Notice of Meeting

Health Scrutiny Committee

Date & time
Friday, 30 May 2014
at **10.00 am**
A private Members pre-meeting will be taking place at 9.30am in the Judges Dining Room

Place
Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN

Contact
Ross Pike or Victoria Lower
Room 122, County Hall
Tel 020 8541 7368 or 020 8213 2733

ross.pike@surreycc.gov.uk or victoria.lower@surreycc.gov.uk

Chief Executive
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 9122, 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 ross.pike@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 Ross Pike or Victoria Lower on 020 8541 7368 or 020 8213 2733.

Members

Mr Bill Chapman (Chairman), Mr Ben Carasco (Vice-Chairman), Mr W D Barker OBE, Mr Tim Evans, Mr Bob Gardner, Mr Tim Hall, Mr Peter Hickman, Rachael I. Lake, Mrs Tina Mountain, Mr Chris Pitt, Mrs Pauline Searle and Mrs Helena Windsor

Co-opted Members

Rachel Turner, Karen Randolph

Substitute Members

Graham Ellwood, Pat Frost, Marsha Moseley, Chris Norman, Keith Taylor, Alan Young, Victoria Young, Ian Beardsmore, Stephen Cooksey, Will Forster, David Goodwin, Stella Lallement, John Orrick, Nick Harrison, Daniel Jenkins, George Johnson.

Ex Officio Members:

Mr David Munro (Chairman of the County Council) and Mrs Sally Ann B Marks (Vice Chairman of the County Council)

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 NHS bodies to secure hospital and community health services to the inhabitants of the authority's area;
- the provision of both private and NHS services to those inhabitants;
- the provision of family health services, personal medical services, personal dental services, pharmacy and NHS ophthalmic services;
- the public health arrangements in the area;
- 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 plans, strategies and decisions of the Health and Wellbeing Board;
- 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 Healthwatch under the Health and Social Act 2012;
- social care services and other related services delivered by the authority.

In addition, the Health Scrutiny Committee will be required to act as a consultee to NHS bodies within their areas for:

- substantial development of the health service in the authority's areas; and
- any proposals to make any substantial variations to the provision of such services.

PART 1

IN PUBLIC

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

2 MINUTES OF THE PREVIOUS MEETING: 19 MARCH 2014 (Pages 1 - 12)

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 Member's questions is 12.00pm four working days before the meeting (26 May 2014).
2. The deadline for public questions is seven days before the meeting (23 May 2014).
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 CARE QUALITY COMMISSION (Pages 13 - 32)

Purpose of the report: Scrutiny of Services

The Committee will be given an overview of the developments in how the Care Quality Commission (CQC) inspects and regulates health services.

7 FRIMLEY PARK HOSPITAL NHS FT MERGER WITH HEATHERWOOD & WEXHAM NHS FT (Pages 33 - 40)

Purpose of report: Scrutiny of Services and Budgets; Policy Development and Review; Performance Management

The purpose of the paper is to provide the Surrey Health Scrutiny Committee with an update on progress towards a possible acquisition of Heatherwood and Wexham Park NHS Foundation Trust by Frimley Park NHS Foundation Trust. The transaction timeline is challenging and many elements are subject to change, but this paper gives a report of the state of play in mid May 2014.

8 RAPID IMPROVEMENT EVENT - ACUTE HOSPITAL DISCHARGE (Pages 41 - 48)

Purpose of the report: Scrutiny of Services

The committee will review the progress and impacts of the actions identified in the July 2013 Acute Hospital Rapid Improvement Event.

9 SURREY DOWNS CCG OUT OF HOSPITAL STRATEGY (Pages 49 - 116)

Purpose of report: Scrutiny of Services and Budgets; Policy Development and Review

Pressure on A&E departments continues with non-emergency admissions. The committee will scrutinise the plans of Surrey Downs CCG to provide more community based care to meet local needs in their Out of Hospital Strategy.

10 REVIEW OF QUALITY ACCOUNT PRIORITIES Verbal Update

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.

11 RECOMMENDATION TRACKER AND FORWARD WORK PROGRAMME (Pages 117 - 130)

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 at 10am on 3 July 2014.

David McNulty
Chief Executive
Published: Wednesday, 21 May 2014

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

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Thank you for your co-operation

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MINUTES of the meeting of the **HEALTH SCRUTINY COMMITTEE** held at 10.00 am on 19 March 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 Tim Evans
Mr Bob Gardner
Mr Tim Hall
Mr Peter Hickman
Mrs Tina Mountain
Mr Chris Pitt
Mrs Pauline Searle
Mr Richard Walsh
Mrs Helena Windsor

Independent Members

Borough Councillor Nicky Lee
Borough Councillor Karen Randolph
Borough Councillor Mrs Rachel Turner

In Attendance

Mr Michael Gosling, Cabinet Member for Public Health and Health & Wellbeing Board

13/14 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

None received.

14/14 MINUTES OF THE PREVIOUS MEETING: 9 JANUARY 2014 [Item 2]

The minutes of the meeting on 9 January 2014 were agreed as a true record of the meeting with the following amendments:

- Item 5/14 paragraph 1 – the Better Services Better Value item should read the Epsom and St Helier MRG.
- Item 7/14 paragraph 5 – be amended to read 12pm (noon).

15/14 DECLARATIONS OF INTEREST [Item 3]

None received.

16/14 QUESTIONS AND PETITIONS [Item 4]

None received.

17/14 CHAIRMAN'S ORAL REPORT [Item 5]

Declarations of interest: None.

Witnesses: None.

Key points raised during the discussion:

1. The Chairman provided the following oral report:

Direction of Travel for the Acute Trusts
All five Acute Trusts in Surrey recognise that they have to change in response to the changed environment in which they find themselves. The report by Sir Bruce Keogh has highlighted the need to move towards seven day working at hospitals and to consolidate specialisms at fewer sites to improve the quality of service provided to patients. To do this the Acute Trusts will have to achieve a sufficient patient catchment and budget.

East Surrey Hospital
We heard from Michael Wilson of East Surrey Hospital at out last Meeting on 9 January and I have little to add, apart from wishing the Trust well in its bid for Foundation Trust status which is due for decision in October.

Epsom Hospital
Several Members of the Committee visited Epsom Hospital on 12 March and spoke to Matthew Hopkins, the CEO, and to Peter Davies their Business Transformation Officer.

For me there are two very encouraging points to be made:

The financial position of Epsom and St Helier Trust has improved dramatically over the past two years and providing that continues the

future of the Trust will be in its own hands. They should not be prey to takeover. All quality measures are good and there is good reason to believe that the Trust will achieve Foundation status within 18 months.

The combined turnover for the Trust is £350 million which gives them a sufficient size to achieve necessary transformation almost completely within the Trust itself and without the need for any merger.

Concerns have now arisen with the news that Matthew Hopkins will be leaving the Trust shortly for a six month secondment and it is hoped that the Trust will continue to work towards a more secure future.

Royal Surrey Hospital and Ashford and St Peter's Hospital
I visited Nick Moberly at Royal Surrey Hospital and separately Andrew Liles at Ashford and St Peters Hospitals. Plans for closer working between the two Trusts are well advanced. The two Boards will soon consider options for how close the cooperation might be.

The combined catchment and budget for the two Trusts should make it a largely self-sufficient entity moving forward. We hope to have an Item on this topic on the Agenda early in the new Council year.

Frimley Park Hospital and Heatherwood and Wexham Park Hospitals
I took part in a public engagement event held by Surrey Heath CCG at which Andrew Morris outlined progress on a take-over by Frimley Park of Heatherwood and Wexham Park Trust. The target date for completion is August of this year.

We need to investigate this further as at first sight it might appear to be a 'significant change' and therefore require convening of a Joint Health Scrutiny Committee of the four Counties covered by the combined catchment area.

South East Coast Ambulance Service
I visited Geraint Davies at SECAmb and discussed further the Patient Transport System. Members of our Member Reference Group will be welcome to attend future Meetings. It was noted that commissioning for SECAmb services has passed from East Surrey CCG to North-West Surrey CCG.

Joint Emergency Service Interoperability Programme
On 22 January several of Members of HSC joined colleagues from the Communities Select Committee in visiting the Fire and Rescue Services HQ at Reigate to hear about the Joint Emergency Service Interoperability Programme JESIP. This covers the 'blue light' services of Police, Fire and Ambulance across Kent, Surrey and Sussex.

The objective is to improve services to the public by moving incrementally to a shared Contact and Control System and hence cutting out the delays in response which can currently occur.

Clinical Commissioning Groups
Since our last Meeting I have visited 5 of the 6 Surrey CCGs and attended a Meeting of the Surrey Health and Wellbeing Board.

Surrey Heath Health and Wellbeing Board
I have joined the Surrey Heath Health and Wellbeing Board, which largely shadows the Surrey Health and Wellbeing Board in its membership. It focuses on local issues and provides an effective forum for interaction with the Borough's Community Services people. Some other Boroughs and Districts have also established local Health and Wellbeing Boards.

Recommendations: None.

Actions/further information to be provided: None.

Committee next steps: None.

18/14 BETTER CARE FUND BRIEFING [Item 6]

Declarations of interest: None.

Witnesses:

David Sargeant, Interim Strategic Director Adult Social Care
Kathryn Pyper, Lead Strategy and Policy Projects Manager
Michael Gosling, Cabinet Member for Public Health and Health & Wellbeing Board

Key points raised during the discussion:

1. The Committee were informed that Adult Social Care were working with the six Surrey CCGs on the Better Care Fund through joint workshops. The draft plan had been submitted to NHS England in February 2014, with feedback received from the Local Area Team which was being reviewed ahead of the final submission on 4 April 2014.

2. Members queried whether the £65 million would be spent on new or existing services and were informed that it was a mixture of both, with the Better Care Fund enabling planned work to take place. The aim was to reduce the strain on A&E services and move people into community care, while the guidance states that the Fund should be used to protect Adult Social Care services.

3. The Committee queried how the Better Care Fund Board aimed to get 'buy in' from the Acute Trusts as their aim was to protect their finances. Officers stated that this was a challenge, but that the government viewed this as a mechanism for taking money out of Acute Trusts and putting it into community care. The Local Government Association has claimed that CCGs had not considered to-date how to remove 15% of funding out of Acute Trusts, but officers felt it was important for the Acute Trust sector to consider how they will respond to a cut in funding, such as the plans in place at Ashford & St Peters and Royal Surrey Hospital to work together.

4. The Cabinet Member felt that it was important to not look at the Better Care Fund in isolation, as it was a government policy for greater integration of health and social care. He stated that they could only

facilitate changes within the health environment, though there was a need to see five reconfigured hospitals within Surrey which provided better services where needed.

5. The Committee discussed the Torbay integrated health system which saw significant savings in health budgets for the money invested. Officers stated that they had spoken to counterparts in Torbay to share learning as the integrated health system was being developed in Surrey at different speeds, and that the local plans which were being developed would facilitate the transition.

6. Members felt that the success of the Fund would depend on whether the changes were communicated well with the public as it was important to ensure they knew where to go when unwell. The Interim Strategic Director informed the Committee that he sat on the Guildford & Waverley CCG governing board and that the CCG was working with GP practices to bring in social care workers into the practices so people could be seen on the same day.

7. The Committee queried how the budgets were being organised and were informed that initially there were going to be six pooled budgets as the Fund was to be allocated on a CCG basis, though this had been revised to be a single pooled budget managed by Surrey County Council. The Council was to manage the budget under Section 75 agreements for tax reasons. It was felt that a single budget was more efficient than six.

8. Officers confirmed they would continue to work with the Health Scrutiny Committee and the Adult Social Care Select Committee during the Better Care Fund process through a joint Member Reference Group which would see the wider impact and have an understanding of the impact of the Fund on the whole healthcare system, alongside the risks associated with the plans.

9. The Chairman confirmed that he and the Vice-Chairman would be kept informed of progress by the Member Reference Group (MRG) and when best for the Committee to scrutinise the process.

Recommendations:

1. Instigate a Joint MRG to liaise with Surrey Better Care Fund Board on a quarterly basis. Taking the Better Care Fund as a starting point with a long-term aim to investigate wider health and social care integration in Surrey. The MRG to have the following proposed objectives:

    a. To oversee the impact on the Better Care Fund plans on Surrey's health and care system; and
    b. The risks to other services of any changes proposed or implemented by Better Care Fund.

2. The following Members of the Committee to sit on this Group:

    a. Richard Walsh
    b. Tim Evans

Actions/further information to be provided: None.

Committee next steps:

The Committee to monitor the progress of the Better Care Fund and its impacts on the whole healthcare system and the risks associated with the plans, when appropriate.

19/14 END OF LIFE CARE [Item 7]

Declarations of interest: None.

Witnesses:

Hester Wain, Collaborative Business Manager, Surrey CCGs
Dr Andrew Davies, Clinical Director Supportive and Palliative Care, Royal Surrey County Hospital
Dr Aruni Wijeratne, Consultant Palliative Medicine, Epsom and St Helier Hospital
Dr Beata LeBon, Lead Consultant in Palliative Medicine, Frimley Park Hospital
Susan Dargan, Macmillan Senior Nurse Specialist Palliative Care, Ashford and St Peters Hospital
Jean Boddy, Senior Commissioner, Adult Social Care

Key points raised during the discussion:

1. The Committee queried whether the Better Care Fund could be used to develop End of Life Care post March 2014 and were informed that the Better Care Fund Board was developing plans around End of Life Care. The Whole Systems Funding was being used to facilitate transition from PCT to CCGs.

2. The witnesses stressed that the challenge to End of Life Care is to provide holistic care without a fragmented system. It was important to identify and develop pathways appropriate to the patient which gave them the dignity they deserved.

3. The National Institute for Health and Care Excellence (NICE) Quality Statements were being applied but there were variations across Surrey with CCGs working to identify the differences.

4. Members queried the level of support provided to family members of the patient after their death. Witnesses informed the Committee there was variation on the approached used by hospitals; Royal Surrey provided family members a pack of information of organisations which could be contacted, Epsom & St Helier had a close link with Princess Alice Hospice and were also organising a memorial service at St Helier Hospital with a plan for a similar service at Epsom Hospital in the future, Frimley Park Hospital provided relatives with comprehensive information pack and provided support if the patient passed away in the hospital, while Ashford & St Peters Hospital provided support to families and were looking at developing a bereavement service.

5. The Committee were informed that it was difficult to identify how many providers and users of the service there were as though all Acute Trusts provided palliative care, Surrey had a number of hospices which were often full, and in addition all hospices had community teams.

6. Deaths in Acute Trusts had dropped in Surrey, with around 18.7% of patients dying at home. Adult Social Care were developing a bid which would enable people to be moved to their home quicker, if that was their wish. However, it was noted that many patients changed their mind close to the end to wanting to die in a hospice or hospital.

7. The Committee discussed the news that a third of those admitted to hospital died within a year and were informed that the figure did not surprise the witnesses, with some feeling the figure is higher in reality.

8. Members queried how End of Life Care was coordinated, how a person was identified for receiving care and whether there was one professional with overview of a patients care. Witnesses informed Members that it varied, though if someone was not in hospital care then it was the role of the GP to identify patients. The CCG representative stated that there was a need to integrate all the services involved in End of Life Care, and that two CCGs were discussing the implementation of an Electronic Palliative Care Coordination System (EPaCCS) which would allow information to be shared more easily across all partners. Members suggested that all the CCGs should commission the same IT package so as to enable better communication. EPaCCS (Coordinate my Care) is in use at Epsom and St Helier Trust and the Specialist Palliative Care team undertake the responsibility of updating the record for patients when they are discharged from hospital

9. The Committee were informed that it was important that a patient's End of Life Advance Care Plan was kept up-to-date, with some Trusts providing patients with paper records which the patient or next of kin looks after. If the patient was in the community then their GP would be responsible for ensuring the details were up-to-date. This plan held the details of the patient's wishes with regards to resuscitation etc. not medical information such as their prescriptions.

10. The witnesses felt that it was difficult to identify patients for End of Life Care if they had no diagnosis but that all patients should receive good end of life care even if they did not have a diagnosis, and have access to specialist palliative care if required.

11. Members felt that due to the demand for End of Life Care outstripping resources that there should be a review of the pathway. Furthermore, the Committee stressed that a single or compatible EPaCCS IT system should be used across Surrey as soon as possible.

Recommendations:

1. Recommend that there is review of capacity and funding of hospices in Surrey (as part of the Better Care Fund work) including private and voluntary providers of End of Life care.

2. Request for a Surrey-wide implementation of an Electronic Patient Coordination System (or systems with inter-operability) that integrates primary, community and acute end of life care. Update from CCGs in six months.

Actions/further information to be provided: None.

Committee next steps:

The Committee to consider the plans for a Electronic Patient Coordination System which integrates primary, community and Acute Trust end of life care in six months.

Councillors Bob Gardner, Chris Pitt and Nicky Lee leave the meeting.

20/14 SURREY & BORDERS PARTNERSHIP UPDATE [Item 8]

Declarations of interest:

Councillor Bill Chapman sits on the Council of Governors for Surrey and Borders Partnership NHS Foundation Trust (SABP).

Witnesses:

Ros Hartley, Director of Strategy and Partnerships, North East Hants & Farnham CCG
Dr Rachel Hennessy, Medical Director, SABP
Andy Erskine, Director of Learning Disabilities Service, SABP
Jane Shipp, Healthwatch

Key points raised during the discussion:

1. SABP provided the Committee with a short overview of their report, including details of recent Care Quality Commission (CQC) inspections of 24 of their sites. Of the 117 outcomes from the reports, SABP were compliant with 60%, CQC had minor concerns with 20% and moderate concerns with 19%. SABP stressed they were working hard to address the issues raised in the reports, and that though they had been selected by CQC for a full scale inspection of all services in June 2014 they had been assured by CQC that it was not due to any particular concerns.

2. SABP felt that the key part of the organisation is that it is a partnership.

3. Members stated that they would have liked to see more segmentation of age groups as a large number of children and adolescents in crises being sent away from home. SABP stated that children's provision was a concern of theirs, though work was being done by NHS England to see what had gone wrong nationally, as they were they were responsible. However, on a short-term basis SABP had agreed to admit children and adolescents when they were certain they could safeguard them, as they believed it was the right thing to do despite

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not being commissioned to provide the service. When young people were admitted it was always recorded as Serious Untoward Incident.

4. The Committee were informed that SABP were commissioned for community work with children and adolescents, but that beds were commissioned by the Local Area Team and NHS England. SABP was raising their concerns regarding the provision of beds with the Local Area Team and with Guildford and Waverley CCG, as lead commissioner of children services.

5. SABP felt there was not enough money in mental healthcare due to a disparity between the capital investment in Acute Trusts compared to mental health, in addition to the disparity in revenue income; the Acute Trusts being paid by tariff and SABP allotted a fixed sum regardless of demand for services. They felt this was discriminatory towards mental health patients. The Commissioner agreed and stated that it was the long term view of CCGs that there should be a greater share of funds for mental health and disabilities, but work needed to be done to find the funds. It was felt that the Better Care Fund could assist in the integration of care.

6. The Commissioner stated that they felt that SABP were providing a vast number of services to the required standard, but recognised that more work could be done.

7. Members queried whether SABP were working with the Police, and were informed that they were where appropriate. SABP were in the process of working with the Chief Constable and Deputy Chief Constable to find solutions to the current problem of the Police having to attend and detain people when it is not the most appropriate course of action.

8. SABP informed Members that they had developed a clinical strategy which stated that more resources needed to be put into early intervention work for all ages, and that they had begun placing practitioners in schools.

9. Members raised concerns over the CQC reports which found only one of seven sites compliant. SABP stated that in light of the Winterbourne View situation they had completed a comparative analysis of services and had found they compared well. CQC had not asked for services to close as the sites were deemed safe, however not necessarily following best practice. SABP had provided with some suggested improvements and were working to implement them. SABP stated that many of the action points related to the built environment, and that they had worked to redecorate sites and were developing a new hospital. An action plan on care plans was being developed and all action plans were being reviewed closely by the CCG to ensure SABP were compliant.

10. The Committee raised concerns that 55% of complaints were not upheld and queried whether SABP dismissed complaints. SABP assured the Committee that each complaint was fully investigated before a decision was made.

11. Members queried whether the public knew the number for the Crisis Line and whether there were enough staff employed to answer calls. SABP informed the Committee that they received a number of calls from across the country, from a person needing someone to talk to, to someone requiring a visit. It was important for staff to have the patients records available so as to give them the best advice during a moment of crisis. The witnesses informed the Committee that they were advised to take more random samples of calls and were doing so to ensure the quality of the service was high.

Recommendations:

1. Request a report on the improvements identified and actions taken in response to CQC inspections in 2013 and comment on where this would leave performance versus aspirations and comparable benchmarks.

2. Request SABP return in six months to discuss:

    a. Development of options for joint working with Surrey Police;
    b. Their Early Intervention services; and
    c. The outcomes of the new CQC inspections beginning in June

Actions/further information to be provided:

Surrey and Borders Partnership to provide the Committee with a summary report of the actions coming out of the CQC inspections.

Committee next steps: None.

21/14 RECOMMENDATION TRACKER AND FORWARD WORK PROGRAMME [Item 9]

Declarations of interest: None.

Witnesses:

Ross Pike, Scrutiny Officer
Nick Markwick, Surrey Coalition of Disabled People

Key points raised during the discussion:

1. The Committee were informed that the commissioner for SECAmb had changed from East Surrey CCG to North West Surrey CCG, with this in mind the recommendations to the commissioner had been referred to them and they were being given some time to address these. Surrey Coalition of Disabled People requested that the committee do not let Patient Transport Service slip as issues still remained with the service.

2. The Scrutiny Officer requested Members to advise him if there were any areas which they would like to be scrutinised in the next council year.

3. Members were informed of the memberships of the Member Reference Groups and Task Groups and were informed that an initial meeting would be arranged in Spring 2014 to discuss the Terms of References of these groups.

4. Members suggested that the SECAmb Member Reference Group should be split into two – Emergency and Patient Transport Service – as the services provided by SECAmb were too broad to cover in single meetings.

5. The Committee requested that Healthwatch share information so Members are able to effectively verify and scrutinise the information provided by organisations at Committee meetings. Furthermore, Members felt that CQC reports would also assist them in their role. The Chairman informed Members that CQC would be providing the Committee with an update in May 2014.

6. Members of the Frimley Park Member Reference Group raised their concerns that the hospital had not been welcoming and that they were unable to fulfil their roles satisfactorily due to being provided with no information. The Scrutiny Officer informed Members that he was in discussion with Frimley Park over the role of the Member Reference Group.

Recommendations:

1. That the following Member Reference Groups be formed with the following membership:

    a. Alcohol Member Reference Group
        i. Peter Hickman
        ii. Richard Walsh
        iii. Karen Randolph
        iv. Tim Hall

    b. Better Care Fund Member Reference Group (joint with Adult Social Care Select Committee)

        i. Richard Walsh
        ii. Tim Evans

2. A Primary Care Task Group be formed with the following membership:

    a. Tim Hall
    b. Tim Evans
    c. Ben Carasco
    d. Karen Randolph

3. Committee members to advise the Scrutiny Officer of items to be scrutinised in the upcoming council year.

Actions/further information to be provided: None.

Committee next steps: None.

2

22/14 DATE OF NEXT MEETING [Item 10]

The Committee noted the next meeting would take place on 22 May 2014 at 10am in the Ashcombe Suite.

Meeting ended at: 12.55 pm

Chairman

SURREY
COUNTY COUNCIL

Health Scrutiny Committee
30 May 2014

Care Quality Commission

Purpose of the report: Scrutiny of Services

The Committee will be given an overview of the developments in how the Care Quality Commission (CQC) inspects and regulates health services.

Summary:

1. CQC is the independent regulator of health and social care services in England. It ensures that services comply with government standards on quality safety.

2. The Commission regularly inspects and monitors health and adult social care services. Inspections are unannounced and inspection teams will work with Overview and Scrutiny Committees and involve other partners and patients to gather information on patient's experiences of health care.

3. Findings are published in reports which include a rating system. If a service is found to not be meeting standards CQC can enforce actions to facilitate improvements.

Recommendation(s):

4. The Committee is asked to consider how it can work in partnership with the CQC in the future.

Report contact: Ross Pike, Scrutiny Officer, Democratic Services

Contact details: 020 8541 7368, ross.pike@surreycc.gov.uk

Sources/background papers: None

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A guide for overview and scrutiny committees for health and social care

How your committee can work with the Care Quality Commission

September 2011

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Contents

Published September 2011

1. Introduction

This is a guide for locally elected councillors and local authority officers involved in the scrutiny of health and social care who want to know more about how their scrutiny committee can work with the Care Quality Commission (CQC). We are the independent regulator of health and adult social care services in England. This guide tells you more about CQC and what we do. It explains what your scrutiny committee can expect from us as we work together locally to improve care. It explains what information you can share with us to help us check on services, and how you can use the information we hold to help your scrutiny committee.

