Dr Timothy Ho, Medical Director, Frimley Park NHS Foundation Trust
Alison Huggett, Director of Quality and Nursing, North East Hampshire and Farnham CCG
Nick Markwick, Surrey Coalition of Disabled People

Key points raised during the discussion:

1. The Chief Executive informed the Committee that the hospital had a catchment area of around 420,000 people and that it was important that the hospital continued to increase its catchment to ensure it continued to be a super-acute hospital supply specialist super-acute services.

2. Heatherwood & Wexham had been in debt since 2009 and CQC had completed a full scale inspection and found the hospital to be inadequate. The hospitals Board and Monitor had reviewed the situation and decided that Heatherwod & Wexham needed a partner and that Frimley would be the best option. Frimley were aware that there was a lot of work to be done, and were strongly of the belief that the performance at Frimley should not suffer due to the merger. Rather, the hospital aimed to raise the standards at Heatherwood & Wexham to the Frimley level.

3. It was envisaged that the merger would save around £10million from back office costs, but would not affect frontline services.

4. Frimley had developed services to be more consultant led with 132 hour consultant cover in the maternity department, one of the highest in the country. It was the aim of the hospital to be at the forefront of delivering services and they wanted to change the culture at Wexham & Heatherwood so as to improve the service delivery.

5. Members were concerned that there needed to be a long term resolution to the issues identified and that services at Frimley should not be adversely affected by the merger. The Medical Director stated that they wanted to maintain the high clinical standards at Frimley, however there was the risk that the hospital would lose services if the merger did not go forward as good clinicians were attracted by hospitals with a broad range of services. Frimley were adamant that the issues at Wexham would be sorted at Wexham. The Chief Executive was firmly of the belief that it was not about rationalising services, however Heatherwood would need to be rebuilt and could become the elective care centre.

6. Members queried whether hospitals could close and were informed that hospitals cannot choose to close services as they were required

to respond to the community's needs. However, once a hospital was in financial difficulty it was hard to get out as they were required to make 4% savings each year. The hospital would need to find solutions to get out of special measures and it was felt that often a culture change was what was needed.

7. The Surrey Coalition of Disabled People were concerned about the patient experience and the requirement to travel long distances for services. The Chief Executive of Frimley Park stated that acute services would be maintained at the sites and patients would only be required to travel longer distances for super-acute services. The hospital did not want to see patients travelling further; they would rather see services repatriated to the hospitals.

8. The Chief Executive informed the Committee that the hospital supported patients in the home where it was appropriate, and they did not have any issues recruiting staff to work in the community as their staff liked the variety of working within a hospital and the community.

9. Alison Huggett spoke on behalf of the Surrey Heath and North East Hampshire and Farnham CCGs. The CCGs were keen to see work towards transforming services and had been fully engaged with Frimley on this work and wanted to assure that services would remain for the community. The CCGs had not seen the full business case, and did have concerns about the quality, sustainability and financial implications of the merger. Surrey Heath CCG and North East Hampshire & Farnham CCG did not want to experience any financial burden from the merger.

10. The Chief Executive informed the Committee that the hospital aimed to have a business case by August 2014 for Monitor to consider. The hospital acknowledged it needed a partner, but would not have chosen Heatherwood & Wexham. The Chief Executive also confirmed that he felt strongly that Surrey CCGs should not take on any financial liability for the transaction. However, Frimley had been advised by Monitor to discuss the merger with NHS England due to the number of CCGs involved.

11. The Chief Executive stated that he would assure that Frimley would continue to have the right senior team running the hospital, while Heatherwood & Wexham would have a separate team.

Recommendations:

1. Committee requests to be kept informed on the progress of the transaction.

2. Scrutiny Officer to liaise with Frimley Park management to agree next appearance.

Actions/further information to be provided: None.

Committee next steps:

1. The Committee to continue to scrutinise the merger of Frimley Park NHS Foundation Trust with Heatherwood & Wexham NHS Foundation Trust.

30/14 RAPID IMPROVEMENT EVENT - ACUTE HOSPITAL DISCHARGE [Item 8]

Declarations of interest: None.

Witnesses:

Sonya Sellar, Interim Assistant Director – Adult Social Care
Susan Reed, Associate Director of Site Services, East Surrey Hospital
Melanie Nunn, Social Care Manager, Ashford & St Peter's Hospitals

Key points raised during the discussion:

1. The Interim Assistant Director provided the Committee with an overview of the work which had taken place during and after the Rapid Improvement Event (RIE) on Hospital Discharge. The aim of the work had been to improve discharge by working together and sharing best practice with colleagues across the health environment in Surrey and representatives from Sussex and Hampshire County Councils.

2. The Associate Director of Site Services of East Surrey Hospital informed the Committee that they were auditing the Going Home Plan to ensure that it for fit for purpose, and there were starting discharge assessments as soon as possible. Furthermore the hospital had started to put on additional patient transport, at cost to the hospital, to ensure that patients were able to travel home.

3. Members queried whether the use of the step-up and step-down beds had been discussed with community providers as they had a number of beds available. The Interim Assistant Director explained that community providers were separate to the RIE and that the work was looking whether Social Care would be able to provide more beds for patients, however she would look into community provider involvement within her area.