The guide has been written by CQC and some local authority officers and councillors working together. We would like to thank those involved for their effort and enthusiasm. Examples from their work have been used in the guide.

We will carry on working with all scrutiny committees in England during 2011/2012, building stronger working relationships with more committees and exploring how to work with elected councillors under new scrutiny arrangements that may develop.

We would like to hear from more scrutiny committees and to use more of the information councillors hold about people's views and experiences of their care. We are especially interested to hear about people's experiences of social care services as well as health care. We hope the examples in this guide encourage all scrutiny committees to share information with CQC to help us work together to improve care.

For more information about our work with scrutiny committees, please go to www.cqc.org.uk/localvoices. For information about HealthWatch go to: www.cqc.org.uk/aboutcqc/whatwedo/improvinghealthandsocialcare/healthwatch.cfm

You can also read *A guide for local councillors: Working with the Care Quality Commission* available at www.cqc.org.uk/localvoices

2. About the Care Quality Commission

We are the Care Quality Commission, the independent regulator of healthcare and adult social care services in England. We check whether care services meet essential standards of quality and safety, and we also protect the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act.

Find out more about us at www.cqc.org.uk

Which services do we check?

We check on these types of services:

- Providers of medical treatment to people of all ages, including treatment provided in hospitals, by ambulance services and by mental health services.
- Providers of care homes for people over 18 who need help to maintain their independence and wellbeing. This includes nursing homes. Care homes can provide residential care for the following:
  - People with long- or short-term health conditions
  - Disabled people and people with learning disabilities
  - Older people
  - People with drug or alcohol problems.
- Agencies that provide care, treatment and support to people living in their own homes to help them maintain their independence and wellbeing.
- Providers of services for people whose rights are restricted under the Mental Health Act.
- We started to register and check on dental services (in the community) and independent ambulance services from April 2011. We will register GP out-of-hours services from April 2012. Subject to Parliament, we will now register primary medical services including walk-in centres and GP services from April 2013.

What standards do we check on?

The Health and Social Care Act 2008 requires providers of all regulated care services to meet government standards of quality and safety – the standards the government says anyone should expect whenever or wherever they receive care. These standards cover things like cleanliness, dignity, safety and staffing.

We register providers if they meet the standards, we check whether or not they continue to do so and we take action if standards aren't being met. Our assessments are based on people's experiences of care and the impact it has on their health and wellbeing, as well as on whether or not the right systems and processes are in place.

We put the views, experiences, health and wellbeing of people who use services at the centre of our work.

You can read our guidance about the essential standards and full details of the outcomes we look for at www.cqcguidanceaboutcompliance.org.uk and at www.cqc.org.uk/_db/_documents/Quick_guide_to_the_essential_standards.doc

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We have also produced guides for the public explaining what you can expect from your care which can be found at:
www.cqc.org.uk/usingcareservices/essentialstandardsofqualityandsafety.cfm

You can expect any of the health or social care services we check on to meet the following essential standards:

You can expect to be involved and told what's happening at every stage of your care

- You will always be involved in discussions about your care and treatment, and your privacy and dignity will be respected by all staff.
- You will be given opportunities, encouragement and support to help you live as independently as possible.
- Before you receive any examination, care treatment or support you will be asked whether or not you agree to it.

You can expect care, treatment and support that meets your needs

- Your personal needs will be assessed to make sure you get safe and appropriate care that supports your rights.
- You get the treatment that you and your health or care professional agree will make a difference to your health and wellbeing.
- You will get the food and drink you need to meet your dietary needs.
- If you have more than one care provider, or if you are moved between services, you will get coordinated care.

You can also expect your needs to be met in relation to:

- Your cultural background and the language you speak
- Your sex (gender)
- Your disability
- Your age
- Your sexual orientation (whether you are a lesbian, gay, bisexual or heterosexual person)
- Your religion or belief
- Your gender identity, if you are a transsexual person
- Your needs if you are pregnant or have recently had a baby.

You can expect to be safe

- You will be protected from abuse or the risk of abuse, and staff will respect your human rights.

- You will get the medicines you need, when you need them, and in a safe way.
- You will be cared for in a safe and accessible place.
- You will not be harmed by unsafe or unsuitable equipment.
- You will be cared for in a clean environment where you are protected from infection.

You can expect to be cared for by qualified staff with the right skills to do their jobs properly

- Your health and welfare needs are met by staff who have the knowledge, skills and experience needed.
- There will always be enough members of staff available to keep you safe and meet your needs.
- You will be looked after by staff who are well managed and have the chance to develop and improve their skills.

You can expect your care provider to routinely check the quality of its services

- Your care provider will monitor the quality of its services to make sure you are safe.
- Your personal records, including medical records, will be accurate and kept safe and confidential.
- You, or someone acting on your behalf, can complain and will be listened to. Your complaint will be acted upon properly.

How we carry out our checks

Under new proposals, we will inspect all adult social care, independent healthcare services, and most NHS hospitals at least once a year. (By NHS hospitals we mean all NHS acute hospitals and all NHS ambulance trusts. We inspect at least one type of service in all other trusts). We will inspect dental services at least once every two years. We check on services more frequently where there are concerns that people may be getting poor care. We identify these concerns by sharing information with a wide variety of organisations, by listening to the public, local groups, care staff and whistleblowers, and by monitoring data. We build a profile of each service that is updated whenever new information arrives. This helps our inspectors to decide where there is a risk that people could be experiencing poor care. The information comes from different sources, including:

- People who use services, families and carers
- LINks (local involvement networks)
- Overview and scrutiny committees for health and/or social care
- Foundation trust councils of governors
- Other voluntary and community groups
- Other regulatory organisations and the NHS Information Centre

- Other organisations such as commissioners of care (like councils) and the health and local government ombudsman
- Staff and other professionals
- CQC inspectors.

Feedback from people who use services is very important to us. We treat it as seriously as we do other forms of information.

When we decide that there is a risk of poor care, we assess whether or not the service is failing to meet one or more of the essential standards. We review the information we hold and we ask the people running the service to prove that it is meeting the standards. We may conduct further visits to the service to observe how care is delivered, talk to the people who use the service and to staff, and to check the provider's records if necessary.

If we judge that services are not meeting essential standards we use our powers to require improvements. We follow up to make sure the improvements are made and we hold services to account if they don't do so. If we judge that people's health, wellbeing and safety are at risk we take swift action to protect them.

Once we have reviewed a service we publish our findings as quickly as possible. Our information can help people choose a service or tell them about standards of care at a local service. We update our website when there are changes to report about checks, improvements or concerns.

What we do if a service doesn't meet the essential standards

If standards aren't being met, we require improvements within a set timescale. The service must then send us an action plan telling us how it will make these improvements.

If the service does not improve, or we have serious concerns about the health and safety of people who use it, we have a range of enforcement powers we can use including fines, warnings, restrictions to the way the service is provided, suspension or cancellation of its licence to operate, and prosecution of those providing the service.

When we propose to use our enforcement powers, the service has 28 days to challenge us before we can make our decision public. However, if we believe there is a serious, immediate threat to people's health and safety, we can act immediately to restrict, suspend or stop the service from being provided and we can make our decision public as soon as we do so.

3. What your scrutiny committee can expect from the Care Quality Commission?

This section sets out how our staff aim to work with all scrutiny committees for health and social care across the country. If the relationship between CQC and your scrutiny committee is still developing, we will gradually introduce the steps set out below.

Regular contact with CQC staff

Your scrutiny committee chair and lead officer (if you have one) can expect to be given a named local CQC contact person and to be informed if this person changes. You will have contact with your local CQC manager or inspector every three months either by phone, email or a meeting. We may have more frequent contact than this if you have shared information with us about local services and we need to discuss this with your committee. When we make contact with your committee, CQC staff can:

- Explain how we check on services and promote the essential standards of quality and safety to your committee.
- Share with your chair, our confidential programme of reviews over the coming six months (without dates), and any current improvement or enforcement actions we are taking that can be made public. **If your chair or committee prefers, we will only share information that is already in the public domain.**
- Find out about your committee's latest work programme and any responses you are making to NHS consultations.
- Hear from your committee about the issues/concerns local people are raising about the health and social care services in the area. These may come from your scrutiny reviews, public meetings, feedback from your members and so on.
- Give you feedback about how we have used any of the information your committee has already shared with us.

How we work with your committee during a review of a service

At the start of a CQC service review we check our records to see whether your committee has recently submitted information to us about the service at any of its locations. We may then contact the committee chair and lead officer (if there is one) by phone or email to let you know about the review and the timescale. We will usually do this where:

- Your committee has raised concerns about the service provider, or
- The service provider is included in your work programme, or
- There are gaps in our knowledge about people's views and experiences of the service provider, that your committee may help us fill.

We will invite your committee to give us any new information about the service. We may encourage you to make contact with neighbouring scrutiny committees if you need to coordinate providing information for CQC.

At each contact/meeting with your committee, we will identify with you any actions you intend to take as a result of our reviews. For example, further evidence-gathering about particular service providers or requests for information. This will help us coordinate our activities better.

How we work with your committee when we take enforcement action

We will aim to let your scrutiny committee know about an enforcement action we have taken as soon as it is made public. This is when the representations and appeals process that service providers can use is also ended. For example, we will aim to share press releases with you as soon as we can. We understand that this is particularly important where your committee has also been seeking local improvements to services from the provider concerned.

We will be interested to know whether your committee plans to take action as a result of our enforcement action, and will work with you to coordinate this with further CQC activity.

How we give feedback to your committee

We will let you know we have received any information that your committee sends us between our regular contacts or meetings. If your committee sends information to us via the CQC webform, you will receive an automatic acknowledgement (see page 11). At our regular meetings/contact with you, we will aim to:

- Give you verbal feedback about how we have used any information you have shared with us.
- Highlight the findings and outcomes of relevant reviews of providers.
- Make sure your committee has a copy of the relevant compliance reports.

Our approach to sharing information that is not yet public or is confidential

We can tell your chair and lead officer (if you have one) about the programme of reviews of services we expect to carry out over the coming six months. We will not tell you the dates for these reviews or whether we will be visiting a service as part of the review. It is very important that we keep our programme of unannounced visits confidential. The public have told us that this is one of the most important things we do. We expect committee chairs and lead officers to respect this information and not to share it with service providers or other groups who may make it public. **If your chair or committee does not wish CQC to share this information with you, please discuss this with your local CQC contact.**

We are unable to share enforcement action we are taking while a service provider has the chance to appeal against this action. Once the appeal period is over, the enforcement action can be made public and shared with the committee.

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CQC will not share confidential personal information with scrutiny committees. Similarly, we would not expect a committee to share information with us that identifies individuals or their families, unless this information comes from the individual themselves, someone has agreed that their information can be shared with CQC or someone has asked a committee to pass the information to CQC.

4. Sharing information with the Care Quality Commission about local services

We hope your scrutiny committee will share information with us about people's views and experiences of local services, and let us know what you are doing to improve care in your area. It will help us if you can:

- Keep in contact with our local CQC staff.
- Share any information with us if you think it helps us check on the essential standards.
- Share information with us about any of the services we check on – adult social care, health services, dentists and so on.
- Let us know if the committee chair or contact officer changes so that we contact the right person.

Your committee can provide information it already holds, such as:

- Formal reports/reviews of local health or social care services.
- Information gathered to inform a review.
- Your committee's workplan.
- Comments gathered at public events about local health or social care services.
- Contact from members of the public.
- Information on local concerns or emerging issues.
- Local surveys and so on.

You may also wish to gather additional information for one of our reviews of a service provider. For example:

- Inviting scrutiny members to contribute information directly to the committee chair to be shared with CQC.
- Holding a meeting or using an existing committee or public meeting to gather information about a service.

How to share your information with CQC

You can share information with CQC in three ways:

1. Through our website, where there is an online feedback form for scrutiny committees, LINks and other groups at www.cqc.org.uk/localvoices. You can complete the form in your own words and you can also attach your reports to the form. It helps to highlight which sections of the report tell us about the quality or safety of care.
2. Through your local CQC contact. You can share information with them by email, phone or face-to-face when you meet them. It is helpful to copy information that

you send through the webform to your local CQC contact so they know this information is available to them straight away.

3. Through our enquiries contact centre at 03000 616161 or enquiries@cqc.org.uk

Top tips about the information you share with CQC

1. If in doubt, share your information with us. We would rather have the chance to read about your concerns and decide what action to take, than not know about them. If you have concerns about the care provided, then it is likely that your information will help us check on services.
2. Try to name the health or adult social care service or services you are describing in all your comments or reports. This is especially important when you are giving us information about several different services.
3. Focus on giving us information that tells us about what you have found out or heard about a service providing care, rather than details of how your committee works.
4. Provide the evidence for your conclusions and comments and any dates whenever possible, and explain what sort of evidence you have (it may be a small number of concerning stories or evidence from a survey or meeting with many more people).
5. Try to match your information to our CQC essential standards of quality and safety. You can relate your information to as many standards as you like.
6. Please let us know whether you are giving us information that is positive or negative about how care is provided. Both positive and negative comments about a service are important in helping us judge whether a service continues to meet our standards.

What we do with your information?

Relevant information from your committee becomes part of our 'quality and risk profile', which we hold for every health and adult social care organisation. The information you share with us will:

- Help us spot problems or concerns in local services that we need to act upon.
- Help in our assessments and reviews of different types of organisations.
- Allow us to look at how well a service provider meets essential standards of quality and safety. This will help us decide if the service provider can continue to register with us and provide its services to local people.
- Help us decide if we need to ask a service provider to make improvements in some areas of its care, to show us that it will meet all these standards in future.

We match your information with our essential standards of quality and safety if we can, and decide whether it is positive or negative. Then we weigh up whether it is clear and whether it is about people's experience of care. For example, does it tell us something that has an impact on a person using the service and does it represent the views of someone using the service (or groups of people using the service)?

We will give your information a score. The higher the score, the more likely it will make a difference to our judgements about the care provided by a service. If your information does not relate to our essential standards we may use it as background information about that service, or we may not be able to use it at all.

Scrutiny committee review reports can be particularly useful in helping us decide which services to review or what to look for when we visit a service.

What to do if you are concerned about someone's safety?

We want people who use care services to be safe, especially if they are in vulnerable circumstances, and may find it difficult to speak for themselves. If you have urgent concerns about the wellbeing of a child or vulnerable adult, your committee should contact your local authority children's or adult social care department. This might be evidence of physical, sexual, psychological abuse, neglect and acts of omission including ignoring medical or physical care needs or discriminatory abuse.

CQC does not deal with these individual cases of safeguarding, but we work closely with local authority safeguarding staff and can use the information in our judgements about services. We can follow up a service where concerns have been raised, and this may lead us to take enforcement action against the service if we find it does not meet essential standards of quality and safety.

If you share information with your local safeguarding team, we hope you will also let your local CQC contact know – in case we also need to act swiftly. Please remember that you can share urgent concerns with us at any time.

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5. Where to go for more information

For more information about CQC go to www.cqc.org.uk or ring 03000 616161

To talk to us about our work with scrutiny committees, email: involvement.edhr@cqc.org.uk

For information about the development of HealthWatch England, please go to our website: www.cqc.org.uk/aboutcqc/whatwedo/improvinghealthandsocialcare/healthwatch.cfm

You can get involved in HealthWatch England developments by sending an email to enquiries@nunwood.com

You may want to talk to some of the scrutiny committees involved in developing this guide. They are:

- Torbay Health Scrutiny Committee
- Joint Health Overview and Scrutiny Committee Pennine Acute NHS Trust
- Leicestershire County Council Joint Health Scrutiny Committee
- Nottingham City and Nottinghamshire County Joint Health Scrutiny Committee
- Cambridgeshire County Council Health and Adult Social Care Scrutiny Committee
- Isles of Scilly Health Overview and Scrutiny Committee
- Ealing Health Scrutiny Panel

6. Examples of working together

Information from scrutiny committees is already helping CQC check on a range of health and social care services. Scrutiny committee review reports and the findings from these have been particularly useful. In some areas, information from scrutiny committees has helped us focus on which aspects of a service to look at in one of our reviews, and which locations to visit.

In this section, we provide examples of how some scrutiny committees have been working with CQC and how information is being shared between us. Each committee works in a different way but these examples show what can be achieved by working together.

Ealing Health Scrutiny Panel

Ealing Scrutiny Committee has worked with CQC during its review of access and quality of care for Ealing patients after hospital or other clinical treatment. The review has identified the main care pathways and service providers involved in aftercare in Ealing, and examined access to and quality standards of aftercare, and the causes of any poor performance. It has examined the initiatives underway to address any concerns and lessons learnt from services elsewhere.

It has focused on hospital admission and discharge, transfers of care, specialist rehabilitation and end of life care.

Isles of Scilly Health Overview and Scrutiny Board

Isles of Scilly Health Overview and Scrutiny Committee has regular contact, by email and phone, with CQC through the Committee chair and the vice chair. The compliance manager addressed the committee, explaining CQC's role and its relationship with scrutiny committees. This has helped the Committee develop the questions for commissioners, providers, patients and carers as part of its review of stroke aftercare services. It has also made use of the CQC's national review of stroke services. The Committee is sharing the findings with CQC and discussing the implications of their final report. Commissioners and providers are aware of the committee's relationship with CQC.

> "The role of health overview and scrutiny committees is evolving and up until recently some members didn't realise the importance of the relationship between CQC and health overview and scrutiny committees. I think we need to further develop our relationship with CQC as the scrutiny function of health overview and scrutiny committees will increase."
> (Chair of the Isles of Scilly Health Overview and Scrutiny Committee)

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Torbay Health Scrutiny Board

Torbay Health Scrutiny Board has been building its local relationship with CQC and held a workshop with elected members and CQC, which has been very positively received. The Committee communicates with CQC whenever necessary by phone and email and regular meetings are scheduled between CQC and the Scrutiny Committee chair. CQC is also attending Scrutiny Committee meetings as an observer in the public gallery.

The Committee aspires to the four principles set out by the Centre for Public Scrutiny:

> "critical friend challenge to decision-makers; enable the voice and concerns of the public and its communities; be 'independent minded governors' who lead and own the scrutiny process and drive improvement in public services."

The Committee has improved its understanding of CQC's role. CQC has shared information about all the 153 service providers in Torbay and the details of the CQC inspectors responsible for these providers. CQC has also shared its confidential programme of reviews planned over the coming months in Torbay, and a list of the essential standards of quality and safety. The Committee receives email alerts and links to publications of any CQC review reports on local providers. As a result, a councillor has already raised an issue about a service provider to the Committee which is being followed up with the provider and the primary care trust (PCT) initially, and the Committee will then update CQC.

The Committee shares its work programme, the minutes of its meetings and forthcoming agendas with CQC. It has also raised a concern about the procedure for safeguarding at one provider which has been followed up.

In future, the Committee will be considering a more formal agreement or protocol between CQC and the Committee. Formal meetings are also scheduled between the scrutiny committee chair, CQC and the LINk/HealthWatch chair to exchange information and work programmes.

Leicestershire County Council Overview and Scrutiny Committee

The Committee has met with CQC locally and developed a working relationship. A meeting was held between the assistant director of strategy and commissioning and the scrutiny officer to discuss how the relationship with CQC might work locally. It was agreed to organise a briefing for all elected members in the county on CQC and its work. The assistant director, scrutiny officer and CQC's local compliance manager met and planned the briefing workshop for councillors about CQC. The scrutiny officer is developing a local guide for CQC and overview and scrutiny committees working together.

Cambridgeshire County Council Health and Adult Social Care Scrutiny Committee

The Committee was invited to contribute to a CQC review of an out-of-hours GP service provided in part of the county in 2010. Through dialogue with CQC, the Committee was able to feed its views and concerns into the review, based on its experience of scrutinising local services, on the information it had picked up from the local community and concerns raised by individual councillors. As a result, it was able to use CQC's findings from the review to inform its response to the PCT's consultation on future provision of the out-of-hours services. The Committee found this very helpful.

The Committee has established an ongoing relationship with CQC, including holding a seminar for all councillors, not just those involved in health scrutiny. The seminar was an opportunity to discuss how individual councillors can contribute information to CQC, as well as the scrutiny committee. Fifteen councillors attended and all considered it was very useful in developing a relationship between the council and CQC.

Nottingham City and Nottinghamshire County Joint Health Scrutiny Committee

The Committee has established local contact with CQC and learnt more about CQC's role. It has shared information about its review of dementia care services.

At the end of every Health Scrutiny Committee meeting in Nottingham City, councillors consider the issues that they have discussed and whether there are any issues that should be referred to CQC, which they do using the CQC webform.

> "We realised that the public nature of scrutiny means that overview and scrutiny committees can provide useful information to the CQC. The committee decided it is important to have a good relationship with our local CQC contacts and to provide CQC with ongoing information as a result of our scrutiny work." (Scrutiny officer, Nottingham County Council)

Joint Health Overview and Scrutiny Committee Pennine Acute NHS Trust

The officer for the Joint Health Overview and Scrutiny Committee and the officer for the Joint Scrutiny Committee for the Pennine Acute NHS Trust now meet regularly with their CQC inspector. The Committee submitted its review of hospital nutrition to CQC, which then inspected nutrition within the Pennine Acute NHS Trust, as part of its national inspection. Recent CQC inspections, following a documentary about the Trust have been discussed with the Committee's officer. Future work by the Committee will focus on the patient experience, and will be shared with CQC.

How to contact us

Phone: 03000 616161
Email: enquiries@cqc.org.uk

Registered Office:
Care Quality Commission
Finsbury Tower
103–105 Bunhill Row
London EC1Y 8TG

We have also produced an easy read version of this guide, which can be found at **www.cqc.org.uk**. Please contact us if you would like a summary of this document in other formats or languages.

Frimley Park Hospital NHS
NHS Foundation Trust

Update report for the proposed acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust by Frimley Park NHS Foundation Trust

Author: Jane Hogg, Integration Director
Date: May 2014

PURPOSE

The purpose of the paper is to provide the Surrey Health Scrutiny Committee with an update on progress towards a possible acquisition of Heatherwood and Wexham Park NHS Foundation Trust by Frimley Park NHS Foundation Trust. The transaction timeline is challenging and many elements are subject to change, but this paper gives a report of the state of play in mid May 2014.

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TIMELINE

- 2012/2013 – HWPH concludes they are unsustainable as a stand alone business. McKinsey report for Berkshire East commissioners concludes acquisition by FPH as a sustainable solution for HWPH
- April 2013 – OBC for the acquisition of HWP by FPH developed for FPH
- August 2013 – review by FPH board of OBC and conclusion to consider proceeding to FBC
- October 2013 to January 2014 – support from central bodies for consideration of the FBC
- February 2014 – FPH board decides to proceed to FBC
- March 2014 – submission of case to Competition and Markets Authority (formerly Office of Fair Trading)
- 1 May 2014 – Care Quality Commission releases inspection report rating HWPH as 'inadequate' and HWPH is placed in special measures by Monitor on 3 May
- 14 May 2014 – CMA clears the proposed acquisition
- Summer 2014 – proposals reviewed by boards and councils of governors of each hospital, and by Monitor the foundation trust regulator, who must approve the transaction

BACKGROUND AND CASE FOR CHANGE

HWPH is currently facing significant financial, operational & clinical challenges. In the absence of the transaction, ongoing financial and operational challenges may risk FPH's sustainability in the medium term

- **Increasing financial and operational pressures** are being placed on acute Trusts. FPH is facing declining surpluses over the coming years and HWPH is in a continuing unsustainable financial position
- **There is a continued drive for high quality sustainable care in the NHS**. FPH is at risk of becoming clinically subscale in certain areas as the NHS consolidates to preserve and improve quality care. HWPH already has areas of poor quality in patient care and has lost certain services
- **FPH and HWPH are facing a growing and ageing population**, coupled with a forecast increase in chronic diseases, which will put additional strain on local services
- **The combined organisation provides the opportunity to achieve critical mass in clinical services** and achieve a sustainable financial position
- **Options appraisal has shown that acquisition offers the best opportunity for FPH** to maintain medium term sustainability at the current time
- **An Outline Business Case for the transaction was approved by the FPH Board in August 2013 and reviewed by Monitor in October 2013.** The FPH Board decided to proceed with a Full Business Case for the acquisition in February 2014

NATIONAL HEALTH CONTEXT

The national context breaks down into four areas which drive the rationale for the acquisition of HWPH.

- **Ongoing financial challenge.** NHS Trusts throughout England are required to deliver efficiency savings of circa 4-5% per annum. Increasingly it is recognised traditional CIP schemes alone will no longer deliver the required savings. Trusts will be expected to engage in wider transformational change and service reconfiguration with other agencies and providers in order to deliver the productivity improvements required.

- **Increasing operational pressures.** Trusts across England are encountering increasing demand for acute services, particularly through escalating ED attendances and unplanned admissions to hospital. Additionally, an ageing population with associated long-term conditions will demand more from health care providers year on year.

- **Increasing quality expectations.** There is ever increasing scrutiny of Trusts, hospitals, departments and individual healthcare professionals. Rolling CQC inspections, the Francis report, and more recently the Keogh Review, are increasing pressure to maintain high standards of care at all times, requiring changes to health service culture and working practices in the context of a constrained funding environment.

- **Doubts over the sustainability of smaller acute Trusts.** A series of reviews and guidance[1,2] have recommended that increased specialisation of clinical teams serving larger populations deliver improved outcomes for patients. Another challenge for smaller Trusts is sustaining services as primary care and specialist secondary care providers increase market share. Additionally the recent report by Monitor on the performance of the Foundation Trust sector for the year ended 31 March shows, that out of 18 failing acute Trusts, 16 are small to medium (that is, have an income up to £400m).

LOCAL HEALTH ECONOMY CONTEXT

At a local level, health services will need to respond to anticipated changes in the demographic and health profile of the local population. Local councils have drawn up Joint Strategic Needs Assessments (JSNA) which identify some common themes that drive the health needs of the local populations. These are:

- **Population growth:** The population is expected to grow by a total of 3.3% between 2013 and 2018.
- **Ageing population:** Growth in the 75+ age group is forecast to be a total of 11.6% between 2013 and 2018. This is significant since more than 70% of people aged 75+ have one or more long term condition. The average person aged 85+ makes three times as many visits to primary care and is 14 times more likely to be admitted to hospital than the average 15-39 year old.
- **Levels of deprivation:** The FPH and HWPH catchment populations in general have low levels of deprivation. However, there are pockets of deprivation within the catchment area, such as parts of Camberley, Aldershot and particularly in Slough. Typically less affluent areas will have a disease profile that is more associated with deprivation such as respiratory disease and diabetes. Comparatively, the more affluent areas have a higher life expectancy, but face the associated disease and need for long term care that comes with an ageing population.
- **Health profiles:** Cardio-vascular disease is the leading cause of death in both males and females across the catchment area. The incidence of chronic conditions is expected to increase over the coming years, stroke continues to increase nationally, and dementia is predicted to increase by over 50% in the next 15 years.

All of the above means that there will be significantly more operational pressures over the coming years on both Trusts. Improved care of the elderly services and implementation of integrated models of care are key to reducing unplanned hospital admissions.

TRUST OVERVIEWS

Frimley Park Hospital NHS Foundation Trust is a district general hospital located in Surrey, close to the Hampshire and Berkshire borders. The Trust provides a full-range of district general hospital services for the population of North East Hampshire and West Surrey. The catchment population has grown significantly from 170,000 in 1974 when the hospital was built to between 400,000 and 500,000 today and this figure is expected to grow further.

Heatherwood and Wexham Park Hospital Foundation Trust serves a population of between 400,000 and 500,000 people from the areas of Ascot, Bracknell, Maidenhead, Slough, Windsor and south Buckinghamshire. The Trust

[1] *"Is volume related to outcome in healthcare? A systematic review and methodological critique of the literature"*, Ann. Intern. Med. 137: 511 – 520 Halm et al, 2002
[2] *Hospital volume and health care outcomes, costs and patient access* ,NHS Centre for Reviews and Dissemination, systemic review 1996

delivers a wide range of healthcare services from two main sites; Heatherwood Hospital in Ascot opened in 1923, and Wexham Park Hospital in Slough opened in 1968.

FPH AND HWPH DRIVERS FOR CHANGE

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The specific imperatives for change for both FPH and HWPH are outlined below:

FPH Hospital Drivers for Change

FPH is facing declining operating surpluses over the coming years, the consequence of annual efficiency targets and increasing clinical and demographic pressures affecting commissioners. The FPH leadership anticipate a real threat to the sustainability of patient services unless a fundamental strategic change takes place.

The leadership team consider the Trust is too small to meet the following future challenges:

- **Clinical:** FPH is at risk of becoming sub-scale as the NHS consolidates into fewer larger Trusts and hence losing services and income over the medium term. NHS England has outlined specialised services provided in centres of excellence as one of their key priorities for Trusts going forward[3].

  The implications of this are that there will be fewer specialist service providers with larger market shares. For FPH specifically, there is a risk of services being lost and volumes being reduced as specialist secondary providers increase market share in response to this.

  FPH also wishes to maintain its current position as a centre of excellence, able to attract and retain the right high quality staff to maintain and improve services for its patients.

- **Financial sustainability:** In light of the scale point above FPH is forecast to suffer from declining surpluses from FY2014/15 onwards. Additionally FPH will find it increasingly difficult to meet the annual circa 4-5% efficiency requirement placed on Trusts, and will face pressure from a shift to move care into the community and a virtually flat funding settlement for the NHS anticipated over the next few years.

Heatherwood and Wexham Park Hospital Drivers for Change

HWPH is at present not financially sustainable and requires significant recurrent financial support and there is an acknowledged requirement to improve governance throughout the organisation. The Trust has been in breach of the terms of its authorisation since 2009 and continues to exist with a significant financial deficit. The Trust has struggled financially since 2009, with a deficit position in 2012/13 of £15.3m. In addition, Monitor announced the Trust had been placed in special measures in May 2014. As part of this process FPH has been invited to 'buddy' with HWPH.

Several attempts have been made to build a viable future, however, the HWPH board in January 2012 recognised that its position as a standalone organisation was unsustainable, chiefly due to the level of capital investment required to provide quality facilities.

The following challenges have been identified:

- **Clinical/ Financial Scale:** The board of HWPH has recognised that in its current position it is unsustainable and sub-scale, having already lost certain services including hyper-acute stroke; the 24/7 PCI service and Level 2+ neonatal care.

- **Patient Care:** HWPH had a red rating recorded on Oct, 2013 – the lowest governance rating since July 2009. The Care Quality Commission (CQC) found serious clinical failings at the Trust during its inspections over the course of 2013 and in a more recent inspection carried out in February 2014. The overall and most recent CQC findings of the Trust were rated as inadequate with a question continuing over its future sustainability. A total of twenty four actions were recommended – eighteen as 'must' happen and six as 'should' happen. On 3 May 2014 Monitor announced HWPH had been placed in special measures.

- **Financial sustainability:** The Trust has been in breach of the terms of its authorisation since 2009, and it continues to have a significant financial deficit, and is unable to deliver the necessary capital expenditure to

[3] NHS England 5 year planning strategy document 2014/15 – 2018/19

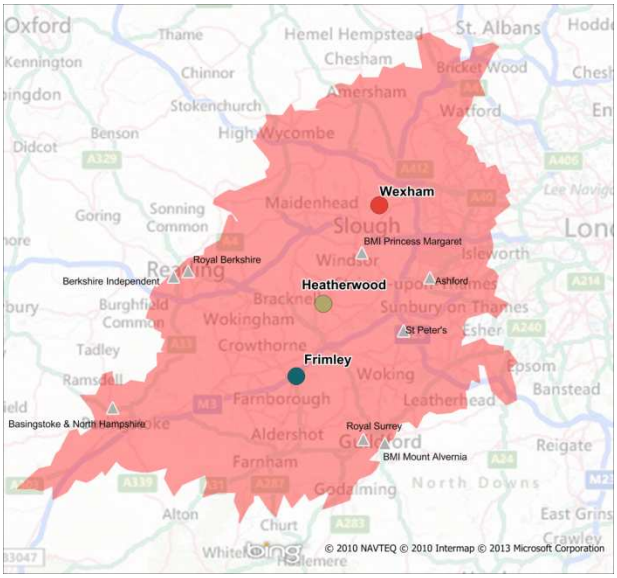
improve the Wexham Park site. It has been classified by Monitor as having a FRR (Financial Risk Rating) of 1 (the lowest rating) since 2009 and now has a CSRR (Continuity of Service Risk Rating) of 2.

- **Governance:** The Trust has been classified by Monitor as a poor performer against its peers for governance standards, scoring a red rating since 2009. Despite several changes of leadership since the Trust was declared in breach of its Terms of Authorisation by Monitor, none have succeeded in resolving the issue. On 3 May 2014, Monitor announced the Trust had been placed in special measures.
- **Human Resources**: The Trust is also facing short-term challenges in providing increased Consultant-led service provision and managing with reduced numbers of junior doctors; while endeavouring to meet the surgical safety thresholds. For example, the new guidance on acute colorectal surgery and increased demand for specialised on-call rotas. It is also struggling to recruit staff, having high levels of agency staff across clinical and non-clinical areas.

OPPORTUNITIES AS A COMBINED ORGANISATION

The acquisition of HWPH by FPH and the resulting increased catchment area of between 800,000 and 1,000,000 people will create the organisational scale necessary to establish robust, sustainable services for the people of Berkshire, Buckinghamshire, North East Hampshire and Surrey. The current geographic catchment of the two Trusts is shown in Figure 1 below and is based on referral patterns and distance to the hospital sites. Figure 1 below shows a 30 minute drive time, and captures around 90% of all the GP referrals to both current Trusts.

Figure 1: Catchment area of the enlarged Trust capturing circa. 90% of GP referrals to the two current Trusts



The acquisition will enable a platform for change, driving forward clinical service changes where appropriate and providing the impetus to create new services to serve the growing and ageing population. The enlarged trust will be better placed to recruit and retain high quality clinical staff and to offer excellent training opportunities. Back-office and operational consolidation will help release resources for front-line services.

The enlarged organisation will benefit from a unique opportunity to focus finances, resources, expertise and equipment to better serve patients. It will provide the capacity and impetus to review and improve delivery models.

VISION FOR THE NEW ORGANISATION

"United in the pursuit of the goal of continuous improvement and the ambition and passion to be the country's best"

- **The enlarged Trust will focus upon developing strong clinical leadership** across all sites, supported by a Board of the minimum size necessary to effectively manage the organisation
- **Effective values**, well established at FPH, will be promoted across all sites
- **A streamlined centralised back office function** will be implemented where possible
- **An integration plan and organisational development strategy have been developed** to support the acquisition.

Delivering the highest quality services for all patients remains the paramount aim for the FPH leadership team. In bringing together Heatherwood, Wexham Park and Frimley Park hospitals, the clinical and managerial leadership aim to deliver an organisation that provides service improvements and long-term benefits for patients and staff across the four counties of Berkshire, Buckinghamshire, Hampshire, Surrey and beyond. A key indicator of success will be the three sites operating together, genuinely integrated as if a single hospital unit.

The FPH management have successfully embedded their vision and principles among the staff through significant communication activities and leadership engagement. Following the acquisition, the executive team will lead the engagement work with teams, explain the imperative for change and cascade a single set of core values across all sites through the local management teams and face to face meetings with the Executives.

PROPOSED CLINICAL VISION

FPH has consistently delivered high standards of clinical quality and patient experience while HWPH is facing a number of clinical quality challenges that have been reported by both the CQC and FPH's clinical due diligence. The enlarged organisation will address these comprehensively.

- The proposed clinical model will bring the following improvements across the enlarged Trust:
  1. **Improve the quality at HWPH** through a common culture based on FPH leadership through robust clinical governance
  2. **Improve existing services and develop new services** for patients based on sharing expertise and developing improved interfaces with community healthcare and the scale of the new organisation will allow for greater subspecialisation
  3. **Provide a new model of elective care including a new centre of excellence** for elective care at Heatherwood and enhanced patient centred models of care e.g. 'one stop shop' services.
- **Implementation will be carried out in a way that clinical quality is maintained and improved at all three site**s throughout the transformation

It is widely recognised that HWPH is facing a number of challenges in clinical quality. These have been demonstrated in an ongoing challenge in delivery of national quality indicators such as the 4 hour Emergency Department target and the 18 week RTT target for elective patients. A number of patient experience measures including the Friends and Family measure and annual patient survey indicate that patients are not happy with the delivery of service. The Friends and Family Test results are poor, particularly in A&E, with a national promoter score of 23 in December 2013 against a national average of 56.

Members of the public expressed their concern to the CQC regarding poor care and loss of privacy and dignity that they and their relatives experienced following treatment at the Trust. The most detailed CQC inspection recommended 24 actions, 18 as 'must happen' priorities.

FPH has consistently delivered a financial risk rating of 4 or above[4] and has won a series of awards[5] for high standards of clinical quality and patient experience. This is supported by a stable management structure that has demonstrated its ability to deliver over a number of years. The acquisition provides a way forward to improve services for both organisations, ensure equity of services and parity of access for the population served by HWPH and FPH. The proposed clinical model will bring the following specific benefits:

1. **Improve the quality at HWPH** through a common culture based on FPH leadership through robust clinical governance
2. **Improving existing services and developing new services for patients** based on sharing expertise and developing improved interfaces with community healthcare. The scale of the new organisation will allow for greater subspecialisation.

[4]Frimley Park Hostpial NHS FT annual reports. Financial Risk Ratings of NHS Foundation Trusts:http://www.monitor-nhsft.gov.uk/about-your-local-nhs-foundation-trust/nhs-foundation-trust-directory-and-register-licence-holders/he-0

[5] Baby Friendly full accreditation (UNICEF); CHKS Top 40 Hospital (awarded for 10 consecutive years); MHP Health Mandate Quality Index Top five acute trust 2013;NHS Staff Survey: Best acute trust in the country for staff engagement (2013);NHS Staff Survey: Best place to work (acute Trusts in England, 2012);NHS Staff Survey: Best job satisfaction of an acute trust (2011);Cancer patient experience survey top 20% of all Trusts (2012/2013);First chemo department to be adopted by McMillan Cancer Care

3. **New model of elective care** including a new centre of excellence for elective care at Heatherwood and enhanced patient centred models of care e.g. 'one stop shop' services

Key specific changes envisaged within the proposed clinical model include:

- Changes in care of the elderly (CoE): proactive management of higher risk patients, provision of front-door CoE physicians, and greater integration with local health providers will create treatment pathways specifically for older adults and lead to both improved hospital care and early supported discharge;
- Changes in the ED model: excellent quality of care (in all 5 quality indicators) will be achieved through streamlined patient flows, 24/7 Consultant-delivered care, and closer integration with community services;
- One site to gain major emergency status
- The intention to deliver a hyper acute stroke unit (HASU) and pPCI at HWPH; and
- Changes in the urology and cancer networks to ensure that more local services are available for patients, including access to highly specialised services where possible.

Overall, the acquisition will significantly improve patient care across the catchment areas of FPH and HWPH. Bringing together two Trusts with important complementaries will deliver improved clinical outcomes through larger clinical teams and improved access to services for patients. The ability to attract and retain high quality staff will support the delivery of these benefits.

Implementation of the clinical model will be carried out to ensure that the existing excellent quality of services is maintained or enhanced, new services are developed and the clinical pathways are transformed over a pragmatic timeline so that senior leaders are able to devote adequate time to the integration. The focus will therefore be on delivering the short-term changes to 'business as usual' that address current clinical issues and preparing the medium- and long-term changes that will drive patient benefits.

This structured approach to stabilising and improving the delivery of services to patients will allow for services to be developed and delivered in appropriately planned ways, with good co-ordination between health and social care providers across the health communities. While HWPH is in an unstable position with an uncertain future, some patients are choosing to go to other parts of the health system in a less planned way, in some cases leading to pressure on services and difficulties in providing the appropriate capacity across the whole system.

The clinical model assumes that the mix of services currently offered to patients in their local area will remain locally. The clinical model is actually proposing that more services which have been lost from the HWPH sites be returned to be provided more locally on those core sites. This should become possible, with commissioner support, as the quality and financial stability of the enlarged organisation is delivered. Should the enlarged organisation wish to make any substantial service changes in the future, it would follow an appropriate process of involving all local stakeholders in shaping plans and giving formal feedback on those plans.

ENGAGEMENT PROCESS

Commissioner engagement

A commissioner engagement process was undertaken, with local and national bodies, to elicit commissioners' views on the transaction and to work through and agree the key principles and finances underpinning it. The Chief Executive and the Medical Director of FPH have attended public CCG meetings to discuss the process of potential acquisition, the drivers for change and the process by which the clinical model has been discussed so far. Clinicians from HWPH and FPH have met on a specialty by specialty basis to discuss opportunities presented by an integrated organisation. Each area has met at least three times. There has also been a meeting with senior clinical leaders in CCGs to discuss and review emerging ideas for clinical services and future improvements in quality and service delivery.

This engagement process is ongoing. High level outcomes include:

- Supportive of plans to improve the elderly care services, including greater integration with community providers
- Supportive of improvements to the HWPH ED to reduce non-elective activity
- Majority supportive of an elective facility being developed at Heatherwood

- Comparison of baseline activity and financial assumptions has shown that there is a strong alignment on the overall forward assumptions for the enlarged Trust, but some difference in starting positions
- Several potential opportunities for repatriation of work such as Obstetrics and Ophthalmology have been identified.

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Public and patient engagement

FPH has been discussing the proposed acquisition with its members, public and patients and the Council of Governors at Council of Governor meetings and at local constituency meetings. The core programme of health events held through the Trust's community includes a dedicated section outlining the Trust vision. These events are typically well attended with 100 to 200 guests.

At each meeting the reasons for considering this acquisition are presented and those attending are encouraged to ask questions and provide feedback. Across the range of meetings that have been undertaken so far, the majority of those present understand the reasons why FPH wants to consider the acquisition.

Public statements about the progress of the acquisition process continue to be shared with local media as appropriate. The Trust plans to utilise its strong and active social media community to engage the public as acquisition approaches.

Phased approach to engagement
FPH is taking a phased approach to engagement as the nature of engagement, messages and stakeholder impacts will change through pre-acquisition, integration and transformation.

CONCLUSION

We are very much aware of the complex issues at Heatherwood and Wexham Park Hospitals NHS Foundation Trust. In supporting HWPH through a buddying process we will do all we can to help lift the trust's performance and improve services for local people, while continuing to explore the potential acquisition of HWPH.

The board at Frimley Park Hospital NHS Foundation Trust continues to work on a full business case examining the prospects of the acquisition in great detail. This stage is due to be finished by the summer. Once completed, the full business case will form the basis of the case made to each trust's board and council of governors and to Monitor, the foundation trust regulator, in seeking their agreement for the acquisition to proceed.

The acquisition has been assessed and cleared by the Competition and Markets Authority, whose review was completed in mid-May 2014.

SURREY COUNTY COUNCIL

Health Scrutiny Committee
30 May 2014

Progress and Impacts of the Hospital Discharge Rapid Improvement Event (RIE)

Purpose of the report: Scrutiny of Services

The committee will review the progress and impacts of the actions identified in the July 2013 Acute Hospital Rapid Improvement Event

Introduction

1. The Acute Hospital Discharge Rapid Improvement Event (RIE) was held in July 2013. The RIE was set against a background in Surrey of:
    - Growing demand on the health and social care system
    - Delayed transfers of care which are often multi-agency and complex, cost the acute hospitals unnecessary resources and block vital beds to other patients
    - Growing awareness that staying in hospital once medically fit is not good for people's health, independence and wellbeing
    - A positive working relationship between local health and social care partners and a desire to build on previous work to further improve the discharge pathway.
2. The ambition of the RIE was to improve the patient discharge process by working together as partners to ensure that as soon as patients no longer need acute hospital care they are discharged safely.
3. The RIE methodology is about having a joint commitment to improvement, senior leadership and sponsorship, and co-design of solutions by front line staff who really understand the challenges. The event was jointly sponsored by the Strategic Director Adult Social Care and the Chief

Executives of the five acute hospitals in Surrey. A multi-agency group of front line staff from across health and social care providers came together for the week-long RIE workshop in July 2013. An annexe is attached showing the organisations involved. The objective was to create:

- Shared understanding and joint solutions
- Consistent discharge pathways
- Common standards to underpin the discharge pathway
- Performance indicators to track and assess collective performance.

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Progress to date

4. The multi-agency group visited colleagues across the five acute hospitals to diagnose the problems with the existing discharge pathway. The group designed solutions and worked with their colleagues to get feedback and refine these ideas. At the end of the week, the group presented their findings to the sponsors and the seven work streams were agreed. These work streams were then developed further in the following months. The work streams of the RIE are:-

   A. Standard Operating Framework

   B. Proactive Multidisciplinary teams

   C. Read only access to partners IT systems

   D. More transport options home

   E. Poster, leaflet and protocol of choice

   F. Step up step down beds in the community

   G. Assessing collective performance

5. **The Standard Operating Framework** was developed. The aim of this was to agree common standards and for these to be implemented locally at each acute hospital. It provides an overarching framework for discharge planning and describes how to apply clinical standards to help to manage the patient journey through the emergency department, assessment areas and the wards to ensure consistent standards of co-ordinated care. All the acute hospitals are working to incorporate the standards into their local operating frameworks. A personalised 'Going Home Plan' was also designed to provide information for patients to help them to prepare for leaving hospital. Information for the Going Home plan was taken from a comprehensive booklet that Frimley Park Hospital had implemented and therefore they continue to use their patient booklet. The other four acute hospitals are piloting the Going Home Plan.

6. **Proactive multi-disciplinary teams** the aim of these was to help to ensure that all relevant agencies are involved at an early stage to help

prevent admission and to facilitate timely discharge. One of the areas of focus was for the teams to ensure that there was regular communication with the patient and/or their family (where relevant) and the community care provider, so that they could all be kept up to date and for them to be pro-actively engaged in the planning for leaving hospital. The Acute Hospitals are implementing this way of working and have aligned it with local work they have been doing to review and improve multi-disciplinary teams. For example in Ashford & St Peters Hospital this is being rolled out via their Discharge Task Force and in Epsom General Hospital it now forms part of the One Ward One Team programme.

7. **Read only access to partners IT systems**, providing nominated health staff with 'read-only' access to partners information about a patient to help prevent admission and assist with background information that would help with the planning to leave hospital. The first step is to provide access for Acute Hospitals to the Adult Social Care (AIS) records. Organisations can only share information with express consent from an individual and we therefore are currently finalising the information sharing and information governance requirements. In the mean time, named health staff have been nominated and our social care teams are provided training on the Adult Social Care (AIS) database. This work is ongoing and once we have the Information sharing matters finalised then health staff will have access.

8. **Transport options home**. This workstream enabled us to explore and identify alternative transport home options for patients to use that would be appropriate to their needs. The RIE recognised that there were issues with patient transport, and the purpose of this workstream was to explore if people were fully utilising all options and if we could develop alternative options to the PTS. We have:
    - Developed a checklist of local alternative transport options that can be used on the wards by staff and patients, this is being piloted in Epsom General Hospital and East Surrey Hospital (SASH).
    - Designed a helpful hints, or fact sheet for care providers to help them to put in place the relevant checks and processes in order that they would be able to offer transport support for their customers. Currently we do have some private providers who already provide this so the ambition is to help build on this good practice and support other providers to consider offering this as part of their service.
    - Designed a pilot in Mid Surrey Social Care, linked to Epsom General Hospital for our in house reablement service to offer transport home, We are aiming for a go live on this trial by end of June 2014 and if successful would look to roll out to other areas. This would also have the secondary gain of helping people to settle in following discharge from hospital

9. **Poster, leaflet and protocol of choice** this is to help ensure that patients have an understanding of the discharge process and to encourage them to think about their plans for returning home, including possible transport options. Each acute hospital is liaising with their internal communications

teams to design a poster with their local branding and in conjunction with local patient groups. The 'Going Home Plan' provides personalised information in leaflet form for patients on their estimated date of discharge and helpful tips on local services and what they might need to consider for planning their return home. A multi-agency working group has co-designed a protocol of choice; this is currently being reviewed by Clinical Commissioning Groups, community health providers and acute hospitals. The protocol of choice is an ongoing piece of work and we are aiming that this will be ready to launch in early June 2014.

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10. The aim of creating additional **step up and step down** beds in the community was to provide a resource to help prevent admission and help patients to leave hospitals as they no longer needed acute medical intervention. This was piloted in one of the Surrey County Council, residential care homes. The pilot concluded that a nursing rather than a residential care setting was really what was needed. The development of these resources will now be taken forward as part of the local partnership work through the Surrey Better Care Fund where Adult Social Care are working with local Clinical Commissioning Groups.

11. The **Assessing collective performance** work stream was to ensure that we had a common set of measures with joint health and social care targets. We have agreed Surrey wide measures as part of the Surrey Better Care fund in order to have a whole system approach for measuring performance. The measures include, delayed transfers of care from hospital, admissions to residential and nursing care from hospital, avoidable emergency admissions, 91 day review of outcomes for older people following discharge who received reablement. The intention is to commence reporting to the Surrey Better Care Board and the Surrey Health and Wellbeing Board in Quarter 1 2014/2015. There is a general clause in the Care Bill which references the duty to cooperate and so this will help to continue to support local partnership working.

12. We are planning **to complete an evaluation** of the impact of the RIE. We hosted a session with the Local RIE leads in February 2014, to review progress, share best practice and for initial feedback. The overall feedback at that point was that the RIE had been helpful in bringing together providers of health and social care to act as a catalyst to take forward improvements and that this has helped to build on local collaborative approaches to improving how we work together.

13. The intention going forward would be for us to continue to host a Surrey wide network every six months to share innovation, best practice and help to support and advice on any emerging. We have a commitment from our provider partners to continue with this forum as one that they value.