4. The witnesses felt that the RIE had enabled the providers to do more for patients and better, as they were now considering the whole system process of a patient's journey. The RIE had been about a change in culture for all involved in hospital discharge with more collaborative working.

5. Members stated that they hoped that there were no longer any discharges taking place during the night.

6. The witnesses stated that the RIE had been a catalyst to bring colleagues from across the health service together and there had been a recommendation to continue to have bi-annual workshops to continue conversations and improvements within the service, as there would always be a need for collaborative and innovative working. The work of the RIE had come to an end, with an evaluation process in July 2014, though best practice would continue to be shared across Surrey.

7. The Committee felt that the RIE had been a good piece of work and looked forward to seeing the evaluation documents to review informally.

Recommendations:

1. The Committee notes the progress made on hospital discharge as a result of last year's Rapid Improvement Event and recognises that the changes made now constitute 'business as usual'.

2. Officers to circulate the evaluation of the work-streams on completion in July whereupon scrutiny of the RIE will come to an end.

Actions/further information to be provided:

1. The Committee to be provided with the evaluation of the work-streams following the evaluation work in July 2014.

Committee next steps:

None.

31/14 SURREY DOWNS CCG OUT OF HOSPITAL STRATEGY [Item 9]

Declarations on interest: None.

Witnesses:

Miles Freeman, Chief Officer, Surrey Downs CCG
Michael Gosling, Cabinet Member for Public Health and Health & Wellbeing Board

Key points raised during the discussion:

1. The Chief Officer of Surrey Downs CCG provided the Committee with a presentation on the Out of Hospital Strategy, a copy of which can be found attached to the minutes.

2. Members queried whether the CCG were monitoring progress against the actions taken, and what had been successful and what had caused difficulties. The Chief Officer explained that they had been focussed on the implementation of new services and felt that it was too early to review the success of the strategy. However, he stated that it appeared they had been able to reduce hospital activity marginally but that the costs had gone up which was being looked into.

3. The CCG felt that they were getting the health system and care right, but still needed to work on the finances. With specialist care commissioned by the Local Area Team it was estimated that costs had risen by 10 – 12%.

4. The Chief Officer informed the Committee that the number of referrals were 500 per week, rather than the stated 500 per year in the strategy document.

5. The CCG were looking to provide GP appointments for patients more at their convenience, whether that be at the patients surgery or elsewhere. The aim was to have a different surgery open later each day, however patients would need to opt in to having their details shared with other surgeries.

6. Virtual Wards aimed to avoid avoidable acute hospital admissions by providing care in the community through Community Medical Teams.

7. The Chief Officer explained to Member that GP services were commissioned by NHS England, and thus the CCG had no contractual control over the service provided by surgeries. However, the CCG was looking to put in an enhanced service with funding, but only if the surgery was of the right standard with appointments available and good customer service. Although the main issue within Primary Care was that there were not enough doctors. The Chief Officer felt that there needed to be a financial incentive to improve customer care at surgeries.

8. The Committee were informed that CCGs were able to put in expressions of interest for co-commissioning GP services by 20 June 2014. The CCG would only consider co-commissioning the service with caveats in place which ensured they would not take on financial strain.

9. Members queried the CCGs strategy for Cottage Hospitals and were informed that there were some ideas, however these had not been formed into a strategy to-date. The CCG had however, modelled where beds were needed during the year and were in discussion with other CCGs which did not have Cottage Hospitals as to whether they would commission beds. Stroke rehabilitation was also a consideration for the use of the beds.

10. Members queried whether difficulties with the different contract types were being tackled. All acute hospitals are paid via Payment by Results. This system makes sense for elective care, where it incentivises short waiting times and promotes choice, but may be the wrong mechanism for non-elective (emergency/urgent) care.

11. The Cabinet Member informed the Committee that he had spoken to the Chief Officer and Clinical Chair of Surrey Downs CCG about the need for greater integration as it would lead to the best care for patients. The Chairman stated that it was important to the Committee that they saw greater integration between health and social care which worked.

12. The Chief Officer stated that Surrey Downs was managing the Continuing Healthcare work-stream within the Better Care Fund, and that there appeared to be duplication with Social Care.

13. The Chairman provided the CCG with support in principle for submitting an expression on interest in co-commissioning GP services.

Recommendations:

1. The Committee recommends that the CCG share the good practice they have developed in their plans for improving primary care.

2. Notes the difficulties of aligned differing models of financial incentive – block contracts and payments by results.

3. Recognises the challenges faced in the Continuing Health Care service in Surrey and the improvements achieved by the CCG.

Actions/further information to be provided:

Response to Surrey Downs CCGs request for an opinion on their interest in becoming co-commissioners of primary care:

Based on the conversation had at the Health Scrutiny Committee's May 30 meeting the Committee is broadly supportive of the CCG's bid to become a co-commissioner of primary care alongside NHS England. It offers an opportunity to develop primary care in the Surrey Downs area and resolve any variations in service and access to care. It may also be an improvement on the current arrangements.