Conclusions:

14. In summary the Acute Hospital RIE has resulted in initiatives being put in place with the aim of improving the patient discharge process by working together as partners to ensure that as soon as patients no longer need acute hospital care they are discharged safely. The majority of the workstreams have been completed and are now with Local Acute

Hospitals and Social Care staff for piloting and implementing. There are some remaining workstreams that we are continuing to work on. These are the Access to Adult Social Care (AIS) Database, the completion and launching of the protocol of choice and with regards to the transport alternatives, the launching of the Pilot of the Surrey Reablement service to offer transport home from hospital.

15. Early indications are that the RIE provided a platform for collaborative working across Surrey and that colleagues have valued the opportunity to share best practice, and local innovation. We are currently in the process of drawing up a survey for those involved to evaluate the impact the RIE and what the impact has been on local partnership working. The proposal is to continue as a professional network and to meet six monthly to share ideas, innovation and best practice that colleagues could consider to adopt or adapt in their local settings.

Public Health Impacts

16. The early feedback is that Acute Hospital Discharge RIE has had a positive impact on the health outcomes of the population in Surrey by providing tools which help to prevent emergency admissions and ensure that as soon as patients no longer need acute hospital care they are discharged safely. An evaluation of the RIE will be undertaken in July 2014.

Recommendations:

17. That the Health Scrutiny Committee supports the continuation of a Surrey hosted County wide professional network of providers. The proposal is that the Network would meet on a six monthly basis to share ideas, innovation and best practice so that colleagues have an opportunity to hear of other initiatives that they could consider adopting or adapting for their local settings.

18. That following the publication of the RIE evaluation this is shared with all whom contributed to the RIE and to Health & Scrutiny Committee.

Next steps:

19. We are continuing to work on the access to Adult Social Care Records (AIS), the completion and sign off of the protocol of choice transport alternatives. It is expected all of these work streams will be completed by end of June 2014.

20. The Hospital RIE is drawing to a close, with most of the workstreams completed and an evaluation pending. We are planning to undertake an evaluation of the impact of the RIE in July 2014.

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Contact details: Phone 01372 832310 or sonya.sellar@surreycc.gov.uk

Sources/background papers: Annexe of organisations involved attached

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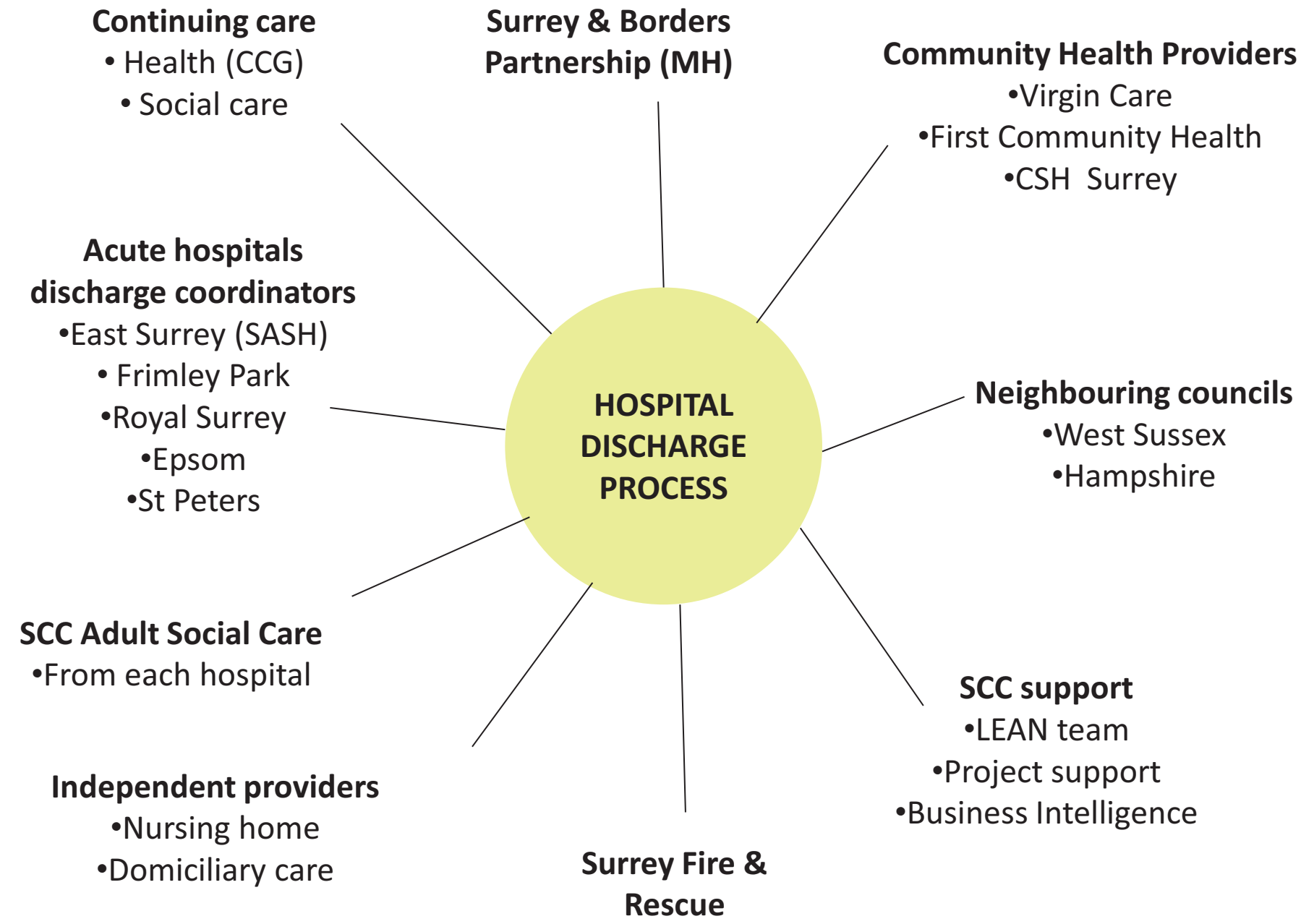
Annex 1


Continuing care
• Health (CCG)
• Social care
Surrey & Borders Partnership (MH)
Community Health Providers
•Virgin Care
•First Community Health
•CSH Surrey
Acute hospitals discharge coordinators
•East Surrey (SASH)
• Frimley Park
•Royal Surrey
•Epsom
•St Peters
HOSPITAL DISCHARGE PROCESS
Neighbouring councils
•West Sussex
•Hampshire
SCC Adult Social Care
•From each hospital
SCC support
•LEAN team
•Project support
•Business Intelligence
Independent providers
•Nursing home
•Domiciliary care
Surrey Fire & Rescue

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NHS
Surrey Downs
Clinical Commissioning Group

Health Scrutiny Committee
30 May 2014

Surrey Downs CCG Out of Hospital Strategy

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

Pressure on A&E departments continues with non-emergency admissions. The committee will scrutinise the plans of Surrey Downs CCG to provide more community based care to meet local needs in their Out of Hospital Strategy.

Introduction

1. From 1 April 2013 NHS Surrey Downs Clinical Commissioning Group has been responsible for commissioning (or buying) healthcare to meet local health needs. This followed the abolition of primary care trusts who previously undertook this role. This strategy is part of our wider commissioning strategy and focuses on our plans to increase investment in community services so that more people can receive care closer to their own homes.

2. The aim of our Out of Hospital Strategy is to deliver more care in community settings and improve quality of care, whilst also ensuring services are sustainable longer term. This work is happening in parallel to work happening as part of the Better Services Better Value (BSBV) programme which is currently looking at acute care standards for hospitals in south west London, which includes Epsom Hospital (our local acute hospital) as it is part of a London facing trust. The focus of this strategy is on community services and getting these right now. We believe these improvements need to happen now, regardless of any other changes that are proposed - it does not pre-empt the outcome of the Better Services Better Value review.

Recommendations

3. The Committee to consider the Surrey Downs CCG Out of Hospital Strategy.

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NHS
Surrey Downs
Clinical Commissioning Group

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Out of Hospital Strategy 2013-2018

Version 1.2

Access | Choice | Experience | Safety | Outcomes

Index

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1. Vision and context

9

Who we are, how we will meet local health needs and our vision for the future

1.1 Executive summary

From 1 April 2013 NHS Surrey Downs Clinical Commissioning Group has been responsible for commissioning (or buying) healthcare to meet local health needs. This followed the abolition of primary care trusts who previously undertook this role.

This strategy is part of our wider commissioning strategy and focuses on our plans to increase investment in community services so that more people can receive care closer to their own homes.

The aim of our Out of Hospital Strategy is to deliver more care in community settings and improve quality of care, whilst also ensuring services are sustainable longer term. This work is happening in parallel to work happening as part of the Better Services Better Value (BSBV) programme which is currently looking at acute care standards for hospitals in south west London, which includes Epsom Hospital (our local acute hospital) as it is part of a London facing trust. The focus of this strategy is on community services and getting these right now. We believe these improvements need to happen now, regardless of any other changes that are proposed - it does not pre-empt the outcome of the Better Services Better Value review.

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1.2 Our role and vision

Surrey Downs CCG serves a population of around 290,000 in an area that covers Mole Valley, Epsom and Ewell, east Elmbridge and Banstead and surrounding areas. We are made up of 33 member GP practices, which operate as four commissioning localities. We have an annual budget of £314m to commission community, acute, ambulance and other healthcare for local people. We are not responsible for commissioning core GP services and do not commission community pharmacy, optometry and dental services as this is done by NHS England.

This strategy is aligned with our over-arching vision which is:

- Through focused clinical leadership and engagement, we will revolutionise the delivery of local healthcare, improving care for local people
- Services we commission will be local, affordable, responsive and deliver improved outcomes for patients
- We need to live within our means – and that means making savings by ‘doing more for less’
- We believe we can achieve this by redesigning care pathways and providing more healthcare in community settings, which will deliver real improvements in patient care.

1.3 How we shaped this vision

Building on our high level vision, we engaged clinicians from our 33 member practices, local people and our stakeholders to develop a series of high level commissioning priorities that were based on local health needs.

During July and August 2012 clinicians and stakeholders were invited to attend workshops and share their views and local people were invited to complete a questionnaire in which we asked them to rank a series of health priorities and to tell us about any other areas they wanted us to focus on. During this period, we engaged with GP representatives from our 33 member practices, as well as a wide range of stakeholders. We also received more than 400 completed questionnaires from members of the public. We collated this feedback and used it to inform the development of our commissioning priorities.

In April 2013, we built on this work through an intensive 10 week programme that involved more than 160 of our GP members and a broad range of stakeholders to develop an Out of Hospital Strategy that supports wider commissioning plans and focuses on providing more care in the community.

9 We have discussed plans to develop our Out of Hospital Strategy with our Patient Advisory Group, which includes representation from carer, patient and other voluntary sector groups and further discussed are planned for September to ensure this group is fully engaged with this work moving forwards. As well as seeking their views on our commissioning plans, we will also be engaging them on how we share and communicate our plans and priorities more widely within the local community.

All this feedback, and comments from our stakeholders, was used to refine develop our Out of Hospital Strategy which addresses six key priorities shown in Figure 1 below:

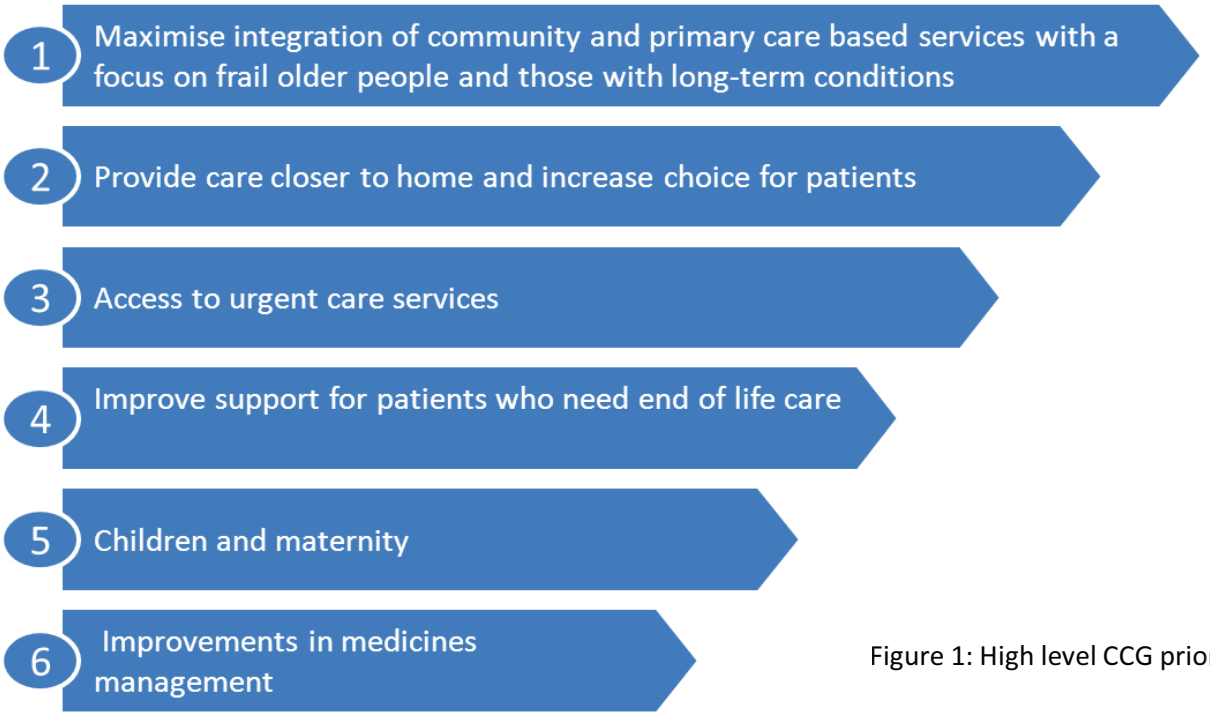

Figure 1: High level CCG priorities

This Out of Hospital Strategy focuses on the first four priorities. Plans to improve children's and maternity care and deliver improvements in medicines management will be developed in due course. To implement these priorities, the Out of Hospital Strategy is separated into four categories of care – admission prevention, urgent care, elective care and discharge. Each portfolio has individual projects with Executive, clinical and operational leads, as well as key delivery milestones and risk.

1.4 Our clinical journey

One of our first major clinical decisions as a CCG was to develop an Out of Hospital strategy programme which would meet the needs of our local communities; ensure we were a credible organisation that fully involved our stakeholders; and provide a locally developed vision in parallel to South West London's vision for Epsom Hospital – Better Services, Better Value.

Our starting point was that the journey had to begin with our membership practices, involve local people and patients, through a 'bottom-up' approach based on clinical best practice, clinical audits and robust evidence to ensure our strategic vision was credible, practical and achieves key quality standards for patients in terms of Access; Choice; Experience; Safety; Outcomes.

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1.4.1 Out of Hospital strategic programme

The process used for developing the Out of Hospital Strategy is described in Figure 2 below. A key design principle underpinning the development of the strategy is stakeholder engagement, both at CCG and locality level, and also with patients and other service users and providers.

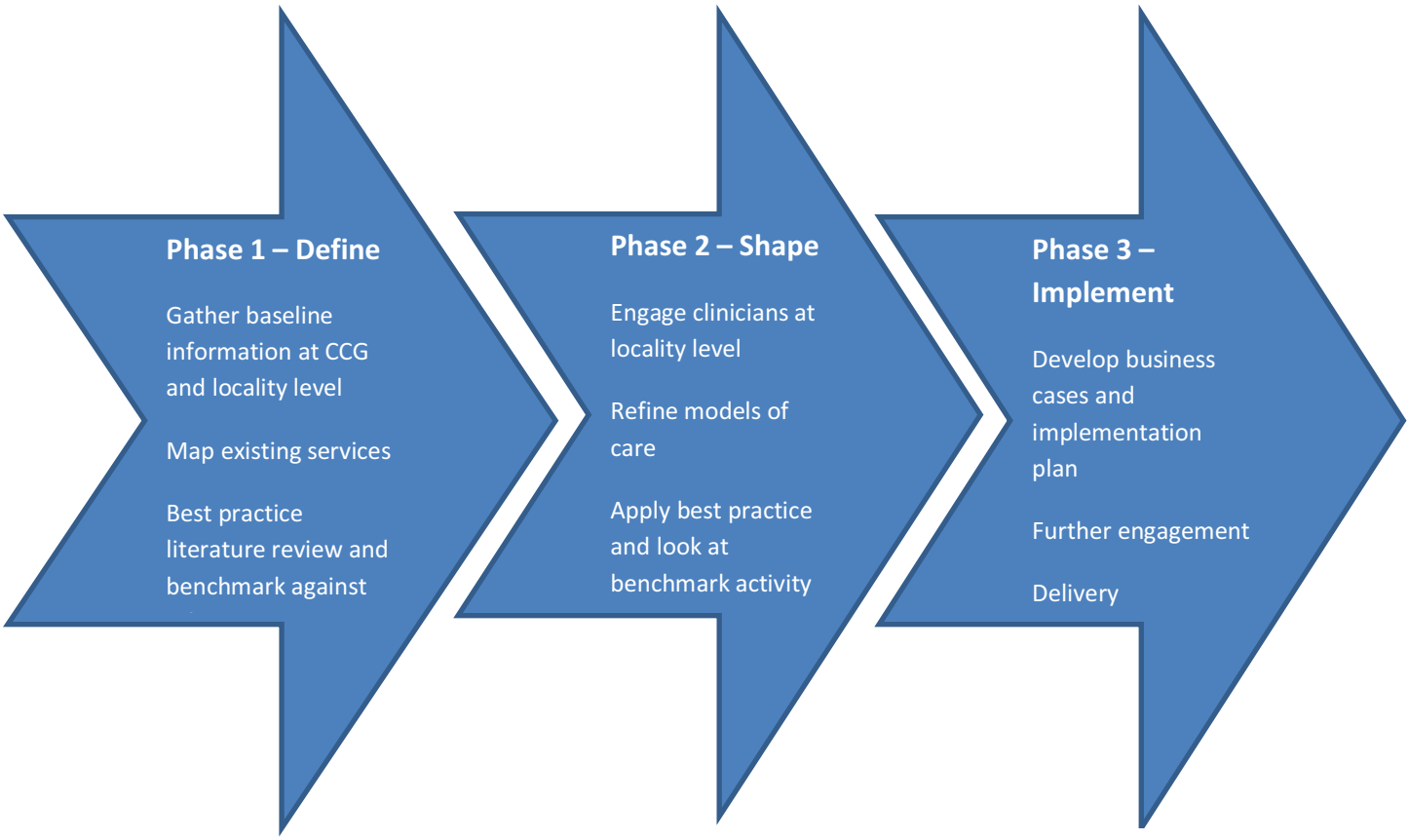

Figure 2: Out of hospital strategy process

1.4.2 Strategic framework

The Out of Hospital Strategy strategic framework is based on the premise that primary and community care needs to be transformed in order to achieve the system changes necessary to deliver high quality and safe care, which is appropriate, closer to home and provided by suitably trained professionals. Furthermore, there needs to be integrated care pathways and joint working with acute and mental

health providers, local authorities, the voluntary sector and other partner organisations. There also needs to be a drive to improve patient education and the self-management of conditions.

The framework is described in Figure 3 below:

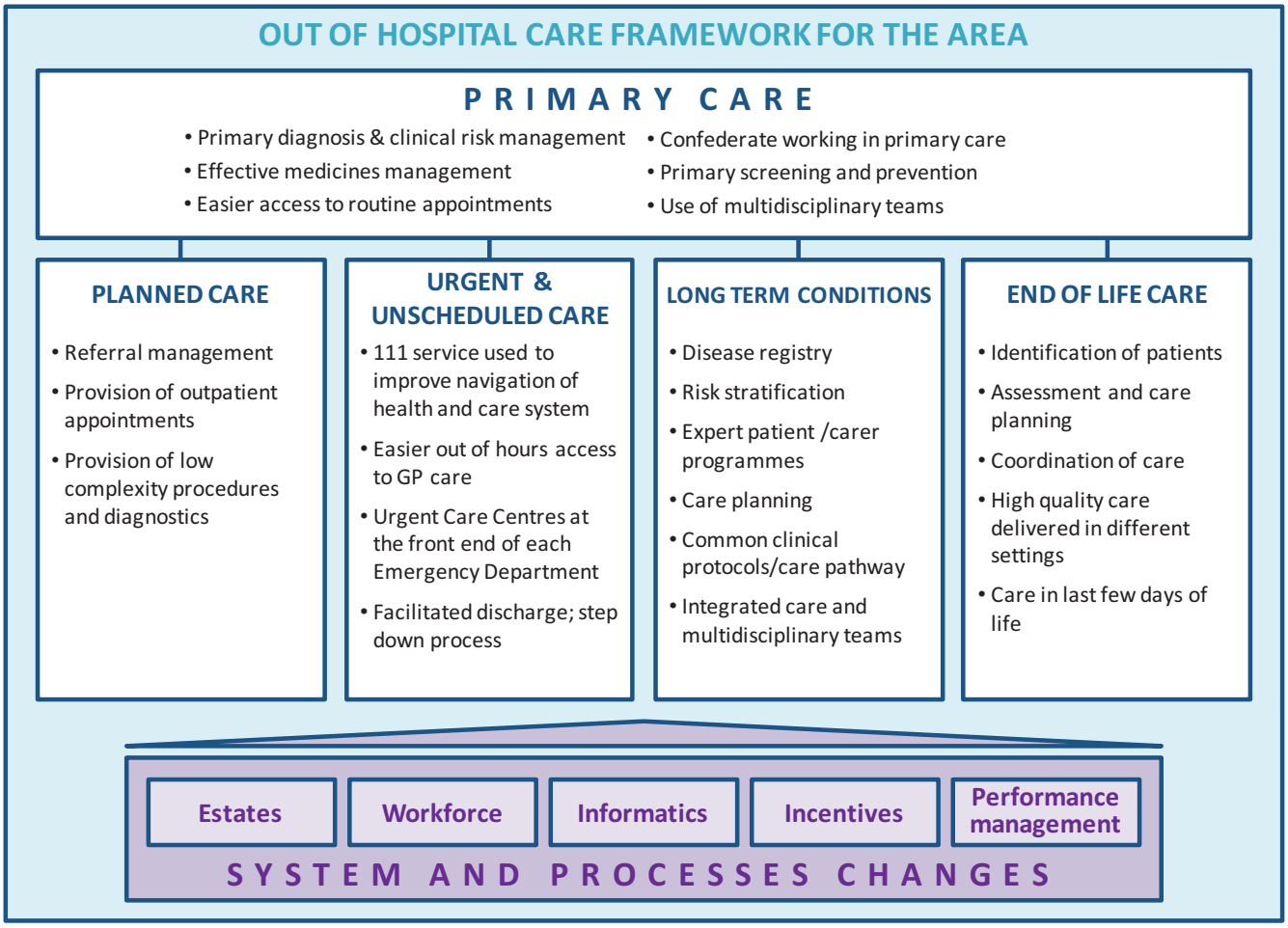

Figure 3: Out of hospital framework

1.4.3 Clinical engagement, workshops and baseline information

The CCG commissioned external support to rapidly accelerate the programme whilst taking our members with us through a clinical engagement process to develop a high quality and clinically effective model of care. To provide a clear baseline, benchmarking data was compiled for each locality. A literature review was also undertaken to inform planning. The process included:

- **Current 'as is' picture** using baseline information, benchmarked performance data and service mapping for out of hospital care. We used this information as the basis for locality based discussion on the current position of the CCG, enabling locality practices to identify opportunities for change and the potential for achieving our stretch targets.
- **Literature review** to evidence models of care used in other areas and provide a conceptual baseline upon which to inform thinking, both at CCG level and at locality level (to take into account geographical considerations and variations).

- Held **facilitated workshops** (one for each of our four localities in April and May 2013) to gain the views of stakeholders and capture thoughts and ideas regarding the future out of hospital care initiatives.
- Formation of **Clinical Reference Groups** for each area of work summarised in the strategic framework above. These groups were used to test ideas and assumptions and maximise clinical leadership and communication between the CCG's four localities.
- Where relevant, interviews were carried out to provide more detailed insight into proposed solutions. The interviews were with GPs, service providers, or other CCGs.

A full summary of the methodology and clinical engagement process are included in **Appendix A.**

1.5 Health and Well-being Strategy

Surrey Downs CCG is an active member of the Surrey Health and Well-being Board and we work closely with Surrey County Council (SCC) to promote good health and well-being within our local population. This Out of Hospital strategy supports the ***Surrey Health and Well-being Strategy*** and uses the evidence presented in Surrey's Joint Strategic Health Needs Assessment (JSNA).

Figure 4 below shows the Surrey-wide priorities and how we are working to deliver these locally through our Out of Hospital Strategy.

Health & Wellbeing Priorities	Some examples of our work
Improving children's health and well-being	Through BSBV, the CCG is reviewing services against key clinical standards as recommended by the Royal Colleges.
Developing a preventative approach	Using risk stratification to identify medium risk patients with lower level medical needs at risk of developing chronic disease in the future, who will benefit from receiving support on a Virtual Ward
Promoting emotional wellbeing and mental health	Commissioning an improved choice of psychological therapies for people suffering from depression and anxiety, through Any Qualified Provider.
Improving older adults' health and wellbeing	Launched of the dementia screening project, with 4 new out-reach workers screening new patients for dementia, supporting Primary Care, to enable better care coordination and earlier diagnosis. The expanded use of community beds, rehabilitation and therapies in the community
Safeguarding the population	Membership of the local Safeguarding Board, Clinical Quality Committees and walk around of local hospitals.

Figure 4: Examples of our strategic thinking aligned to our Health and Well-Being priorities

1.6 Our local population and their health needs

In order to commission local healthcare to meet local needs it is vital that we fully understand the specific health needs of our local population.

Following recent NHS reforms as part of the Health and Social Care Act (2012), responsibilities for public health now reside with Surrey County Council (SCC) and Surrey's Health & Wellbeing Board. To ensure we are commissioning the right services, our plans are informed by detailed public health data and developed in collaboration with local partners.

9 We work closely with Surrey County Council and our public health colleagues and our four local borough and district councils – Mole Valley, Epsom and Ewell, Elmbridge and Reigate and Banstead – to ensure the population of Surrey Downs CCG generally enjoy good health and well-being.

1.6.1 Overview of health needs

Detailed analysis of the health needs of people living in the areas within Surrey Downs CCG can be found in the ***Surrey Joint Strategic Needs Assessment*.** The headlines for Surrey Downs CCG are summarised below.

- **Surrey is relatively affluent** and, with a higher than average rate of employment, is one of the least deprived counties in the country. However there are **pockets of deprivation** in Surrey Downs that are ranked among Surrey's most deprived; Court (Epsom and Ewell); North Holmwood (Mole Valley) and Preston (Reigate and Banstead).
- **Life expectancy in Surrey Downs is high** at 84 years for women and 81 years for men, although in more deprived pockets of the CCG area this is up to seven years lower.
- **Large elderly population** (over 18% are over 65 years) and a high prevalence of long-term conditions
- High number of carers and high number of traveller and gypsy communities

1.6.2 Specific groups in Surrey Downs CCG

In addition to the headlines above, Surrey Downs also has a number of specific groups with specific health needs that require a more targeted approach. Our commissioning intentions will need to ensure health provision for these groups which include:

- **Carers:** more than 27,500 people of all ages provide unpaid care; 1,500 are over 65 providing more than 20 hours a week just in Mole Valley and Epsom and Ewell
- **Older people:** particularly with the high rate of falls, hip fractures, and increasing impact of excess winter deaths on local populations

- **Gypsy, Roma and Traveller community:** Surrey has the 4th largest gypsy, Roma and traveller community in the country. Surrey Downs CCG has around 7 authorised gypsy, Roma and traveller sites
- **Prisoners and ex-offenders:** Down View women's prison including the Josephine Butler Unit for female juveniles and High Down men's prison located in Banstead
- **Children and young people –** ensuring robust safe guarding processes, promoting healthy lifestyles and social engagement and education/training.

1.6.3 Population profile

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Figure 5 below shows the current population of Surrey Downs. Compared to the rest of England Surrey Downs CCG has:

- More children aged 5-12 years
- Fewer young adults aged 20-34 years
  A greater proportion of adults aged over 40 years

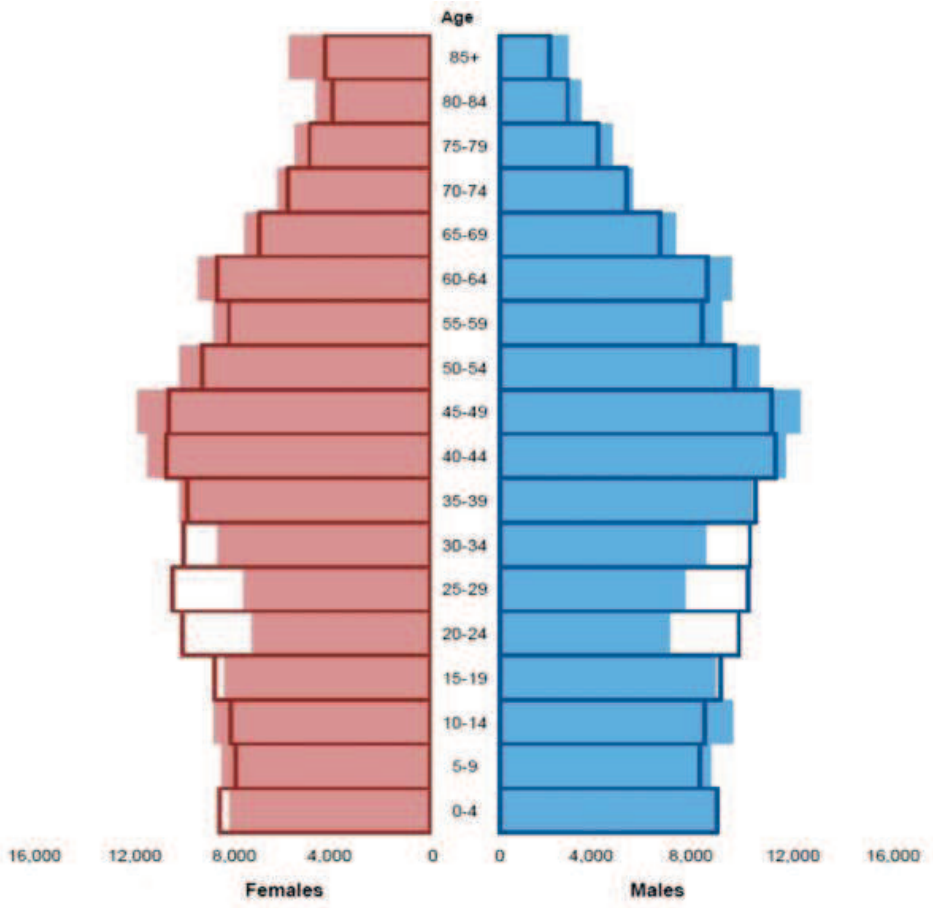

Figure 5: The Surrey Downs population

1.6.3.1 Population projections

With significant population growth expected over the next few years, our plans need to take projected changes in population into account, as well as the impact these changes are likely to have on the health needs of local people. Figure 6 below shows projected population growth between 2013 and 2021 compared to the rest of Surrey and England.

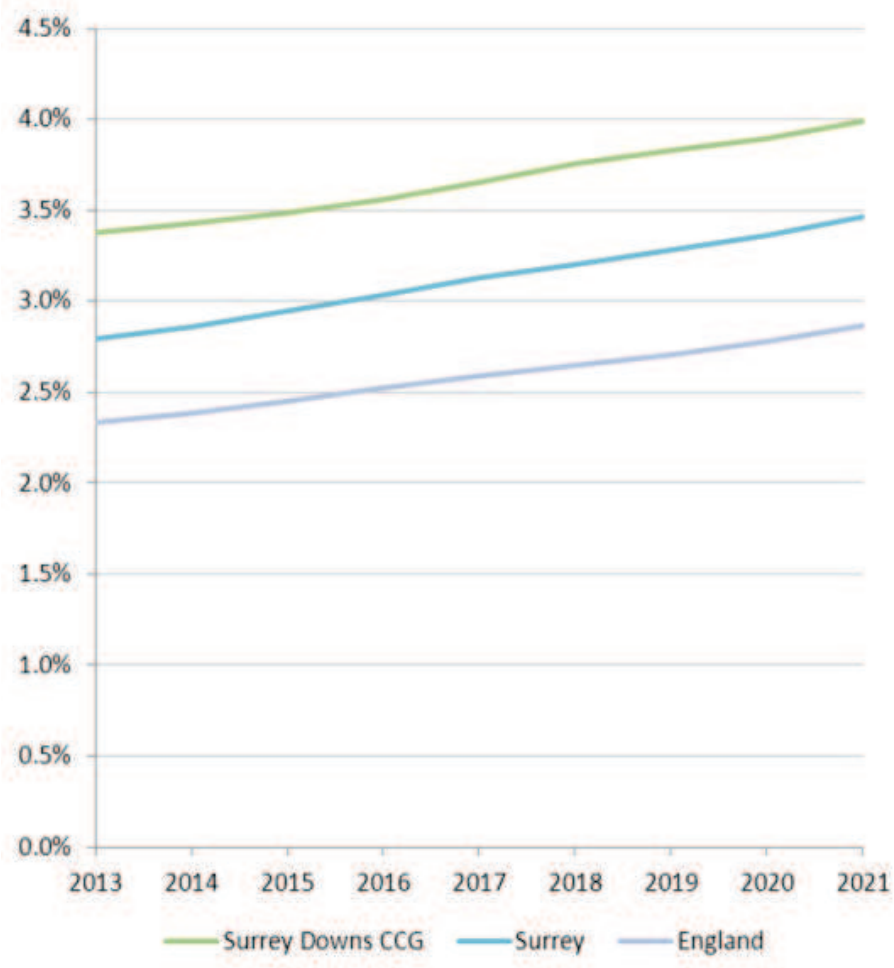

Figure 6: Projected population growth

In summary Figure 6 shows:

- The over 85 population is growing at a similar rate to the national average
- 3.9% of the population of Surrey Downs CCG is projected to be over the age of 85 years by 2020

1.6.4 Health risk factors

Tables 1 and 2 below show the risk factors in relation to disease, mortality and morbidity rates. It is important to recognise the profile of poor health, long-term conditions, of which people can experience more than one and lifestyle factors such as poor diet, smoking and excessive intake of alcohol.

The Health and Well-being Board has set out a number of key priorities for managing morbidity, mortality and unplanned admissions by:

- Early identification and management of risk factors such as smoking, alcohol, diet, obesity, and exercise
- Prompt diagnosis and effective management of long-term conditions with treatment based on evidence based guidelines
- Improving the quality of care received by people, whether at home or in residential care, e.g. relating to recognising the symptoms of a stroke

These key priorities have informed both the focus and the planned execution of our Out of Hospital strategy.

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The top ten risk factors are shown in Table 1 below.

Top ten risk factors contributing to the overall burden of disease in the UK			
1	Smoking (12%)	6	Diet- low fruits (5%)
2	Hypertension (9%)	7	High total cholesterol (4%)
3	High Body Mass Index (9%)	8	Diet- low nuts/seeds (3%)
4	Physical inactivity (5%)	9	High fasting glucose (3%)
5	Alcohol (5%)	10	Diet- high sodium (3%)

Table 1: Top ten health risk factors

The CCG will continue to work closely with the Health and Well-being Board to ensure health promotion and prevention is central to all our initiatives. Our membership practices, as GPs, already provide a number of enhanced services on behalf of public health to promote healthy living – such as smoking cessation, sexual health, and immunisation.

Table 2 below shows the top ten causes of mortality in the UK.

Top ten risk causes of mortality in all age groups in the UK			
1	Ischaemic Heart Disease	6	Colorectal Cancer
2	Lung Cancer	7	Breast Cancer
3	Stroke	8	Self Harm
4	Chronic Obstructive Pulmonary disease	9	Cirrhosis
5	Lower respiratory tract infections	10	Alzheimer's disease

Table 2: Top ten causes of mortality

The Out of Hospital Strategy focuses on supporting people with long-term conditions through providing care closer to home and preventing avoidable admissions. The development of integrated teams and virtual wards will ensure integrated health and social care services can support people to maintain independent lives. Integrated care is important as risk stratification of our population shows people experience more than one long-term condition, particularly over the age of 80 and there is a high prevalence of mental health problems such as anxiety and depression. Surrey and Borders Partnership NHS Foundation Trust provide mental health support through our virtual ward and the CCG now commissions a wider range of psychological therapy providers to improve access for local people.

Table 3 below shows the top ten causes of morbidity in the UK. As part of our commissioning intentions we are considering these areas to ensure we have the right services in place. For example, our planned investment in community services and the development of an enhanced virtual ward model will increase support for people who are risk of falls, those with Chronic Obstructive Pulmonary Disease (COPD) and support those needing crisis mental health support out of hours. As part of our wider commissioning plans, we also commission care through a range of community-based clinics. These include specific clinics for patients with back pain, ENT issues and musculoskeletal problems.

Top ten risk causes of morbidity in all age groups in the UK			
1	Lower back pain	6	Anxiety disorders
2	Falls	7	Chronic obstructive pulmonary disease
3	(Major) Depression	8	Drug Use disorders
4	Neck pain	9	Asthma
5	Other musculoskeletal problems	10	Migraine

Table 3: Top ten causes of morbidity

1.6.5 Admissions

There is an apparent increase in urinary tract infections, pneumonia and gastroenteritis diseases relating to hospital admission. Recent CCG clinical audits suggest 46% of overall admissions could be preventable, or treated in the community, with the right model of out-of-hospital care (see Figure 7 on the following page).

The CCG is developing a model of integrated care with all providers to prevent these admissions, including a local Rapid Response Service (RRS), which will assess and treat people in their own homes within two hours.

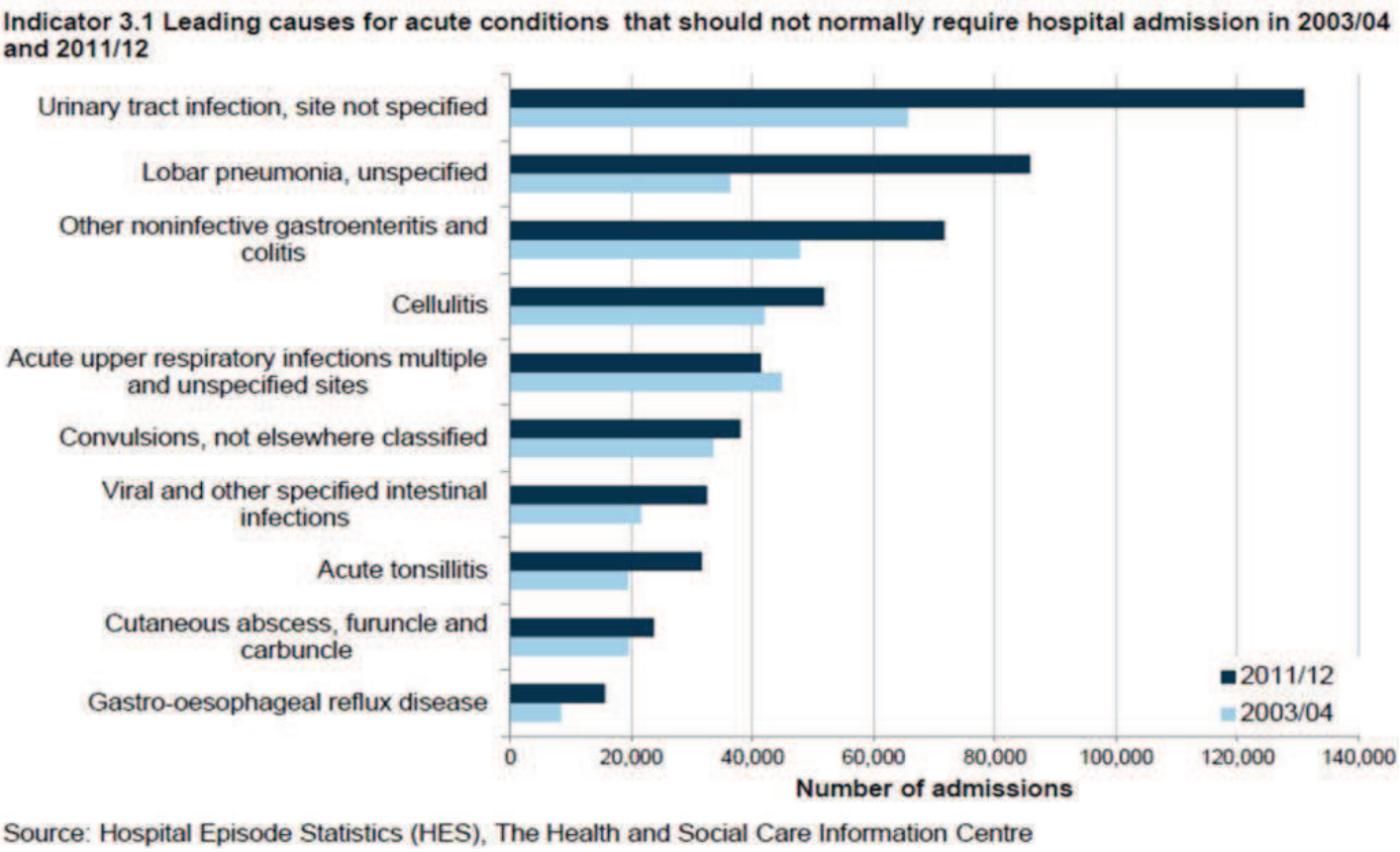

Figure 7: Leading causes for acute admissions that would not routinely require admission

1.6.6 Programme budgeting

Programme budgeting provides a useful tool to understand the impact of investment in relation to health outcomes.

Figure 8 on the following page benchmarks our performance against other areas and shows Surrey Downs CCG spend and outcome relative to other CCGs in England 2011-12.

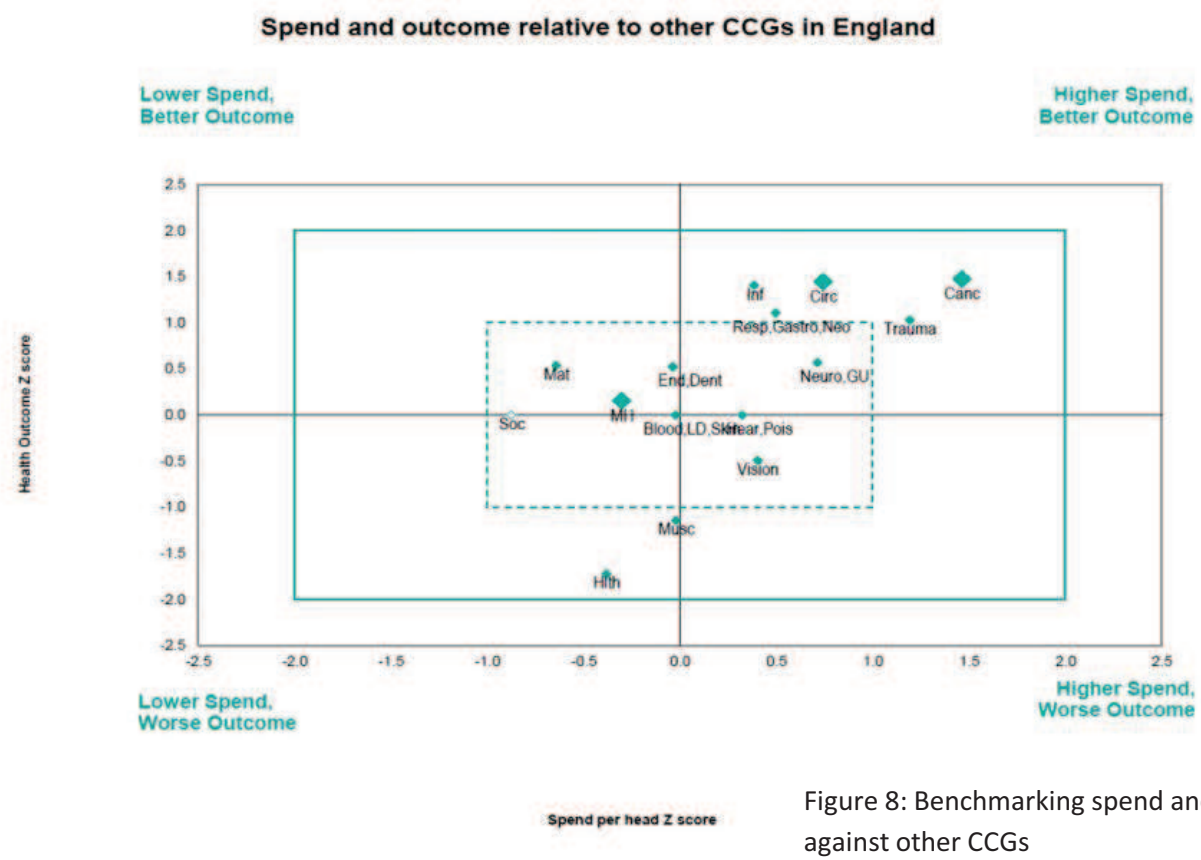

Figure 8: Benchmarking spend and outcome against other CCGs

In summary Figure 8 suggests there is an opportunity for Surrey Downs CCG to improve outcomes and reduce spend when compared with the performance of other similar CCGs.

Figure 8 shows the following:

- The bottom right quartile shows **higher spend areas with worse outcomes**, such as caring for people with learning disabilities.

- **Higher spend can result in better outcomes (top right quartile)**, such as cancer treatment and trauma services, with the rare exceptions in the top left quartile where **lower spend offers better potential outcomes** and ostensibly better value for money, such as maternity, end of life care, social care and mental health.

- Caution should be applied when interpreting this data as value for money is based on contractual and finance information, which is subject to Key Performance Indicators and contractual adjustments, that may affect the real cost of service provision. Some pathways are more complex than others, meaning some conditions have multiple codes and activity recording depends on whether conditions were recorded as primary and secondary diagnosis.

- Whilst caution should be applied to programme budgeting and financial data, which needs to be explored in more detail, Figure 8 suggests there is an opportunity for the CCG to learn from the **lower spend, better outcome areas,** as to what makes these effective, better quality pathways

1.7 Case for change

We took an evidenced based and factual approach to developing our Out of Hospital Strategy. This included benchmarking ourselves to peers, regional and national averages for activity and spends, coupled with clinical audits, before engaging with clinicians and stakeholders to develop proposals. The following four areas provide a compelling case for change:

1.7.1 Admission prevention

- **41% of non-elective admissions in Surrey Downs CCG were for less than one day**
- The median spend on non-elective admissions per population weighted list size is £165 in Surrey Downs CCG, compared to £149 in other CCGs within the same ONS cluster
- The average length of stay for patients in the Surrey Downs CCG is 11% higher than comparable CCGs in the same ONS cluster
- Reduction to peer group average represents potential savings of £1.28million.
- In a recent audit non elective admissions within the local hospitals, the clinicians involved all agreed that **46% of patients could have been managed in primary or community care.**

1.7.2 Earlier discharge

- In 2012/13 the average length of stay (ALOS) for Surrey Downs CCG was 11% higher than comparable ONS cluster and 12% higher than the national figures.
- The total savings opportunity available to Surrey Downs CCG for non-elective excess bed days is £2.08m based on spend in 2012-13.
- **The 30 day readmission rate for our local hospitals ranges from around 25-35%, which is within the normal range, but a key area of improvement for integrated care.**

1.7.3 Urgent care

- Of the A&E attendances 16% of patients going to A&E fell into the 'no investigation, no significant treatment' category. This cost the CCG £681k based on a tariff of £54 per patient
- A further 28% required basic treatment (category 1 investigation) such as an ECG, dressings and urine analysis. This cost the CCG £1.8m based on a tariff of £81 per patient
- Surrey Downs CCG A&E attendances were above the median and above the peer and national cluster median (266/1000 patients, compared with 250 and 212)
- **15% of attendances for Surrey Downs related to patients who were not able, or thought they were not able, to get an appointment with their GP (GP Survey 2011).**

1.7.4 Elective care

- Surrey Downs CCG has a higher GP first outpatient referral rate per 1000 population when compare with the peer average.
- In 2011/12 the CCG spent £13,8m on GP first outpatient appointments.
- **Achieving similar results to our peers would represent a potential saving of £4.2m.**

1.7.5 Benchmarks and best practice: Surrey Downs CCG and localities

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We understand that there are significant opportunities for optimising activity and finance. Table 4 on the following page shows the best performance across southern CCGs. No CCG is achieving all these levels of performance, but it does show that Surrey Downs CCG could potentially save £24.9m of efficiencies if it achieved best practice in all domains.

Table 4 shows that the key areas for improvement are non-elective admissions, out-patient referrals and elective care (spells).

If Surrey Downs met the performance of its peers (mainly in Surrey and the home counties) £24.9m could potentially be used differently to meet peoples' healthcare needs.

							Opportunity to Best Quartile (£'000s)*			
POD	CCG (inc. private) rate per 1000 population	CCG Peer Average rate per 1000 population	CCG Peer Best Quartile rate per 1000 population	Opportunity to best quartile (%)	SDCCG 2013-14 Spend (£'000s)	Opportunity to Best Quartile (£'000s)	Mid-Surrey	MEDLinC	East Elmbridge	Dorking
A&E	266	250	212	20%	9,499	1,900	750	1,050	100	0
Non elective care	70	70	61	13%	58,997	7,400	1,950	3,650	0	1,800
Outpatients (all referrals)	675 (880)	794	705	20%*	36,769	7,400	1,900	4,000	900	600
Elective care	93 (109)	102	88	19%*	43,313	8,200	3,200	4,100	0	900
TOTAL						24,900	**7,800**	**12,800**	**1,000**	**3,300**

Opportunities scaled using locality list size and rate for each POD

Source: NHS comparators 2011-12 for rates, SDCCG 13-14 Financial Plan for finances, 2012-13 Private (out of hospital)provider activity, * includes private providers in analysis

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Table 4: Benchmarking analysis and opportunities to improve outcomes and performance

1.7.6 The 'do-nothing' scenario: The case for change is also strengthened by the 'do-nothing' scenario for the year-on-year growth in acute hospital activity. Surrey Downs CCG has analysed historical performance and projects that activity will increase by 3.56% per annum over the next 5 years. On the basis of current financial assumptions for future funding this would leave a financial gap of around £16.7million a year, or a cumulative deficit position of £34milion (Table 5).