The Committee offers this support with caution due to the potential for a conflict of interest with GPs co-commissioning primary care and the potential tensions it could create in the relationship between GPs and CCG leadership.

Committee next steps: None.

32/14 REVIEW OF QUALITY ACCOUNT PRIORITIES [Item 10]

Declarations of interest: None.

Witnesses: None.

Key points raised during the discussion:

1. The Committee agreed to consider Quality Account priorities informally.

Recommendations: None.

Actions/further information to be provided: None.

Committee next steps:

1. The Committee to consider Quality Account priorities informally.

2. The Committee to continue to have Member Reference Groups to enable Quality Accounts to be reviewed by the Health Scrutiny Committee.

33/14 RECOMMENDATION TRACKER AND FORWARD WORK PROGRAMME [Item 11]

Declarations of interest: None.

Witnesses:

Ross Pike, Scrutiny Officer

Key points raised during the discussion:

1. The Committee noted its recommendations tracker and forward work programme.

2. The Chairman informed Members that after the Committee meeting on 3 July 2014 there would be an informal workshop to discuss items to be scrutinised in the next year.

Recommendations: None.

Actions/further information to be provided: None.

Committee next steps:

1. The Committee to review its recommendations tracker and forward work programme at future meetings.

34/14 DATE OF NEXT MEETING [Item 12]

The Committee noted the next meeting would be held on 3 July 2014 at 10am in the Ashcombe Suite.

Members were also reminded that the Health Scrutiny Event would be taking place on 19 June 2014 at Guildford Borough Council.

Meeting ended at: 1.10 pm

Chairman

Scrutiny and regulation working together

Claire Martin
Inspection Manager
GPs (Surrey and Sussex)

CQC strategy 2013-16

Care Quality Commission

CQC's Strategy for 2013 to 2016 states that

'locally we will focus on developing relationships with local authorities…overview and scrutiny committees".

Also 'in involving ….overview and scrutiny committees…we will make sure we better share information locally about people's experiences of care.'

Frances report recommendations

Care Quality Commission

“CQC should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information source” (47)

About this presentation

Care Quality Commission

These slides give an overview of:

- CQC's new strategy
- Changing our approach to regulating, inspecting and rating services
- How we want to work with your Overview and Scrutiny Committee
- Further information

Our purpose and role

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care

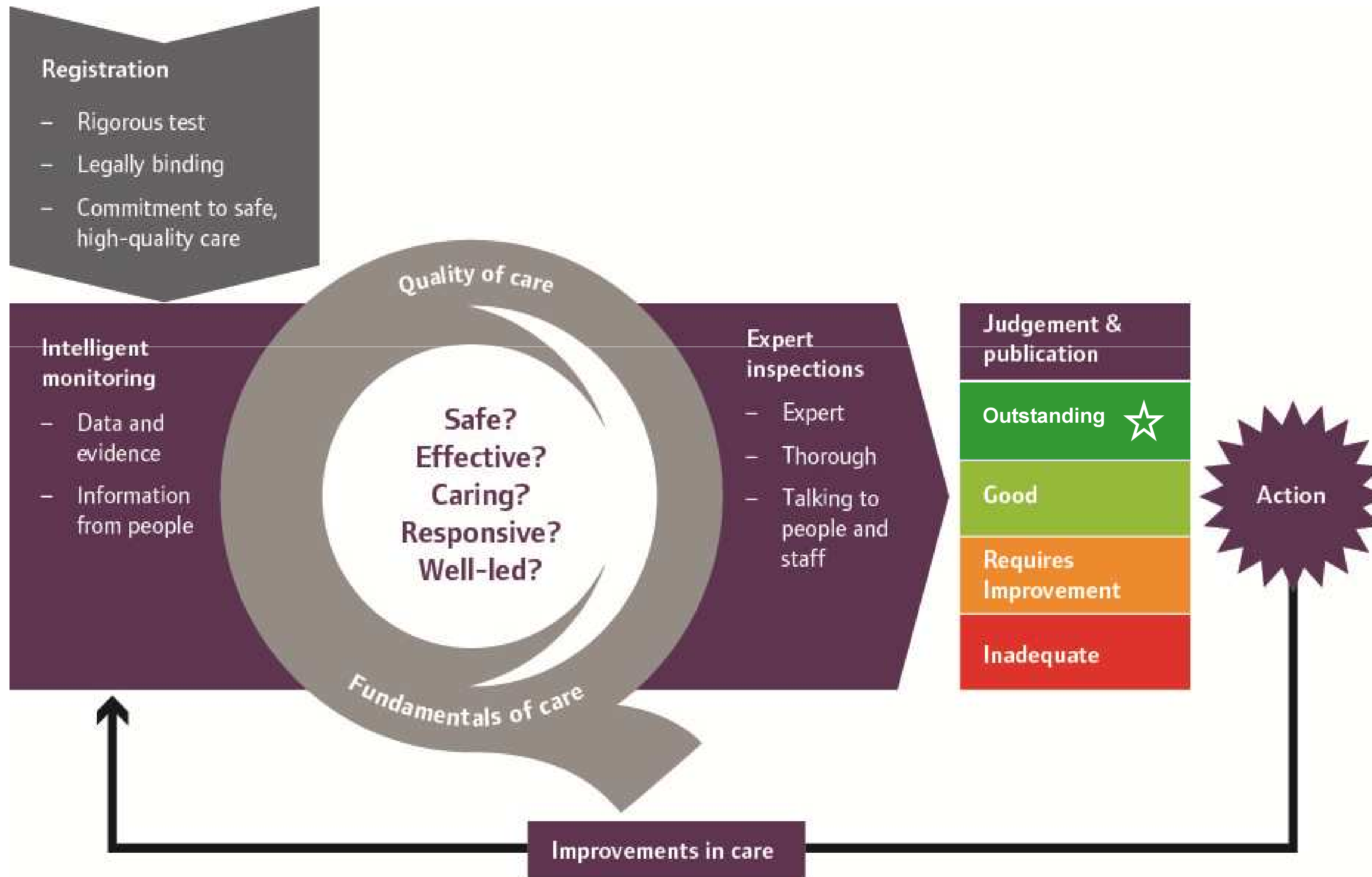
We will be a strong, independent, expert inspectorate that is always on the side of people who use services