Scenario	Composite Acute Rate	2017/18 Surplus (deficit)	2017/18 cumulative surplus (deficit)
Lowest	2.50%	(£9.5m)	(£17m)
Low	3.00%	(£12.3m)	(£24m)
Base	3.56%	(£16.7m)	(£34m)
High	4.0%	(£19.8m)	(£41m)

Table 5: The 'do nothing' scenario

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1.7.7 Summary

There is a strong clinical and financial case for change to commission sustainable services over the next five years. The most compelling argument is the opportunity to commission integrated care that achieves key standards for patients - Access; Choice; Experience; Safety; Outcomes.

The following section of this strategy outlines our commissioning intentions and the key benefits for patients which will arise through improving the quality of the services we commission.

2. Out of Hospital Strategy

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Commissioning intentions and priorities

2.1 Our Out of Hospital Strategy – an overview

Our Out of Hospital Strategy, which has been developed by clinicians, addresses local health needs and focussing on delivering more healthcare in the community over the next five years. This section summarises what we plan to achieve through this strategy and the plans we are putting in place to deliver improvements in care for local people.

2.1.1 Aims

To commission high quality services, meeting national standards that:

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- Reduce the number of preventable non-elective admissions and readmissions to hospital
- Enable patients to die in their preferred setting of care
- Reduce length of stay in hospital
- Delay incapacity and promote independent living through increasing reablement provision and support in the community
- Reduce emergency admissions to residential care and incidence of high cost residential placements
- Meet the projected growth in demand for continuing care through the above

2.1.2 Proposed clinical commissioning standards

Through engagement with our practice members and wider stakeholders, we have identified the following standards, from which to commission high quality service provision for our local population.

1. Patients will have equitable **access** to services and be offered patient **choice**

2. Continued improvement in patients' **experience** of care and their journey through the care system

3. An absolute commitment to commissioning **safe** services and robust **safe guarding** processes

4. Adopt the very best practice and clinical practice to ensure high quality **clinical outcomes**

2.2 Overview of priorities and proposals

Surrey Downs CCG has six high level commissioning priorities that were developed by our member practices and shaped by local people and key stakeholders (see Figure xx below).

Our Out of Hospital Strategy focuses on the top four priorities below.

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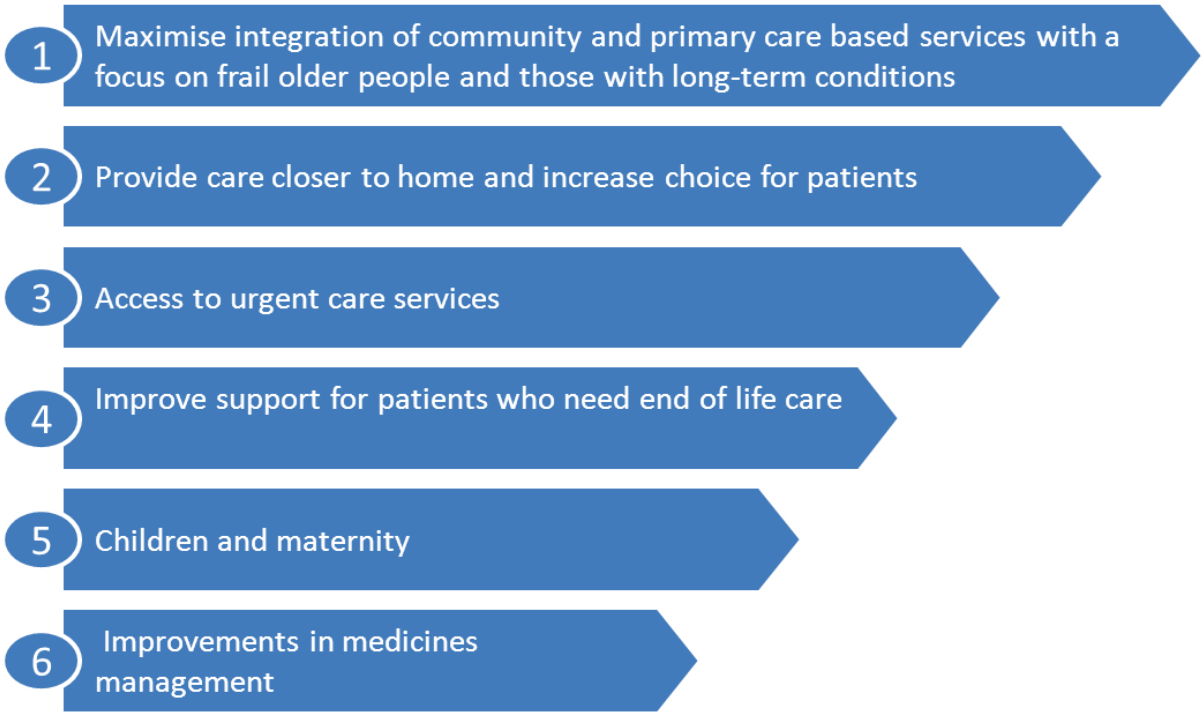

Figure 9: Surrey Downs CCG's high level commissioning priorities

In this section we detail the plans we have developed to address each of these areas and the benefits to patients.

1 Maximising integration of community and primary care based services with a focus on frail older people and those with long-term conditions

2.2.1 Maximising integration of care

We believe that integrated care can ensure more patients are treated closer to home. This helps prevent avoidable admissions and leads to earlier discharge if patients do need to be admitted to hospital.

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2.2.2 Admission prevention

Our plans include extending services that already exist in the community and increasing capacity to enable more patients to be treated in community settings.

- Expansion of virtual wards to medium and high risk patients to increase capacity and target a wider patient group
- Reconfiguration of Community Assessment Unit and step-up beds so that patients continue to have access to diagnostics and assessment in the community
- Expansion of rapid response service involving the Red Cross and community medical teams to ensure integrated, patient-centred care

2.2.3 Timely discharge from hospital

- Agree clinical thresholds for 'step down' community hospital beds, care homes and virtual ward so that more patients can benefit
- Community led team (from point of admission) to co-ordinate care
- Roll out Acute Medical Unit discharge model with Epsom to ensure timely discharges
- Expand use of step-down beds in community hospitals/nursing homes to increase capacity in the community
- For all practices to see patients within five days of discharge to improve discharge process and involvement of primary care

Admission prevention and early discharge will be underpinned by the development of Integrated Teams involving community nursing, rehabilitation and therapy staff.

2.2.4 Our approach to risk stratification

The CCG has worked with member GP practices to utilise risk stratification. This tool reviews data sets using predictive modelling capacity that has been developed by the King's Fund. The tool shows the

likelihood of people being admitted to hospital based upon their previous use of services, medical conditions and other risk factors. The tool complies with strict Information Governance standards, whereby GPs review their stratified patient lists to identify individual patients who may benefit from specific services.

Our key challenge is to provide care to more patients before they reach an acute period or episode with their condition. By focusing more resources earlier in their journey, before people have an **'intense year'** it is more likely that more preventable admissions will be achieved and people are able to maintain independent lives with care closer to home (Figure 10).

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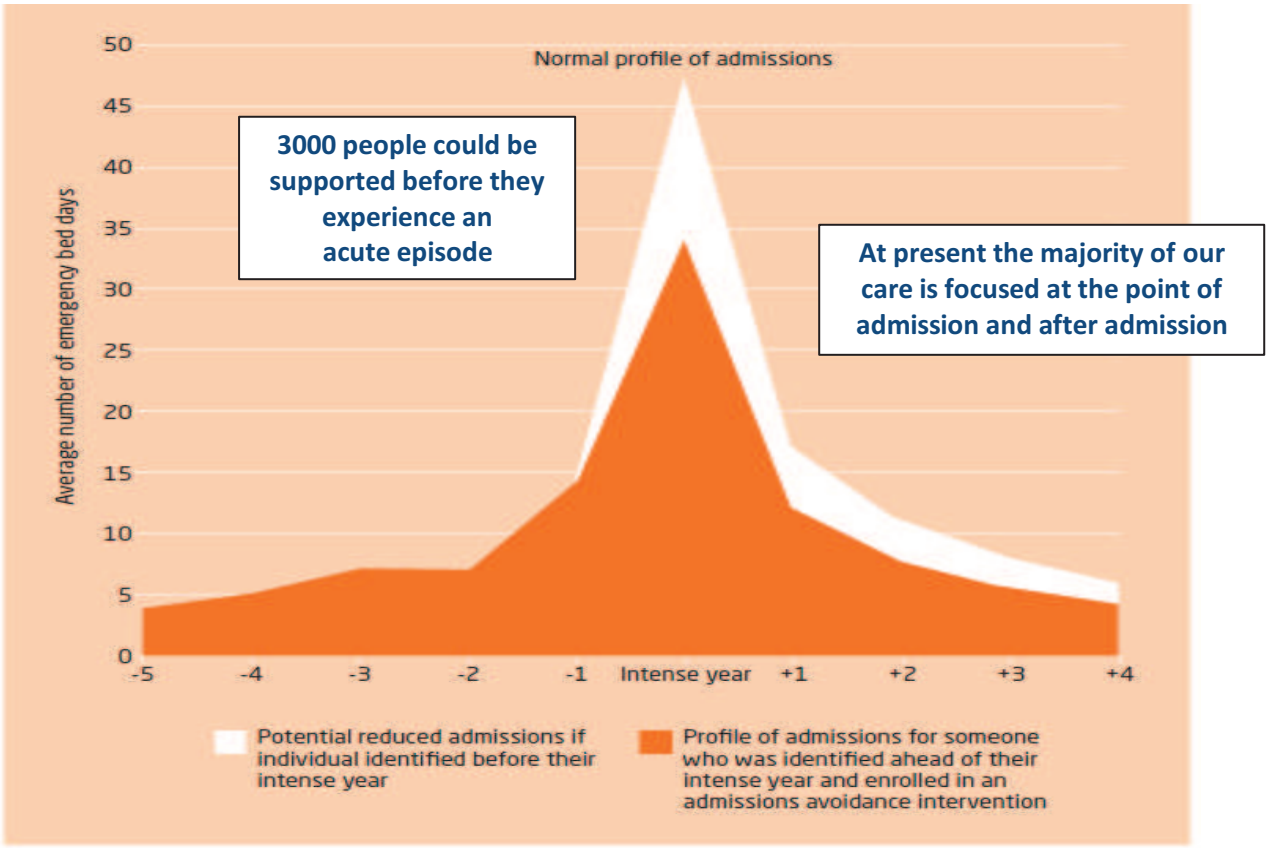

Figure 10: Predictive modelling and benefits

2.2.5 Virtual wards

Across Surrey Downs, we estimate there are around 5,000 patients in the high and medium risk categories that would benefit from community care such as a virtual ward, supported by multi-disciplinary teams of nurses, mental health practitioners and social care.

Virtual wards are managed by GP practices and supported by our local community provider who uses a risk stratification tool to provide case management support to patients with long-term conditions or other co-morbidities. Many of the patients referred into this service are older people over the age of 75 years.

The virtual wards are supported by Integrated Community Teams, which operate in each area and have a single point of access for elective referrals, rehabilitation services and urgent care rapid response services. Further support is provided through an integrated mental health service provided by Surrey and Borders Partnership NHS Trust.

Through virtual wards GPs are able to manage more patients outside of hospital by making sure they have the right level of support to help manage their conditions at home and in the community.

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Figure 11 on the following page shows the Two Tier virtual ward model. It identifies these patients and summarises how the virtual ward model could support these patients, depending on their specific health needs and the level of complexity.

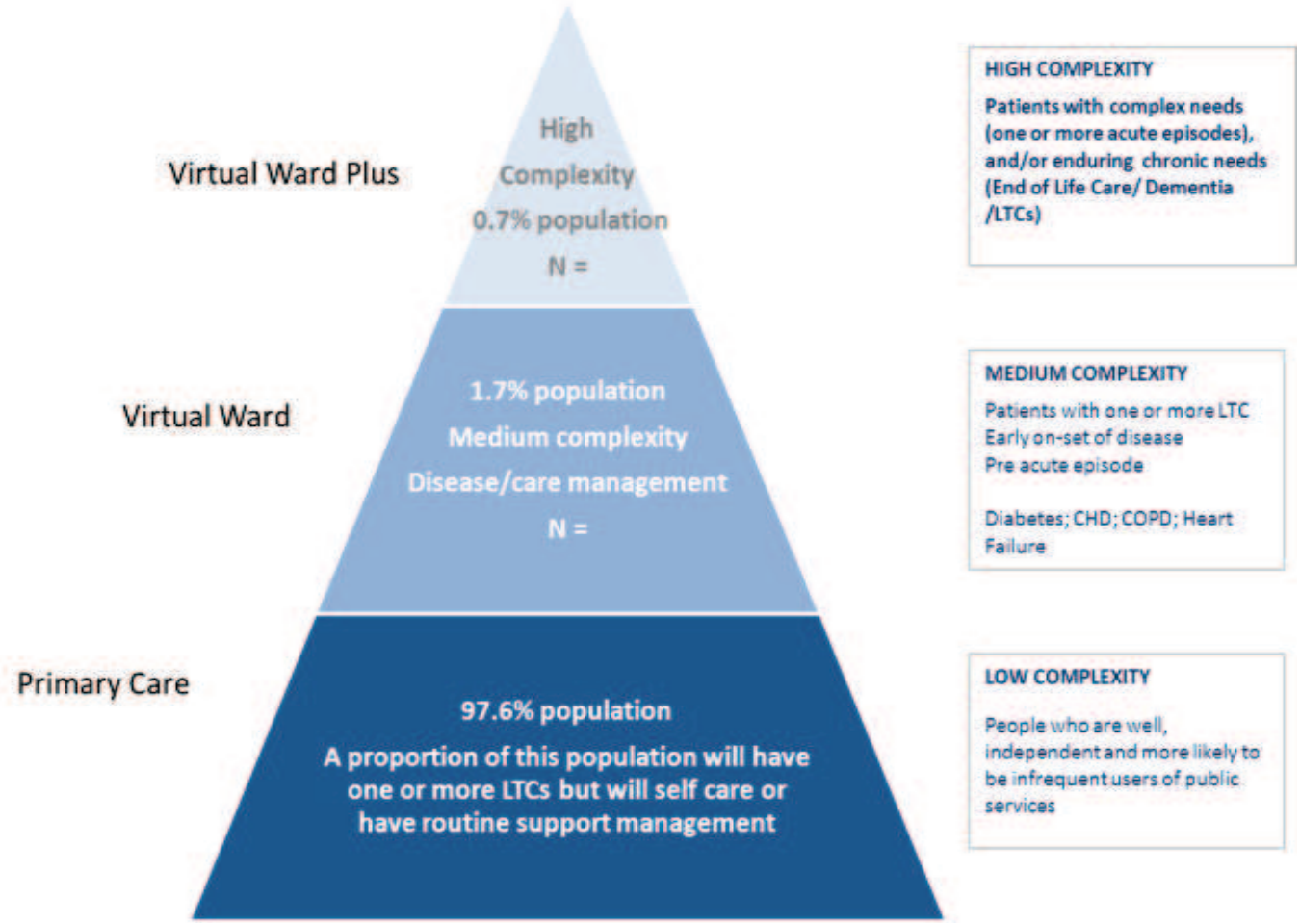

Figure 11: The virtual ward model

2.2.5.1 Our plans for virtual wards

- Each Locality will have a **two tier virtual ward** offering case management to patients who are at risk of hospital admission
- There will be a new virtual ward for **medium complexity** patients referred by GPs using a risk stratification tool
- The existing virtual wards will be reconfigured into Virtual Ward Plus for **complex patients.** More than 60% of patients are estimated to have high complexity needs. If these patients no longer require specialist acute medical care they may be admitted directly to the service from acute hospitals.
- Virtual wards will have **medical support**, medicines management, mental health and access to an expanded range of voluntary sector services including support from the Red Cross.
- **Enabling services** will support the virtual wards to offer rapid response care to prevent admission (through the Community Assessment Unit, Out of hours and Rapid Response teams)
- **Integrated Community Teams** offering therapies and rehabilitation support to each virtual ward.

2.2.5.2 Commissioning clinical functions around virtual wards - Developing a new model of care

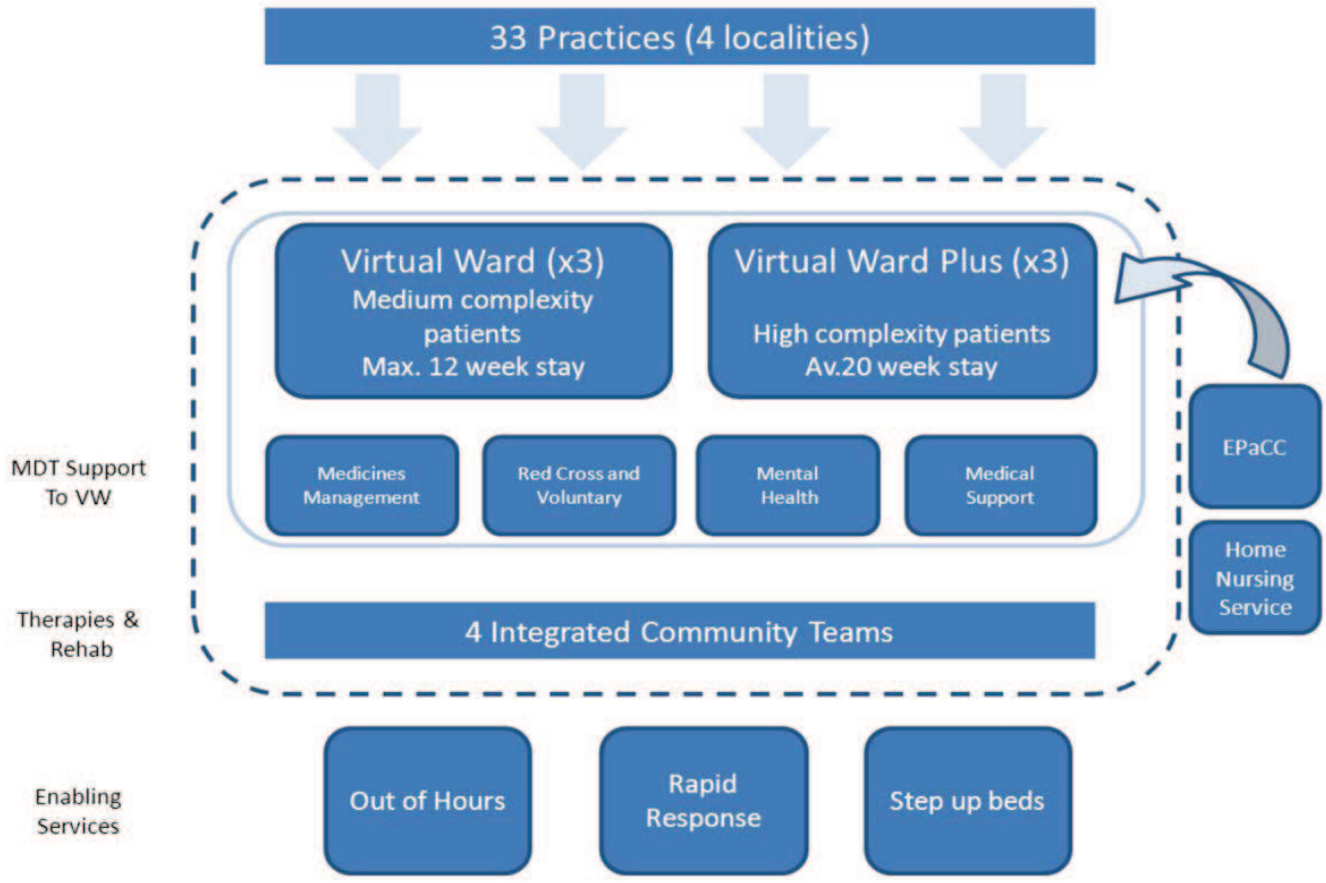

Figure 12: The Two Tier virtual ward model with multi-disciplinary involvement

As a result of the virtual wards already in place we are already seeing a reduction in preventable unplanned admissions. Under these plans the service will be extended and capacity increased enabling more patients to benefit. This will enable us to further reduce unplanned admission and readmission rates for these patients.

2.2.6 Our plans to improve the discharge pathway

- New clinical thresholds for the step down pathway particularly for community hospital beds, care homes and the virtual ward to ensure timely discharge to appropriate alternative services
- Introduce a model of discharge planning with a community led team to manage the discharge process from the point of admission
- Work with Epsom Hospital to roll out the Acute Medical Unit discharge model to improve the discharge process
- Expand the use of community hospitals and nursing homes to ensure there is sufficient capacity in the community
- All GP practices to see patients within five days of discharge to support process and increase primary care involvement

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2.2.7 Investing in community beds

The future role of community hospitals in Surrey Downs will be central to the clinical vision of enabling people, particularly the frail and elderly, to receive care closer to home in the community:

Step down care: Rehabilitation and therapies in the community, with GP medical cover to ensure people do not spend extended and unnecessary periods of time in acute hospitals. Patients are discharged as soon as they are medically fit without delay and/or if their condition is not an acute illness.

Step up care: A same day assessment from a physician in our Community Assessment Unit, with step up beds, to prevent avoidable admissions (8am-8pm). For example, GPs will be able to directly refer to the service for diagnostics, second opinions and specialist assessment of ambulatory conditions, including where the patient is medically unstable, requires intravenous therapies and treatment for deep vein thrombosis.

Figure 13 below shows the current bed capacity at community hospitals in the Surrey Downs CCG area:

	Total beds	Beds open	Beds closed
Dorking	28	12	16
Leatherhead	21	15	6
Molesey	20	12	8
NEECH	21	15	6
TOTAL	90	54	36

Figure 13: Community bed capacity

2.2.7.1 Increasing bed capacity

- Our clinicians have audited bed usage and believe that more of the patients who are treated in acute hospitals (64%) could be discharged to receive support in community hospitals, when they are medically stable and requiring daily GP care.
- **Of the 90 available beds, only 53 beds (60%) are currently utilised as capacity was restricted over the past several years aligned to financial pressures.**
- The CCG is working closely with Epsom Hospital and Central Surrey Health to review the audit and look at the future options for transforming community beds.

2.2.7.2 Key issues

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- Estimate of more beds needed - 31 step down and 6 step up beds
- There would not be sufficient capacity to commission the required number of beds for the Epsom and Ewell population (ie at Leatherhead and NEECH)
- With the exception of Dorking (28 bed unit) the other hospitals are small units making it more difficult to sustain, high quality cost effective care.
- There has been a long standing discussion about Epsom Hospital hosting a community ward which needs further consideration.

2.2.8 Improving dementia care and support

In Surrey Downs CCG clinicians are leading a major programme of work to improve early diagnosis and support for people living with dementia.

Using funding secured through the national Dementia Challenge Fund, the CCG is working with NHS and community partners on two projects that focus on making sure dementia patients get the care they need. With a focus on early detection and diagnosis of dementia, the first project aims to help reduce unplanned hospital admissions and improve dementia care by making sure patients are supported at home or in the community. Based on similar initiatives that have delivered improved dementia care in other parts of the country, a team of new community-based specialist nurses are being introduced.

Working closely with mental health and community colleagues, their role will focus on diagnosing dementia earlier and closer integration of services to make sure services are joined up and patients get the level of support they need. Partnership working is key and we are working closely with Surrey and Borders Partnership NHS Foundation Trust, Central Surrey Health, Princess Alice Hospice, Alzheimer's Society and Carers Support to deliver the project.

The following summarises the prevalence of dementia locally and the issues the project aims to address:

- The greatest risk factor for dementia is age related: 85+ the prevalence rate is 30-50%.

- Relative to England, Surrey Downs CCG has a greater proportion of adults 40+; 3.9% of SDCCG population projected to be 85+ by 2020
- In SDCCG in 2011/12, the dementia prevalence rate was 1.4% meaning 4,060 people were living with dementia. In Surrey only 42.1 % of dementia cases are diagnosed on GP registers
- The average cost of a hospital stay for a patient with dementia is £3.7k, compared with £1.9k for patients without dementia
- The average length of stay for patients discharged with dementia for Surrey acute hospitals is 12+ days whilst for non-dementia, the average is 2.5+days

The project we have launched aims to close the gap between the number of people with dementia and the number of people who are undiagnosed (see Figure 14 below).

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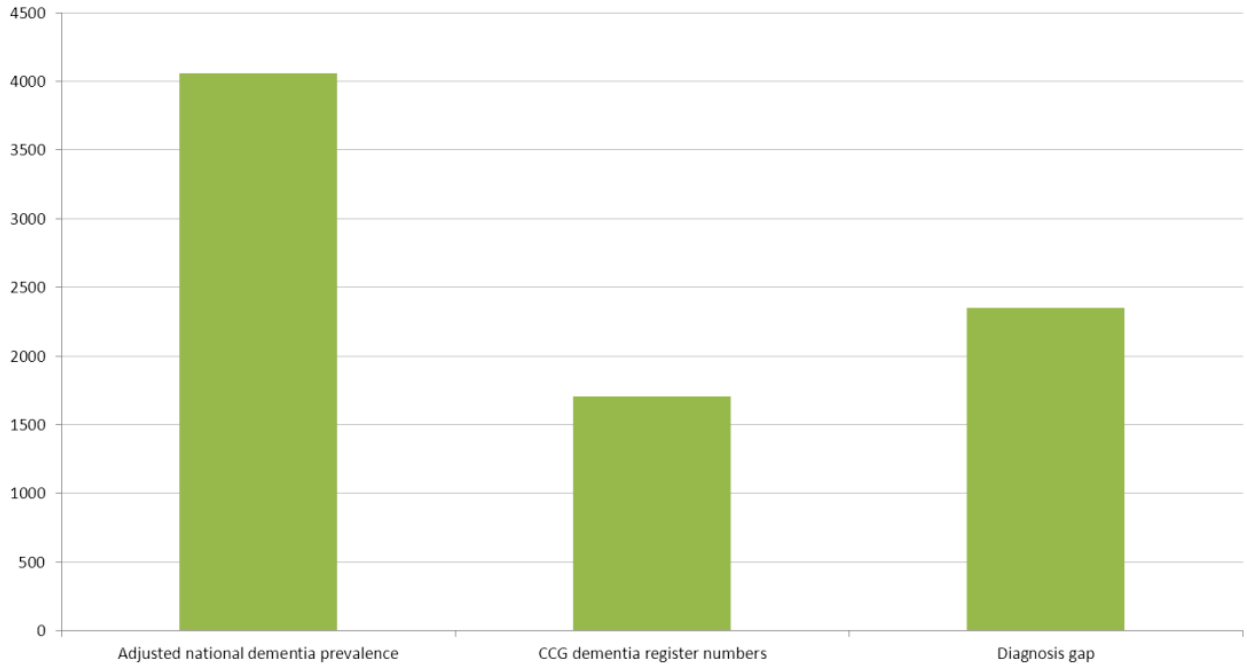

Figure 14: The dementia diagnosis gap

2.2.8.1 Our plans to improve dementia care

Link Practitioners will be the initial point of contact for patients and GPs. They will carry out cognitive screening and offer pre and post screening support linking with the consultant led memory clinic team.

- Our plans include a 12 month project piloted in Dorking.
- The aim is to increase the diagnosis rates of dementia by inviting those at risk to be screened in the practice or at local Well-being Centres and increase public awareness of dementia
- The project will also support GP practice teams through providing specific education in dementia

2.2.8.2 Patient benefits

Our plans offer many benefits to patients living with dementia and their carers and families, who will also be affected. These benefits include:

- More long term support pre and post diagnosis
- De-stigmatising dementia
- Improved signposting to support services
- Advance care planning and living wills
- Ability to stay independent and live well for longer

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2.2.8.3 Clinical benefits

Our plans also offer the following clinical benefits:

- Earlier access to specialist treatment and investigations
- Identify those at risk and address risk factors
- Improve care by targeting interventions and support

The project we have launched aims to close the gap between the number of people with dementia and the number of people who are undiagnosed.

2 Provide care closer to home and increase choice for patients

The CCG plans to improve patient choice for elective care and ensure greater acuity in our care pathways. This means all patients should receive care as quickly as possible, in the appropriate setting of care and all clinical work-ups are completed to avoid unnecessary follow-up appointments.

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2.3.1 Increase choice for patients in elective care

- Implementation of a CCG hosted referral support system for local GPs to support patient choice
- Leading to service redesign and improvements in elective care for patients
- Implementation of effective commissioning guidance in line with best practice to ensure the best clinical and quality outcomes for patients

2.3.2 Key issues

The case for change is outlined above in financial and activity terms. The real drivers for implementing this initiative are the promotion of choice and optimising the referral process, which will result in better patient experience and outcomes.

The key issues and drivers for change are summarised below:

- There is not currently a consistent approach to referral management
- A comprehensive directory of services is not uniformly available
- Some patients are referred without adequate work up
- There is poor visibility of referral data at locality and practice levels
- The current provision of referral management support with Surrey Downs CCG is not optimised to reduce referral activity or report on the quality of referrals.

2.3.3 Our plans for a referral support service

- To implement a new clinically led, independent Referral Support System hosted by the CCG, which will be responsible for all non-urgent referrals
- The service would be managed by a lead clinician, with clinical triage provided by local GPs (through a competitive selection process)
- Capture all referral data and information to identify less effective referral pathways in order to inform future commissioning decisions
- Use the hosted service to develop and share best practice and local knowledge of providers to ensure patients receive the highest quality care

Figure 15 on the following page shows how the referral support system will operate.

2.3.4 Referral support system: Developing a new model of care

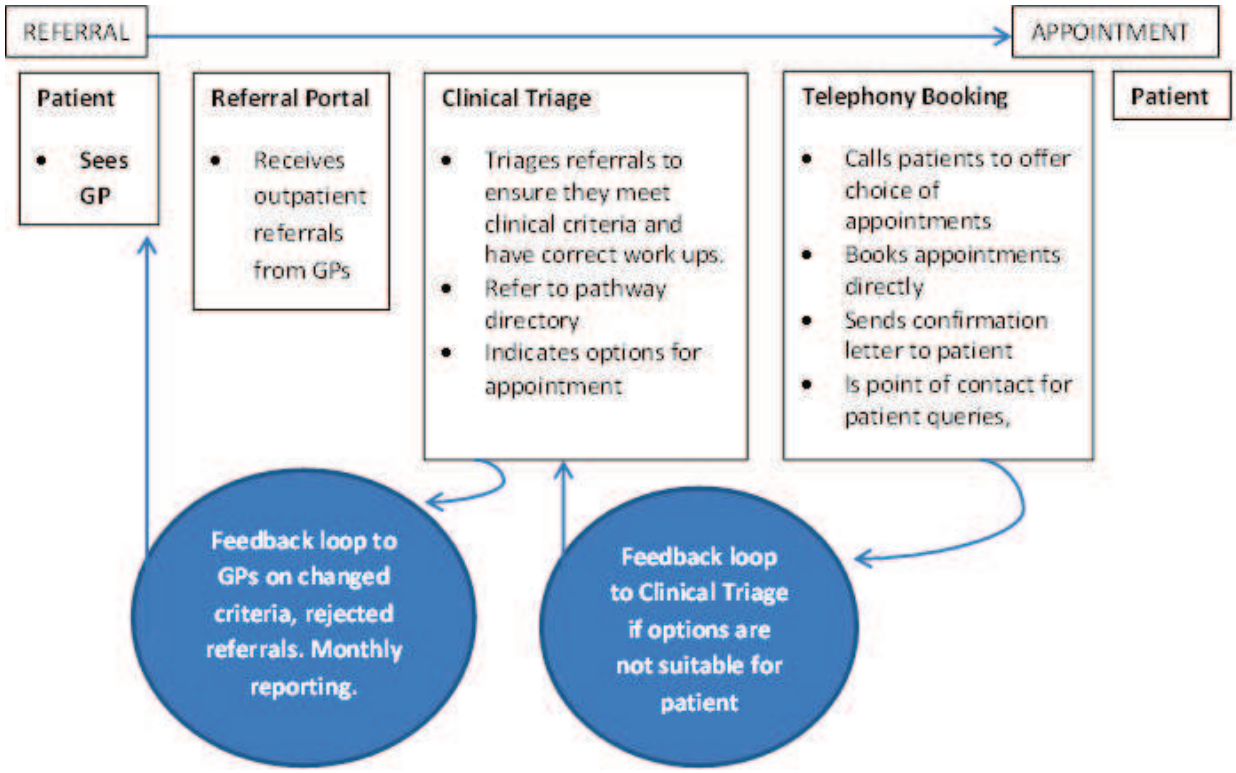

Figure 15: The referral support model

2.3.5 Benefits of a referral support service

Establishing a referral support service offers many benefits. These include:

- Improving the patient experience through improving the acuity of referrals and avoiding unnecessary appointments and referrals
- Supporting clinicians to develop expert knowledge of local pathways across all providers to increase choice for patients
- Providing training, education and support to practices, particularly newly qualified doctors or those new to the area
- Ensuring probity and transparency, resulting in greater patient choice
- Identifying opportunities to redesign services and improve pathways for the future
- Monitoring referrals to ensure they are clinically appropriate and reducing variation between practice referral rates to ensure equity of access to care

3 Access to urgent care services

Accessing urgent care can be confusing and time consuming for patients, as there are many services available and it is not often clear when and where to go. Our patients currently access three main Accident and Emergency departments – Epsom, Kingston and East Surrey Hospital - and GP commissioners are working with Consultants on all sites to deliver improvements through local Transformation Boards.

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2.4.1 Our plans to improve access to urgent care

Our plans to improve access to urgent care include:

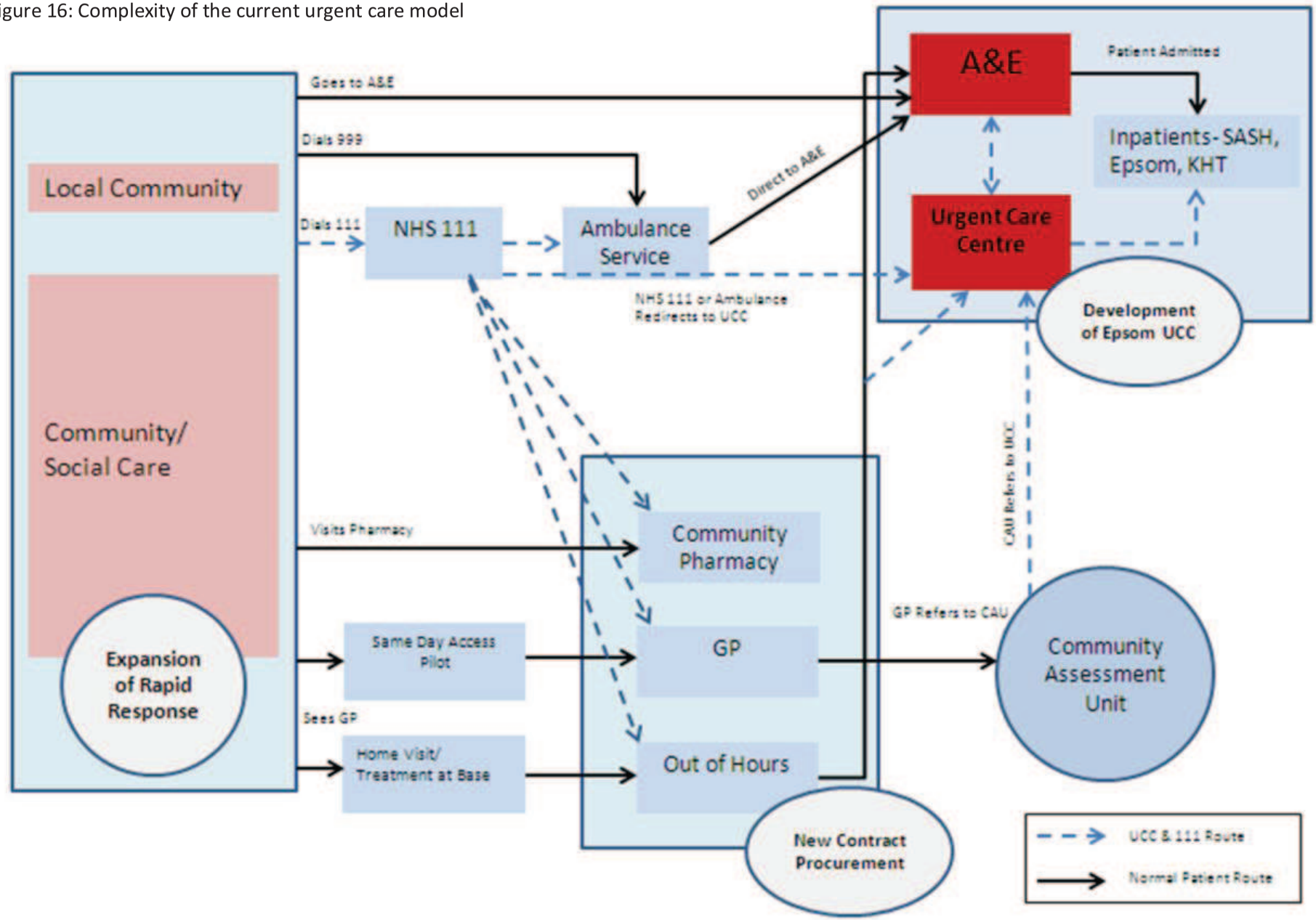
- Establishing an Urgent Care Centre at Epsom to improve access to urgent care
- Same day access in primary care to improve access to GP services
- Re-procuring Out-of-Hours GP services (2014) to ensure patients have access to high quality GP services outside of working hours

2.4.2 Overview

- A feasibility study to see if an Urgent Care Centre should be established with GP involvement at Epsom-integrated with A&E.
- A reconfigured Community Assessment Unit co-located at Epsom, remaining at Leatherhead during the transitional process, with expanded scope and access to dedicated step up beds. Option to integrate with a future Urgent Care Centre.
- The Out of Hours Service will be procured in 2014, with a centre co-located with A&E / future Urgent Care Centre; and suitable provision within all localities. Options include suitable Out-of-Hours Centres at East Elmbridge and Dorking at peak times, with home visits.
- To expand the pilot of same day access services, with telephone triage, in primary care to allow for proper consideration of clinical efficacy and impact.

An overview of the current model of care is provided in Figure 16 on the following page. This illustrates the complexity for patients to navigate the current system of urgent care. Our plans in this area will address the current complexities and ensure patients receive urgent care in the most appropriate setting. This work will also include a communications campaign to raise awareness of the services available out of hours and to reinforce key messages about where to access care locally.

Figure 16: Complexity of the current urgent care model



4 Improve support for patients who need end of life care

Improving end of life care for our population is a key priority for the CCG, linked to our growing aging population and ensuring people and their families are able to access the care they need, as well as die with dignity in their preferred setting of care. There is also a growing prevalence of dementia with people in Surrey Downs living longer, which requires commissioning screening, diagnosis and support services to help people maintain independent lifestyles, as well as their carers.

2.5.1 End of Life Care - Case for change

- In an ageing population, the number of deaths in England is set to rise from 500,000 to 590,000 over the next 20 years increasing pressure on the quality of EOLC services.
- EOLC is one of the 12 national QIPP work streams and is a national priority. Combined with the EOLC strategy (2008)) the focus is on early identification of patients, integration of services and patient centred 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
- Research shows that (after friends & family) people turn to GPs for information about EOLC- education, training and professional support are key to the EPaCCS

2.5.2 Our plans to improve end of life care

Our plans include:

- Implementing an Electronic Palliative Care Co-ordination System
- Increasing early identification including risk stratification to ensure patients get the support they need
- Integrating care services and enable whole system working
- Gold Service Framework Accreditation for end of life care provided in care homes for people with dementia.

Implementation of an Electronic Register (Palliative Care Co-ordination System) will enable us to:

- Identify people who are considered to be in their last year of life and, with appropriate consent, add them to an electronic register
- Co-ordinate the care of patients on the register to ensure that patients are supported within their last year of life with reduced levels of non-elective admissions
- Support people to die in the place of their choosing and with their preferred care package
- Enable all providers, including out of hours and ambulance services to access the inter-operable EPaCCs to prevent avoidable acute admissions
- Educate clinicians in Primary, Community Care and other providers to manage EPaCCs and provide gold standard care.
- The propose pathway is outlined overleaf.

End of life care pathway

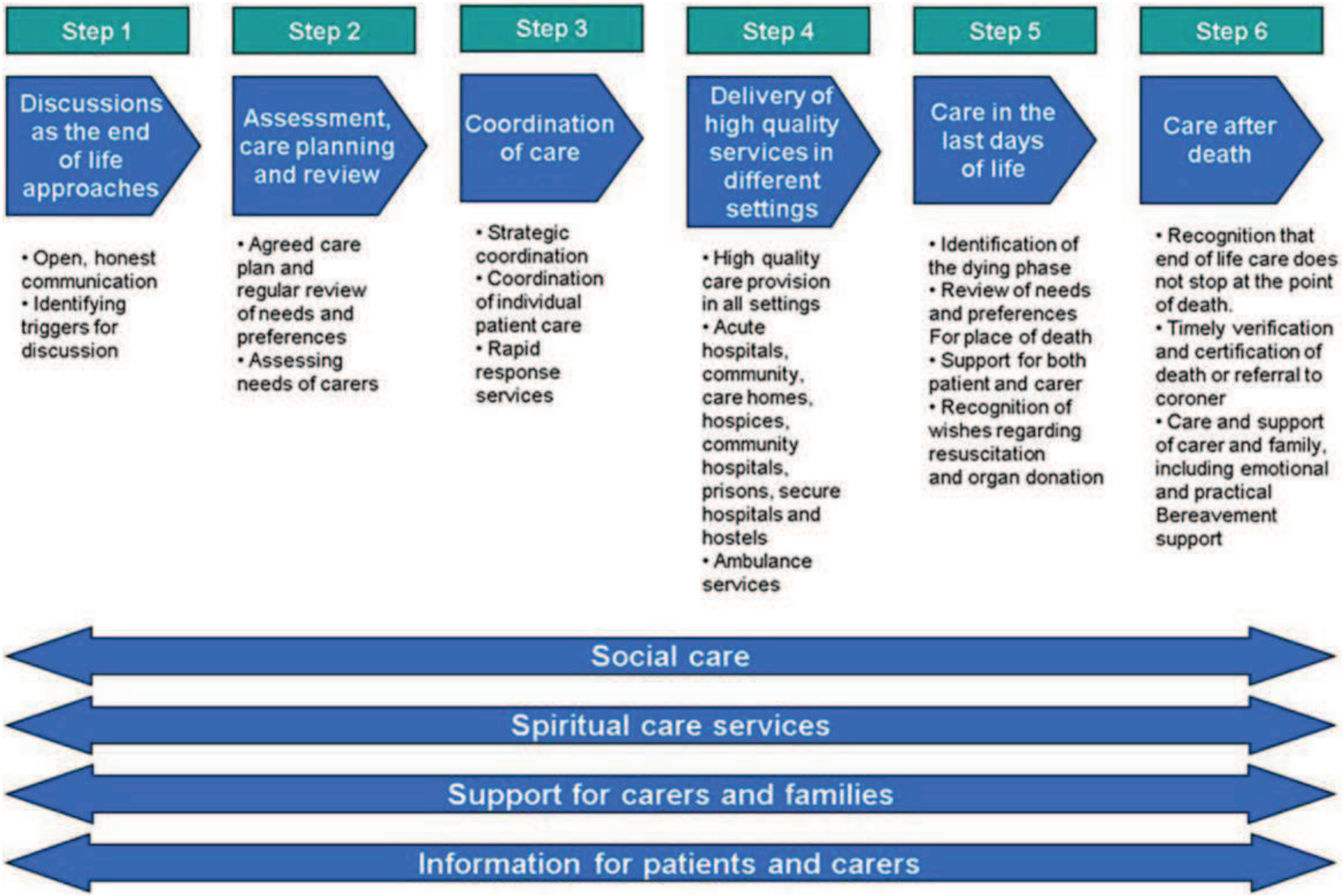


Figure 17: The end of life care pathway

5 Children and maternity

The CCG is working with all providers to agree the appropriate clinical standards for children's and maternity services.

2.6.1 Improving children's and maternity services in line with best practice clinical standards

Surrey Downs CCG has participated in the Clinical Reference Groups (Better Services, Better Value) with clinical peers and is reviewing the appropriate clinical standards for acute care set by the Royal Colleges. With cognisance that many of our patients access care across Surrey based hospitals which will not be working to other standards. We believe all our children and families should have access to high quality care and will work with all our stakeholders to agree the future configuration of services.

9

BSBV Recommendations- Children's Clinical Working Group	
Recommendation 1	More care for children and young people should be provided at home and in the community
Recommendation 2	There would be quality, safety, training and productivity advantages in developing a managed care network for children's medical and surgical services across Surrey Downs
Recommendation 3	All patients with access Type 1 A&E must also have a dedicated children's A&E service (open 24/7) with a primary care led Urgent Care Centre (UCC) at the front end
Recommendation 4	A consistent model of paediatric consultant led 24/7 Children's Short Stay Units (CSSUs) should be developed on all sites that provide A&E care for children. These should have 14-hour consultant presence.
Recommendation 5	The workforce should be networked to increase paediatric cover and improve quality of care and patient experience
Recommendation 6	There should be consolidation of general paediatric inpatient care from the current five inpatient units
Recommendation 7	There should be further consolidation of inpatient surgical care and specialist/tertiary care

We are also a member of a Regional Clinical Network which is looking at quality standards across the region and opportunities to deliver further improvements for patients.

6 Improvements in medicines management

Surrey Downs CCG has inherited a medicines management programme, which is now led by GPs, that will enable on-going improvements in primary care prescribing, as well as optimisation of medicines with acute hospitals across the whole pathway.

- Robust decision making processes
- Systems and processes
- Improved patient care
- Education
- Patient safety
- Data and information

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2.7.1 Overview - providing quality, value for money care supporting the whole health system

Our plans in this area involve:

- Building on existing work to drive improvements and efficiencies through effective medicines optimisation
- Focusing on patient benefits and outcomes
- Improving quality to generate value for money across the whole healthcare landscape rather than reducing prescribing costs in isolation.

2.7.2 Our plans for managing medicines better

- Locality and individual practice plans to deliver QIPP: prescribing reports to enable the CCG and practices to monitor performance
- Medication Reviews for Vulnerable People: ensuring appropriate prescribing and monitoring for more vulnerable patients in care homes/ at home with co-morbidities.
- Support the redesign of care pathways: Ensuring high quality and cost effective care is delivered through a whole pathway approach including medicines management
- Education of GPs, practice nurses and patients: raising awareness of appropriate management and care through information and educational events.
- Prescribing audits- NSAIDs, hypnotics, antibiotics, antipsychotics, anticoagulant monitoring, to improve quality
- Repeat prescribing systems – involving all practice staff and patient groups in the review of repeat prescribing systems to improve patient safety and reduce medicines waste.
- Developing the prescribing advisory database: easy access for healthcare professionals / public in relation to local decisions

3. Financial Strategy and opportunities

3.1 Our Out of Hospital Strategy and our financial forecasts

The Out-of-Hospital Strategy provides a financial forecast and plan to 2017-18 for the full five year implementation process.

- These are initial figures based on successful delivery of clinical projects to improve service provision and patient experience that will result in better value for money.
- This will be done by greater acuity of referral activity, preventing avoidable admissions and providing more care closer to home in patients' homes.
- Commissioning integrated care is at the centre of the strategy and will result in some efficiencies, as well as supporting clinicians to work differently within more efficient pathways and adopting IT innovation such as electronic registers that coordinate peoples' care more effectively.

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Our approach to commissioning and financial planning is clinically led. This means we have tested out the scale of the plans with clinicians and independently benchmarked ourselves against other high performing areas at every level – locally, regionally and nationally.

Governing Body members and our Membership Council have reviewed the plans so that we can assure ourselves and identify confidence levels in the data.

We believe our plans are robust and can contribute to the financial challenges faced by the NHS as well as local partners. The plans have been set out at 3 levels and the base case (the likely scenario) will still be challenging and does not close the whole financial gap for the CCG.

For example, the gross projected savings for the Out of Hospital strategy will be in the region of £18.6m (2017-18). This will involve reconfiguring our current spend and purchasing services differently.