'Raising Standards; Putting People First 2013-2016'

- Better information for the public including ratings
- Improved assessments of services and Chief Inspectors
- Stronger national and local partnerships – eg.health and wellbeing boards, Healthwatch, OSCs
- A more rigorous test for organisations applying for registration with CQC
- Changing our approach to the NHS acute trusts and mental health -New fundamental standards
- Improve our assessments of how services work together – for example dementia care

Our new approach (1)

CareQuality Commission



Underpinning our approach

Care Quality Commission

Our judgements will be independent of the health and social care system

We will always be on the side of people who use services.

This is why our relationships with overview and scrutiny committees are an important part of how we work.

Developing the changes

CareQuality Commission

We are co-producing the changes by working closely with our partners, providers, key stakeholders, the public and people who use service:

- **A new start consultation launched June 2013**
- **Advisory and co-production groups**
- **Targeted focus groups and research**
- **Activities on public online community**
- **Social media activity E.g. Twitter chats**

What will be different?

Future
More targeted inspections
Making judgements using the 5 key questions
Commitment to taking firm action
Clearer reports
Better information

Timetable

Care Quality Commission

Oct 2013 – March 2014	Co-production and development to shape consultation proposals
April 2014	Consultation on regulatory approach, ratings and guidance
June 2014	Evaluation; guidance and standards refined.
July 2014	Consultation on regulations and enforcement policy
Oct 2014	New approach fully implemented and indicative ratings confirmed

Five areas of quality and safety in our new approach to inspections

Our new inspections across all sectors ask:

Are services safe?

Are they effective?

Are they caring?

Are they well-led?

Are they responsive to what people tell them?

We want to use any information available from OSCs to support these inspections – especially feedback from local people

Safe

Care Quality Commission

By safe, we mean that people are protected from abuse and avoidable harm.

Effective

Care Quality Commission

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Responsive

Care Quality Commission

By responsive, we mean that services are organised so that they meet people's needs.

Well-led

Care Quality Commission

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality care, supports learning and innovation, and promotes an open and fair culture.

What we will continue to do

- Inspections at any time in response to concerns
- Reviews on particular areas of care – including a review of emergency mental health care and a review of end of life care
- Regulatory and enforcement action

Care Quality Commission

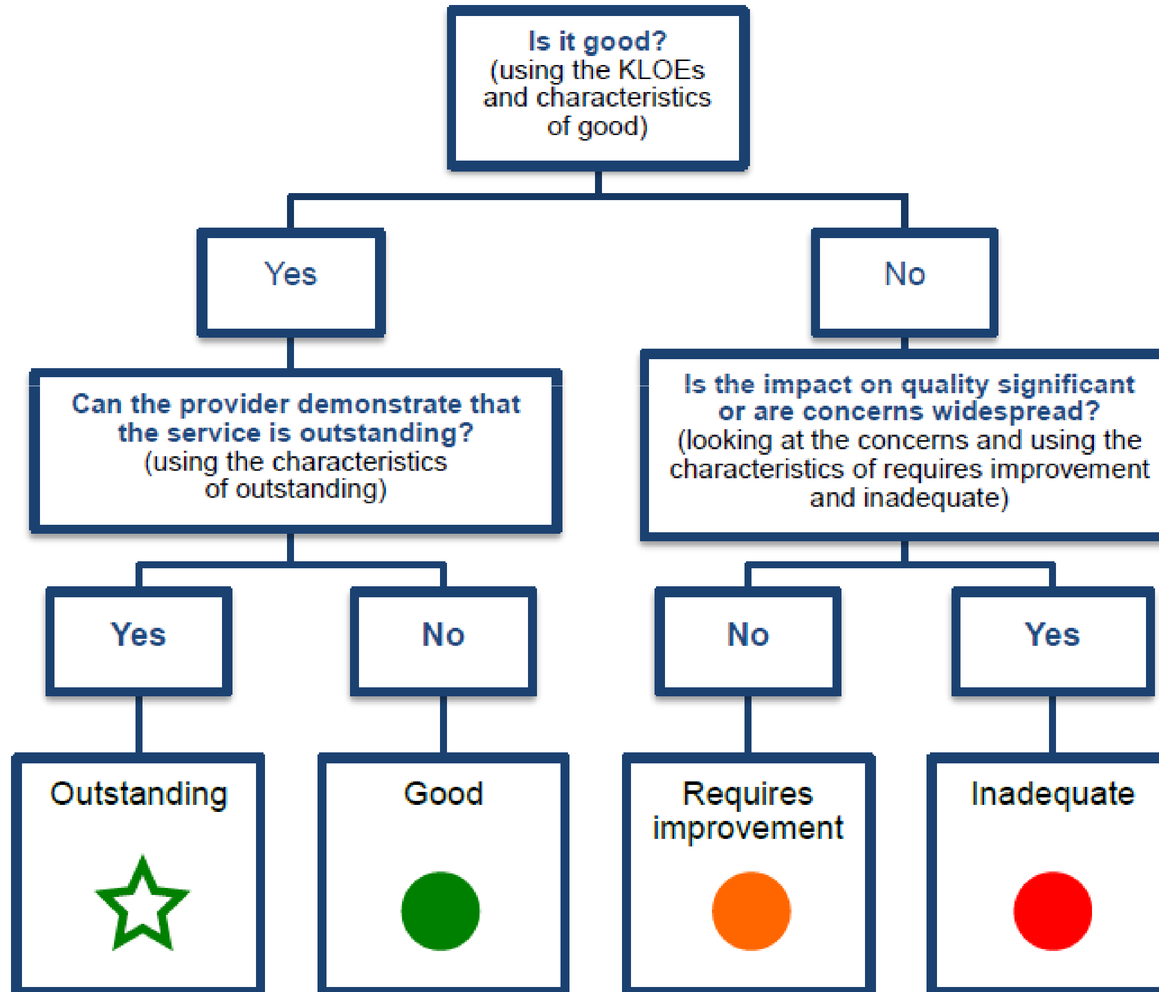
Ratings

Four point scale

Judgement & publication	High level characteristics of each rating level
Outstanding	Innovative, creative, constantly striving to improve, open and transparent
Good	Consistent level of service people have a right to expect, robust arrangements in place for when things do go wrong
Requires Improvement	May have elements of good practice but inconsistent, potential or actual risk, inconsistent responses when things go wrong
Inadequate	Severe harm has or is likely to occur, shortfalls in practice, ineffective or no action taken to put things right or improve

How do we decide a rating?

Care Quality Commission



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How do we give ratings?

Services will be rated at two levels:

- level one - we will produce separate ratings for each of the five key questions
- level two - we will combine these separate ratings up to get an overall location rating using 'ratings principles'

Level 1

	Safe?	Effective?	Caring?	Responsive?	Well-led?
Rating	Good	Good	Good	Inadequate	Good

Level 2

Overall rating
Requires improvement

Ratings principles

Care Quality Commission

Overall ratings are given using the following principles:

- If two or more of the key questions are rated ‘inadequate’, then the overall rating will normally be ‘inadequate’
- If one of the key questions is rated ‘inadequate’, then the overall rating will normally be ‘requires improvement’
- If two or more of the key questions are rated ‘requires improvement’, then the overall rating will normally be ‘requires improvement’
- At least two of the five key questions would normally need to be rated ‘outstanding’ before an overall rating of ‘outstanding’ can be awarded

From April 2014

- We now have a new organisational structure
- Our new approach to acute hospital inspections has been introduced following our pilot inspections – **July – September 2014 Inspection Programme has recently been announced**
- Adult Social Care and primary care inspections started
- We continue to inspect other services as usual

CQC in the region

Care Quality Commission

- We have inspection teams responsible for:
- Primary and integrated care
- Adult social care
- Acute, community and mental health services

We will maintain local relationships with scrutiny committees

Inspection teams will work together to coordinate their contact with scrutiny committees

We want Overview and Scrutiny Committees to:

- Continue an ongoing relationship with local CQC staff
- Advise us as part of our new inspections of NHS trusts – sharing evidence and contributing to the Quality Summits
- Know what we have done with your information
- Know about all our inspection activity and where we have concerns about services
- Explore how we best work with scrutiny committees in the new primary care and social care inspections

CQC and CfPS

Care Quality Commission

We will be working with the Centre for Public Scrutiny to develop closer working relationships with scrutiny committees and elected members to:

- Help improve the consistency and quality of local relationships
- Increase evidence gathered and used to inform our regulatory activity
- Increase the use of CQC information in local scrutiny
- Develop information sharing between scrutiny, Healthwatch and Health and Well Being Boards

Top tips for scrutiny committees

- Build a dialogue with CQC – with regular informal contact and chairs able to ‘pick up the phone’
- Let CQC know your committee’s plans and progress of work
- Meet with CQC – as a partner not as a ‘witness’
- Use our information – the registered services in your area, our inspection activity and our findings
- Share information with CQC about people’s experiences of the local health and care system and of individual services
- Information from scrutiny reviews, public meetings, issues from councillors can all be useful to CQC
- Share your findings and recommendations from reviews
- Expect feedback from CQC on how we use your information

In return, your local CQC contact will:

- Aim for a ‘no surprises’ relationship – regular structured contact
- Meet with OSCs – but as a partner, not an interviewee
- Explain how CQC fits into the local health and care system
- Provide feedback on how we use information from scrutiny
- Explain how services do/don’t meet the fundamental standards and what CQC expects of providers
- Have confidential conversations with the chair/lead officer where agreed
- Hold joint meetings where needed with you and the local Healthwatch
- Help councillors understand the inspection process

Reports, alerts and ebulletin for OSCs

CareQuality Commission

- We will continue to write to all scrutiny committees as we announce new inspections and alerting committees to public listening events
- You should receive local press releases and updates on our national reports.
- We now send a two monthly ebulletin for all OSCs– setting out our latest news and ways you can get involved in our work
- We are planning an updated briefing for OSCs about working with CQC (due summer 2014)
- A new report on how CQC and district councillors can work together (due summer 2014)

Reports, alerts and ebulletin for OSCs

CareQuality Commission

On our website, you can now sign up to receive alerts about our inspections of your local care services.

You can subscribe to receive alerts from the profile of any service in England. See our instructions on how you can sign up for these alerts. http://www.cqc.org.uk/public/our-email-alerts

As well as subscribing to email alerts, you can find out where we have published reports on the Our latest reports page

More information

Care Quality Commission

Read the CQC strategy on our website at

Care Quality Commission www.cqc.org.uk

Telephone 03000 616161 if you want to speak to someone at CQC

Email enquiries@cqc.org.uk to send us information from your scrutiny reviews and other work from your programme

Please email involvement.edhr@cqc.org.uk if you want to get involved in national CQC developments. This will take you directly to the involvement team

More information

Guide for local councillors on working with CQC

http://www.cqc.org.uk/sites/default/files/media/documents/a_guide_for_councillors.pdf

Guide for overview and scrutiny committees on working with CQC

http://www.cqc.org.uk/sites/default/files/media/documents/a_guide_for_oscs_0.pdf

Information about the government standards we check on

http://www.cqc.org.uk/public/what-are-standards/national-standards

This is an example of a public guide - about the standards you can expect in hospital. http://www.cqc.org.uk/public/what-are-standards/standards/standards-hospitals

There are also guides about what you can expect from your care in care homes, care at home and dentists

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Surrey Downs
Clinical Commissioning Group

Health Scrutiny Committee:
Surrey Downs CCG Out of Hospital Strategy

Miles Freeman, Chief Officer, Surrey Downs CCG

30 May 2014

Expanding our Out of Hospital Strategy

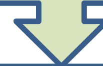
- Our Out of Hospital Strategy was developed from April to June 2013 when CCGs were entering into their first year.

- At the end of year one, the following has changed the roles and responsibilities of CCGs:
  - Creation of the **Better Care Fund**
  - End of **Better Services Better Value programme**
  - Department of Health and NHS England's **'Transforming Primary Care' strategy** (April 2014)
  - **'Improving General Practice: A Call to Action'-** NHS England consultation (August 2013)
  - **Everyone Counts & Putting Patients First planning guidance** for 2014-2019 (two operating planning rounds)
  - **Primary care co-commissioning-** Simon Stevens' offer to CCGs (May 2014)
  - **Devolution of responsibilities** from the Area Team

This has resulted in the evolution of our Out of Hospital Strategy into a wider reaching 5 year integrated commissioning plan…

Summary of our priorities for 2014 - 2016

6 Key Clinical Priorities plus supporting programmes and projects (2 – 5 year Operating and Strategic Plan 2014 - 2019)



Priority 1 (P1)
Maximise integration of community and primary care based services with a focus on frail older people and those with Long Term Conditions

Priority 2 (P2)
Provide elective and non urgent care, specifically primary care, closer to home and improve patient choice

Priority 3 (P3)
Ensure access to a wider range of urgent care services

Priority 4 (P4)
Enhanced support for those patient who require End of Life care

Priority 5 (P5)
Improve the access and patient experience of children's and maternity service

Priority 6 (P6)
Improving patient experience, outcomes and parity of esteem for people with mental Health and Learning Disabilities (including dementia)

Key Headlines of transformational clinical programmes

- Locality Integrated Teams providing 5 day rehabilitation at home and 2 hour rapid response services.
- Transform Continuing Health Care Services. **(P1)**

- Developing Primary Care Clinical Networks, providing a community medical network for chronic disease management **(P2)**

- Developing an Urgent Care and Discharge system that works to enable people to return to a suitable care environment earlier in their recovery pathway **(P3)**

- Improving our End of Life care pathway focusing on person centred care **(P4)**

- Surrey Wide redesign and recomissioning of Child and Adolescent Mental Health Service **(P5)**

- Continued developed of Dementia Services moving away from bed model of care by increasing community support
- Increase annual health checks for people with a learning disability **(P6)**

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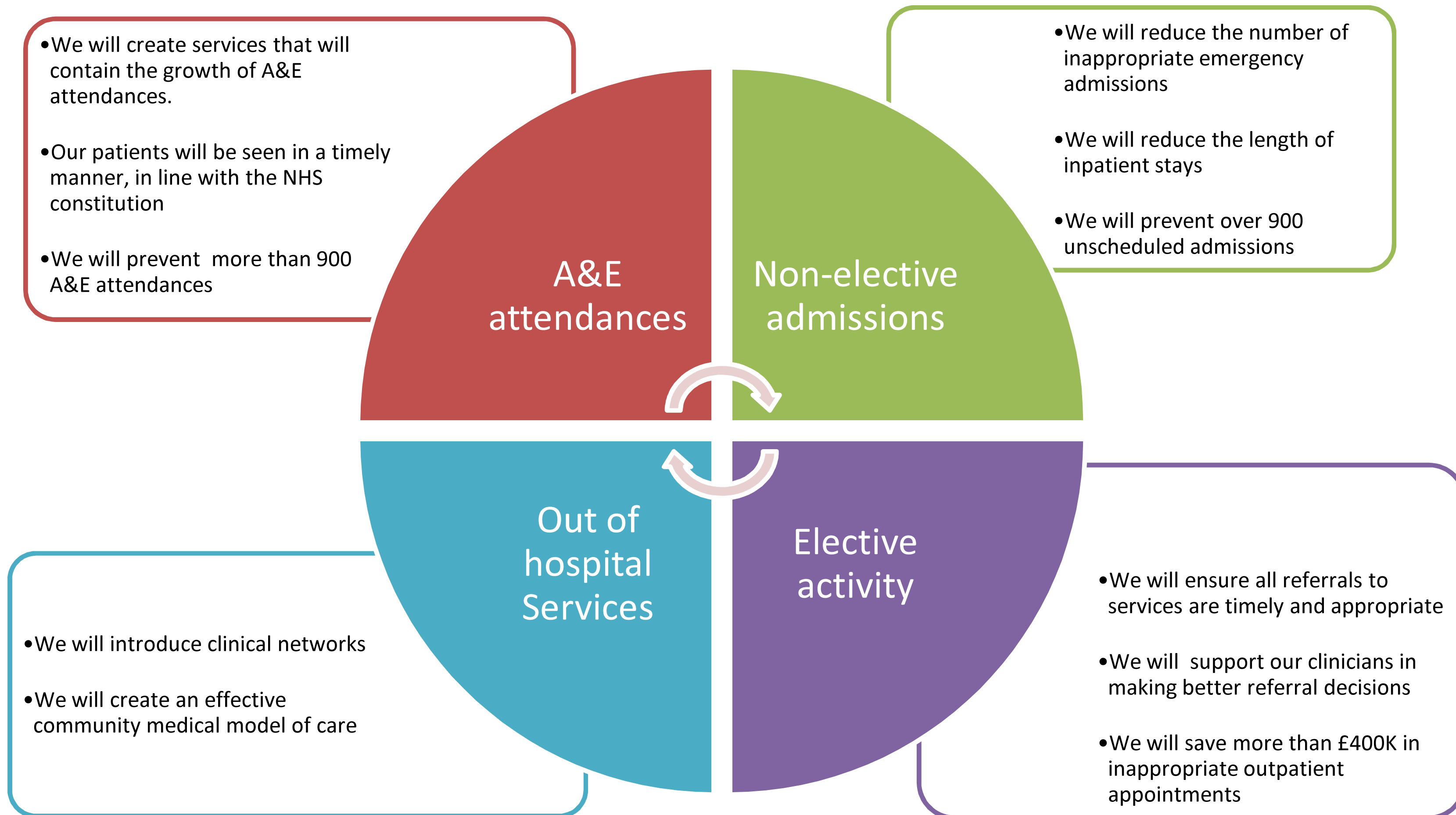
Our interventions will have an impact in how our population uses health services



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Primary Care Case for Change

1. Inadequate **capacity** for rising need

2. **Variation** between areas and practices

3. The need to extend the scope of Primary Care to enable it to **manage Long Term Conditions**

4. No alignment of **incentives**

5. No economies of **scale**

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Transformational Change:
Developing Primary Care offer

Inadequate capacity for rising need
More access within general practice through INCREASED access and IMPROVED access

Variation between areas and practices
Standardised set of services available to ALL patients within a **network of practices**

The need to extend the scope of Primary Care to enable it to manage Long Term Conditions and our most vulnerable patients
Best practice Chronic Disease Management

Continuity of care for most vulnerable patients in our Acutes/Community Hospitals/ GP Practices through to Home Visiting

No economies of scale, No alignment of quality, financial or clinical incentives
Creating and incentivising **working at scale**

Community Medical Team (CMT)

The health and social care economy is no longer just primary, social care and secondary care. Our approach to BCF is to **integrate provision for community housebound chronic illness.** Initially CMTs will focus on **high risk housebound patients** and in time possibly move to **medical provision for all.**

A CMT will provide integrated care for chronic disease management e.g. those identified as being 'at risk' as a result of their disease/social profile:

- **Medical case management in the community, or 'wrap around care' working with community, social care and mental health services.**
- **Medical management of community beds and interfaces within acute hospital.**
- **Acute/Ambulatory Assessment Units for rapid diagnostics (day case only) to prevent admissions.**

Out-of-hospital medical care for chronic disease management

Referral Support System (RSS)

- Surrey Downs CCG commissioned a referral support service in October 2013 due to a number of issues:

- There is was no **consistent approach** to referral management
- A **comprehensive directory** of services was not uniformly available
- Some patients were referred **without adequate work up**
- There was **no transparent system to promote patient choice**

- We have implemented a new **clinically led, independent** RSS, hosted by the CCG , which IS responsible for all **non-urgent referrals across the CCG**.

- The service **supports GPs, promotes patient choice,** ensures patients are referred to the **right clinician** and sign-posts patients throughout the process.

- **All of our practices are signed up** to the RSS and the majority are now using the service. The service is **receiving 500 referrals per year.**

Benefits to patients and organisations					
Improve patient experience through improving the acuity of referrals and avoiding unnecessary appointments	Develop expert knowledge of local pathways across all providers	Training, education and support to practices, particularly newly qualified doctors or those new to the area	Ensure probity and transparency, resulting in greater patient choice of services, with patients choice of OoH providers, Community and Acute services	Identify opportunities to redesign services and improve pathways for the future	Reduce variation between practice referral rates

Priority 3 (P3)
Ensure access to a wider range of urgent care services

Proposals- Urgent Care System

- The **out-of-hours service** will be procured this year, with a centre co-located with A&E and weekend bases across all localities.
- We are working towards weekday extended access (8-8) service provided by our practices as it works better for patients; including dialogue on standardising appointments across practices.
- **Our Community Assessment Unit** at Leatherhead has been co-located at Epsom to ensure a more resilient model of care with A&E
- We have also launched an Ambulatory Care Unit at Epsom so that more patients can receive day care and be returned home with support from community services (and in future the community medical teams) as an alternative to admission.
- A similar unit has been co-funded at Kingston Hospital for East Elmbridge residents

Priority 4 (P4)
Enhanced support for those patient who require End of Life care

Nationally 70% of people would prefer to die at home, yet 51% die in hospital. **In areas using EPaCCS, 76% of people die in their preferred place** & 8% die in hospital- a significant improvement in quality of care

End of Life Care

We have implemented an **Electronic Personal Care Record** to:

- **Identify** people who are considered to be in their last year of life and, with appropriate consent, so that they can die in their preferred setting of care.

- **900 patients** have requested a record since the register was launched and local clinicians have been trained in hospitals, community, primary care, SECAMB and out-of-hours.

- SCC & CCG are developing a programme to ensure Gold Standard Framework is implemented across all providers including nursing and residential homes.

Dementia

- All 33 practices are now using the dementia screening tool to ensure earlier diagnosis.

- To date **1,353** have been screened by the service with patients referred to memory services and other Surrey & Borders NHS Trust.

Priority 5 (P5)
Improve the access and patient experience of children's and maternity service

Children's and maternity commissioning priorities 2014/2015

- **Child and Adolescent Mental Health Services (CAMHS)**
  - Re-procurement in conjunction with Surrey County Council
- **Children with complex needs**
  - Children & Families Act (SEND, PHB) working towards joint commissioning around the child
- **Perinatal mental health**
  - Links to 'Surrey Emotional Wellbeing and Adult Mental Health Commissioning' strategy
- Surrey-wide focus on **looked after children, early help and safeguarding**
- Integrated models of care **around the child and mother**

High level of **partnership working** with Surrey County Council and NHS England's public health team to **integrate service delivery** for children and families

Reviews in process (community services):

- Speech and language therapy- *Complete*
- Occupational Therapy- *Due*
- Dietetics- *Complete*
- Specialist School Nursing- *Complete*
- Joint review of short breaks provision- *Ongoing*

For review:

- Physiotherapy
- Wheelchairs and other equipment
- Continence services
- CCNT (support from NHSE)

Priority 6 (P6)
Improving patient experience, outcomes and parity of esteem for people with mental Health and Learning Disabilities (including dementia)

"No health without Mental Health"

- Mental Health Strategy for England 2011

Through **integrated working** with all partner organisations including the voluntary sector we will work towards jointly agreed **health and social care outcomes** for people in Surrey Downs

Local priority areas are being drawn together through clinical leads and reference groups

- **IAPT** service development: pilot to send referrals through the Referral Support Service
- Mental health promotion and prevention – including **prevention** of suicide and substance (including alcohol) miss-use
- **Dementia** pathway redesign: including dementia screening project
- Integrated **Community** Hubs

Surrey-wide themes are supported through close working with Mental Health Clinical Commissioning Collaborative Forum and projects are developed locally

- Psychiatric liaison and crisis pathway development: local mapping and gap analysis
- Single Point of Access

Summary and Next Steps

- Tight financial environment
- Strategy based upon containing demographic growth and managing care out of hospital
- Reductions in costs outside hospital
- Requires system wide responses not salami slicing
- Integration to reduce duplication , improve care and constrain cost

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