The plan consolidates the individual business cases within the Out of Hospital strategy and the cost of actually commissioning these new services. The CCG estimates that with inflation, the new services will cost in the region of £10.3m and potentially less if economies of scale result in lower operating costs for our providers c. £9.4m

BASE CASE

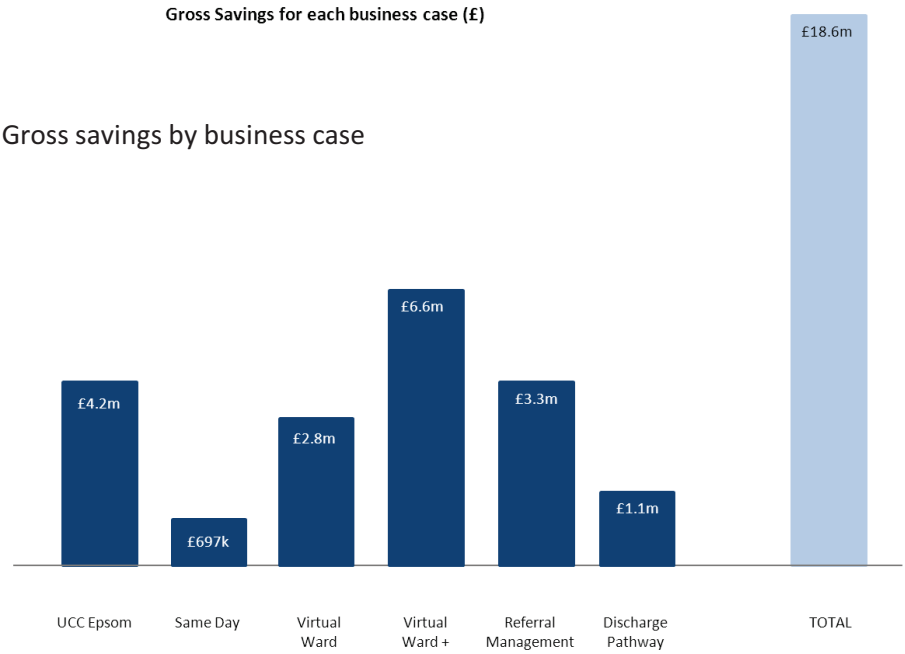
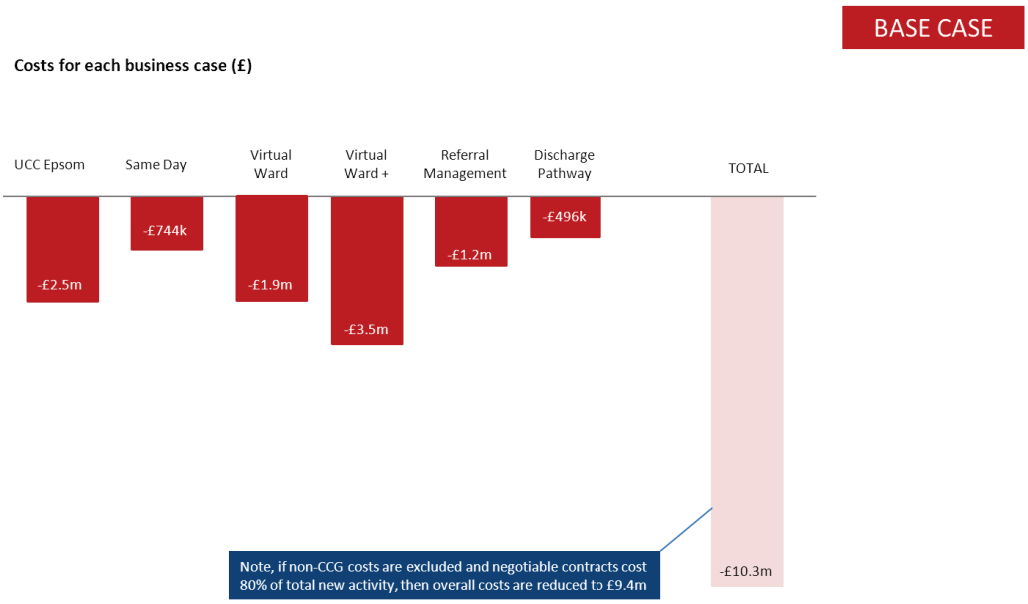


Figure 17: Gross savings by business case

Source: SDCCG / CSH cost modelling



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Source: SDCCG / CSH cost modelling

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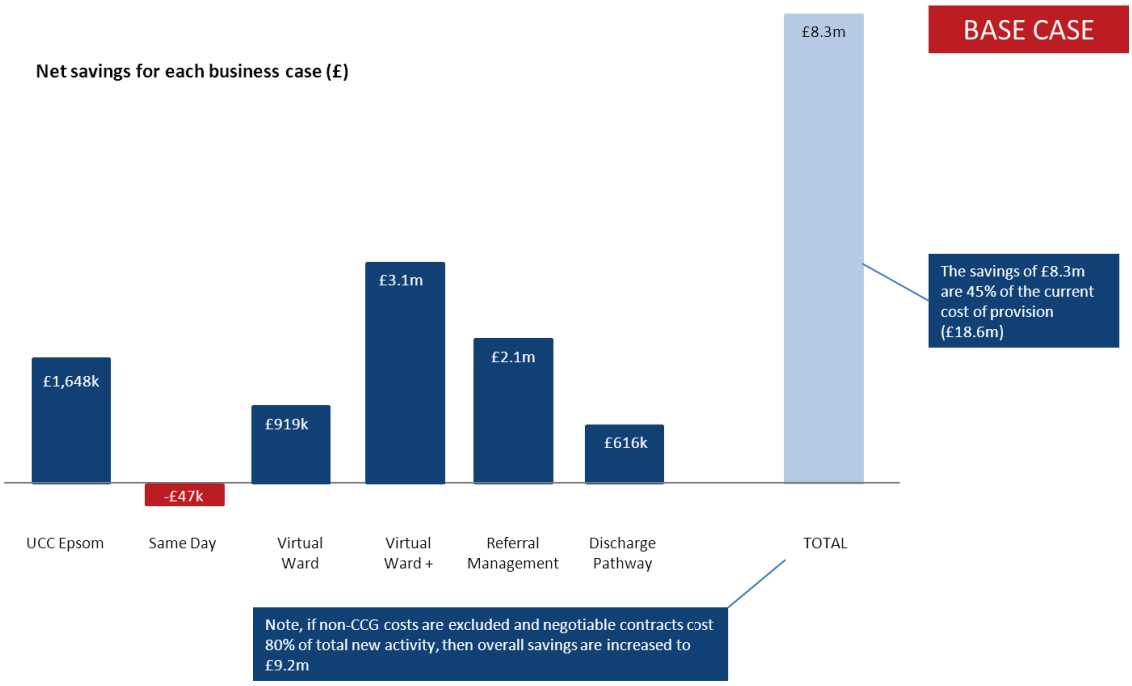
Figure 18: Cost of business cases

The net impact of the plan is that by reconfiguring the original investment of £18.3m and reinvesting resources into the new model of care at a cost of £10.3m, the CCG is likely to run new services at 55% of the original cost of these services – resulting in £8.3m of clinical efficiencies (45%).



Source: SDCCG / CSH cost modelling

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Figure 19: Net savings by business case

Scenario	Composite Acute Rate	2017/18 Surplus (deficit) OOH Low	2017/18 Surplus (deficit) OOH Base	2017/18 Surplus (deficit) OOH High
Lowest	2.50%	(£5.1m)	(£1.7m)	£1.7m
Low	3.00%	(£7.9m)	(£4.5m)	(£1.1m)
Base	3.56%	(£9.8m)	(£6.7m)	(£4.2m)
High	4.00%	(£15.1m)	(£11.7m)	(£8.2m)

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Table 6: Alternative acute growth rates

The CCG is realistic about the level of challenge to the local system of care in achieving this transformation of services and will prioritise the safety and quality of services above all else. This requires working closely with our partners, so that changes in one part of the system, does not have any unintended consequences on the care people receive in other parts of the health and social care system. Our ethos as a membership organisation is to be vigilant and proactive in safely managing the change process with strong stakeholder and patient engagement, including informal feedback loops.

3.1.1 Summary

- The majority of our funding is invested in acute care and fluctuations in demand have a significant impact on the CCG's budgetary spend. The CCG has reviewed historical activity over the past three years for these areas and associated cost levels for acute service provision, including our Out-of-Hospital sector.

- A realistic base case has been set at 3.56% for future growth in acute activity and benchmarked against neighbouring CCGs to establish reasonable assumptions about future spend.

- The base case shows that even with the delivery of the OoH strategy and transformation of the model of care, there could be £4.2m deficit against the level of funding available to the CCG. The only scenario in which a surplus would be achieved is with 2.5% acute growth (1 % below our forecast)

- Appendices B provide a summary of the financial assumptions that underpin the financial case, growth estimates across all sectors, historical growth assumptions and the ONS cluster group – CCG peers.

3.2 QIPP (Quality, Improvement, Prevention & Productivity)

The CCG developed its initial QIPP plan in Q4 of 2012-13, which is outlined below. Since then significant work has been completed in developing projects further and testing out of our key assumptions and clinical delivery. The current QIPP challenge is £10.6m across the following sectors with a balanced QIPP Plan.

QIPP Challenge: £10.6m
QIPP Plan: £10.6m
Redesign: £4.935m
(Gross using 2% for costs)
Contracts: £5.637m

	Sector (£000's)
MH	214
Community	367
Corporate	966
Medicines Management	2,000
Acutes	7,025
Total	10,572

N.B. The above schedule represents gross savings only

Table 7: QIPP savings by sector

3.2.1 Delivering on our QIPP targets

The Out-of-Hospital strategy will contribute to the Quality Innovation Prevention and Productivity (QIPP) schedule as outlined below. The QIPP schedule was risk assessed at the beginning of the year and progress has also been reviewed at Quarter 1 with a full risk assessment.

Table 8: QIPP schedule A

QIPP SCHEDULE A Service Redesign Projects (2013-14)		METRIC Numerator	SAVINGS Gross Savings	 Net Savings	Key Risks (AS OF Q1)	
1. Maximise integration of community and primary care based services with a focus on Frail Older People and those with Long Term Conditions						
1.1	**Virtual Wards & Rapid Response**	Total number of Patients managed on the VW (CHD, Diabetes, COPD, Heart Failure). Excludes EOLC (last year of life).	£ 1,057,500	£ 807,500	GREEN	• VW Up and running • Review completed to identify new model of care • CQUINs developed to drive importance
1.2	**Early Discharge**	Number of Patients discharged by Early Discharge Service with care plan	£ 225,000	£ 225,000	AMBER	• Business case developed to improve discharge pathway • CQUINs developed to improve performance • Increased presence at Epsom & Kingston • Amber due to awaiting Q1 data
2. Improve support for those patients who require End of Life Care (EOLC)						
2.1	**Virtual Ward / End of Life Care Register - Community Services .025% of Practice list size**	Number of patients proactively managed on an EOLC register	£ 549,375	£ 549,375	AMBER	• Localities signed-up to procure new Electronic Register • Procurement pipeline initiated • CQUINs developed to improve performance • Impact scheduled for Q3 on target • Amber due to procurement decision
2.2	**Virtual Ward / End of Life Care Register - General Practices .025% of Practice list size**	Number of patients proactively managed on an EOLC register	£ 549,375	£ 361,875		
3. Provide Care Closer to Home and increased choice						
3.1	**5% optimisation in Out-Patients (Upper Quartile 11% - McKinsey)**	Number of 1st OP appointments reduced (GP referral)	£276,976	£ 201,976	AMBER	• Localities signed up to referral management system • Business Case developed pending sign-off • Implementation scheduled for Q3 – on track • Amber due to sign off of BC

3.2	**Non GP referred activity (eg C2C)**	Number of 1st C2C appointments reduced (GP referral)	£276,976	£276,976	**GREEN**	• KPI in place with Epsom Hospital
4. Medicines Management						
	Nursing Home Medicines Review; Systems & Processes; Drug safety & improved patient care; Drug rationalisation		£ 2,000,000	£ 1,945,307	GREEN	• Procurement on Script Switch underway and on track • Awaiting month 1 data
	TOTAL SERVICE REDESIGN QIPP **(OUT-OF-HOSPITAL)**		**£ 4,935,202**	**£ 4,368,009**	AMBER	

QIPP Schedule B: Surrey Downs QIPP also contains a contractual schedule which aims to deliver £5.6m in 2013-14. There is no pump-priming or additional investment anticipated for these initiatives. (please see overleaf)

Table 9: QIPP schedule B

QIPP SCHEDULE B	Summary	Summary	TOTAL SAVINGS NO INVESTMENT REQUIRED	Risks/Actions
Mental health	Surrey & Sussex Borders NHS Trust - Willows & Meadows	Contract adjustments	£ 106,984.00	Risk is dependent on Closing Rehab Unit (Meadows). MH Commissioner confident that mental health placement savings can re realised in year (Willows).
Acute	All Acutes (13-14)	Key Performance Indicators & Contract Challenges	£ 2,032,000	Pending CSU modelling of KPIs for SW London and Surrey Acute Hospitals. Scheme downgraded until CSU confirmation received.
PMS+	Tier 2 review from Surrey PCT.	£1.3m - contract variation or notice.	£ 325,000	Pending outcomes of Tier 2 review from Surrey PCT. Possibility of 3 month full-year effect, pending decision and review and reprovision process of existing services.
Independent Sector contracts	Out-of-Hospital & Private Provider activity. (Edics, Dorking, M-Edics, Ashtead)	FOT £23,539m (12-13) at 9% growth (20% with Ashstead). Savings predicated on 4% growth (with 5% saving).	£ 882,713	Risk dependent on managing drivers of 12-13 growth. Switch to PbR (c.£500K growth-cost pressure will stop). Plans - activity audit; Move to SuS and coding improvement.
Community	Block contract price adjustment (-1.5%)	Contract Efficiencies	£ 367,000	Tariff Deflator/reflected in SLA
Corporate	Management Cost reductions		£ 966,000	-
Elective	Referral Management	Stretch target from 12-13	£ 207,000	-
Other	Service improvements	Service improvements	£ 750,000	-
TOTAL	CONTRACTUAL AND OTHER QIPP INITIATIVES		£5,636,697	
TOTAL	**QIPP SCHEDULE A&B**		**£10,571,899**	

4. Delivery

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4.1 Organisational requirements and enablers

The organisational requirements and enablers are outlined for our commissioning areas below with a focus on clinical leadership, contracting arrangements, information communication and technology, workforce and funding arrangements.

1. Long Term Conditions - Integration of community and primary care based services	
Clinical Leadership	The CCG will appoint clinical leads for Community Services – see Clinical Leadership Framework.
Contracts	Pump-priming resources, where available, will help contribute to increased operational costs, above existing service investments. Contract mechanisms will be introduced through LES, community/acute contracts and QoF.
IT	Risk stratification; training for providers and practices; inter agency - information governance protocols
Workforce	The CCG will seek assurances from providers that a programme of CPD is in place to ensure the development of appropriate workforce competencies and multi-agency working
Funding	Overall, it is anticipated that more patients will receive urgent care in Primary and Community care at lower cost settings.

2. Elective Care – Provide care closer to home and increase choice for patients	
Clinical Leadership	Clinical leadership for planned care will be through the Clinical Triagers being recruited to the Referral Support Service, overseen by Clinical Locality Chairs
Contracts	The majority of planned care will be contracted through Acute SLAs, via the CSU as well as through the community contract, Out-of-Hospital providers, and Direct/Local Enhanced Services.
IT	A Referral Support Service for GP referrals is being reviewed, including options of clinical triage, IT support, Choose & Book.
Workforce	Support for the role of Practice Nurses, with on-going GP education initiatives and workforce assurance framework with all providers.
Funding	Funding is via SLAs, with specific initiatives based on business cases approved via Governing Body.

3. Access to Urgent Care	
Clinical Leadership	Urgent care responsibilities will be part of Clinical Chairs roles as part of the Executive, as well as specific projects for 111 and out-of-Hours. The Epsom Transformation Board has a sub-board for Urgent Care co-chaired by Governing Body Lay member and Chair. An A&E improvement plan is also being established for Epsom Hospital.
Contracts	Procurement processes are in place and will be completed in 2014 for new Out-of-Hours services contracts. Review of existing community contracts and variation where required for the new model of care for LTC. The proposed Urgent Care Centre at Epsom is part of current contractual

	discussions, overseen by the new Urgent Care Board.
IT	The development of IT systems which are compliant with NHS Information Governance for risk stratification of patients. The development of a 111 Service Directory for Surrey Downs has been signed off by the Exec.
Workforce	Collaborative working with all providers to seek assurances that Continuing Professional Development programmes are in place for the clinical workforce to ensure more people can be safely and effectively treated in the community. This includes the development of mental health awareness across the workforce of services we commission.
Funding	Funding is allocated to 111 and OOH services with business cases for all other initiatives.

4. End of Life Care (EOLC) inc dementia	
Clinical Leadership	The CCG is in the process of appointing a clinical lead for EOLC as part of the Clinical Leadership Framework, with an existing lead for dementia in post for the past year.
Contracts	EOLC is part of the community services contract and also the QoF Quality Points specification for General Practice. The dementia pilot launched in 2013 and is under contract with Surrey & Borders NHS Trust.
IT	The implementation of a new Electronic Palliative Care Register - Coordinate My Care, will be integrated with the local rollout of the Single Digit Number (111) rollout. IT systems will have to support a single register and will need to ensure that patients' preferences and treatment plans are available to all relevant parties in the health and social care system. Use of CMC will be underpinned by QoF QP and CQUINs with all providers.
Workforce	The need for home-based care is likely to increase. This will require decision-making about the skill mix required and competencies, roles and responsibilities. GPs are being supported by new Link Workers specifically recruited for dementia promoting a new type of workforce model.
Funding	Contract and funding has been signed off for CMC and the dementia project.

5. Children & Maternity	
Clinical Leadership	The CCG has appointed a clinical lead for Children's Services at Governing Body level and in two of our localities.
Contracts	Contracts will be monitored by the CQRG for children's community services and by the Surrey's Children's Trust across inter-agency working.
IT	N/A
Workforce	Continuing with the Safeguarding Framework for vulnerable children all providers will ensure that Continuing Professional Development programmes are in place for the clinical workforce and those working with in proximity to children.

6. Improvements in Medicines Management	
Clinical Leadership	The CCG has 4 clinical leads in post for medicines management under the clinical leadership framework.
Contracts	Contractual medicine management improvement schemes are in place with practices as part of the QIPP
IT	Prescribing + has recently been procured to support practices.
Workforce	CPD is provided to practices via the medicines management team.

4.2 Timeframes for delivery

To mobilise delivery the Out of Hospital Strategy is categorised into four clinical pathways – admission prevention, urgent care, elective care and discharge. Each pathway has a portfolio of individual projects with Executive, Clinical and Operational leads, as well as key delivery milestones and risk.

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1. Admission avoidance via Community Services	RISKS		QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4	EXEC LEAD Karen Parsons	CLINICAL LEAD Dr Steve Loveless	OPERATIONAL LEAD Mark Needham
Virtual Wards	Inability to meet 13/14 QIPP targets		Review of Virtual Wards complete	Make decision on future expansion / investment in VWs (Dependent on VWs)	Agree next steps dependent on Exec decision Q1	Mobilisation pending sign-off	Karen Parsons	Dr Steve Loveless	Emma Jackson
Integrated Teams	Inability to meet 13/14 QIPP targets		Development of model of care within OoH Strategy	Agree model of care with clinical leads	Implementation of appropriate model of care / Pending Exec sign off. Sign-off of implementation plan.	Mobilisation pending sign-off	Karen Parsons	Dr Steve Loveless	Mark Needham
Rapid Response Service	Inability to meet 13/14 QIPP targets		Development of model of care within OoH Strategy	Business case to be reviewed by Exec	Service specification to be signed off by Transformation Board and Exec	Mobilisation pending sign-off	Karen Parsons	Dr Steve Loveless	Emma Jackson
End of Life Care - Electronic Palliative Care Register in place	Inability to meet 13/14 QIPP targets		Action not started	Electronic Palliative Care Co-Ordinate system training to be initiated (September)	EPaCCs live across all providers	Monitoring of admission prevention and reduction of deaths in hospital	Karen Parsons	Dr Kate Laws	Emma Jackson
McMillian Clinical Leader appointed	Inability to meet 13/14 QIPP targets		Action not started	SDCCG McMillian Clinical Lead appointed (Aug 13)	No further action required	No further action required	Karen Parsons	Dr Kate Laws	Emma Jackson

COPD Pathway (Epsom Transformation Board)	Inability to meet 13/14 QIPP targets		Participation in Epsom COPD Pathway	Extension to whole system pathway - in agreement with Epsom Transformation Board	Mobilisation pending sign-off (full roll-out across Primary, Community & Acute Care)	Roll-out to Voluntary Sector	Miles Freeman	Dr Andy Sharp	Emma Jackson
Telehealth (Partnership Grant)	Inconsistent pathways will reduce impact on health outcomes		Development of model of care within OoH Strategy	Rollout of project to patients	Full mobilisation of project	Full mobilisation of project	Karen Parsons	Dr Andy Sharp	Steph Isherwood
Heart Failure pathway	Inconsistent pathways will reduce impact on health outcomes			Business case to be approved by Exec	Mobilise heart failure pathway with adherence to Exec conditions	Service operational	Karen Parsons	Dr Steve Loveless	Emma Jackson
Community Assessment Unit - (Epsom Transformation Board)	Inability to prevent avoidable admissions		Development of model of care within OoH Strategy	Business case to be reviewed by Exec / Epsom Transformation Board	Service specification to be signed off by Transformation Board and Exec	Mobilisation pending sign-off	Miles Freeman	Dr Claire Fuller / Mark Hamilton	Mark Needham
2. Urgent Care Systems							**Karen Parsons**	**Dr Steve Loveless**	**Mark Needham**
(e)Extend existing Out of Hours contract	Gap in provision from April 2014 if existing contract not extended		North West to renegotiate and extend exiting Out of Hours service until October 2014 (June 13)	No further action required	Mobilisation of new provider (Sept 13)	No further action required	Karen Parsons	Dr Steve Loveless	Jack Wagstaff
(e) Develop Out of Hours Service	Fragmented provision of OoH		1st Draft Service Specification shared with other CCGs (June	Consultation process to support drafting of	Specification signed off by Executive Committee and	No further action required	Karen Parsons	Dr Steve Loveless	Jack Wagstaff

Specification	service		13)	specification	Governing Body (October 13)				
(e) Procurement of Out of Hours service	No service		No action required	No action required	No action required	Start procurement process (Feb 14)	Karen Parsons	Dr Steve Loveless	Jack Wagstaff
A&E Minors - Epsom Hospital (Epsom Transformation Board)	Poor performance of A&E		Development of model of care within OoH Strategy	Business case to be reviewed by Exec / Epsom Transformation Board	Service specification to be signed off by Transformation Board and Exec	Mobilisation pending sign-off	Miles Freeman	Dr Claire Fuller / Mark Hamilton	Mark Needham
3. Elective Care							**Karen Parsons**	**Dr Andy Sharp**	**Mark Needham**
Referral Management Service	Opting out could have an impact on delivery of SDCCG OOH strategy		Scoping of Referral Management systems as part of Elective OOH strategy (July 13)	Referral management system approved and Outline Business Case signed off (September)	Implementation of Referral management system (Sept-Oct 13) in starting with Medlinc & Mid Surrey followed by Dorking and East Elmbridge (TBC)	Review of Referral management System (March 13)	Miles Freeman	All CL Chairs	Karen Parsons / Mark Needham/ Steph Isherwood
Elective pathway redesign projects eg MSK/ Ophthalmology	Inability to improve pathway with associated costs		Baseline OP activity across top 10 specialties	Identify key specialties for redesign (Dependent on RSS timeframe)	Launch redesign and/or procurement of new care pathways	Mobilisation of pathways	Karen Parsons	All CL Chairs	Kate Taylor

Community Clinics	Inability to improve pathway with associated costs		Review of OoH contracts	Review of interim community clinics Business case to be reviewed by Exec	Launch of new pathways	Mobilisation of pathways	Karen Parsons	All CL Chairs	Kate Taylor
4. Discharge Pathway (inc Community Hospitals)	Inability to meet 13/14 QIPP targets						Miles Freeman	All Cl Chairs	Mark Needham
Kingston Transformation Board	Delays and Excess Beds Days		Kingston Discharge Pathway to Molesey Hospital / East Elmbridge and community services. Complete modelling/costs for Executive Committee	Develop Business Case for Exec - expansion of Community Beds and redesign of pathway	Development of pathway with Kingston Transformation Board and Kingston/Richmond CCGs	Options TBC for future of Molesey Hospital	Miles Freeman	Dr Jill Evans	Mark Needham / Locality Manager
Epsom Transformation Board	Delays and Excess Beds Days		Epsom Discharge Pathway to NEECH/Leatherhead Hospital and community services. Complete modelling/costs for Executive Committee	Develop Business Case for Exec - expansion of Community Beds	Redesign of Epsom pathway with Epsom Transformation Board and option to relocate NEECh / Leatherhead Hospital	Timeframe TBC dependent on Epsom Transformation Board agreement to relocate beds and potential consultation period	Miles Freeman	Dr Claire Fuller / Mark Hamilton	Mark Needham / Locality Manager
SASH Transformation Board	Delays and Excess Beds Days		SASH Discharge Pathay to Dorking Hospital and community services. Complete modeling/costs for	Develop Business Case for Exec - expansion of Community Beds. Sign off service	Re-open Dorking Hospital (Sept)	Service operational	Miles Freeman	Dr Steve Loveless	Mark Needham / Locality Manager

			Executive Committee	specification and business case with SASH Transformation Board					
Stroke Pathway (Acute & Community Pathways linked to Transformation Boards)	Delays and Excess Beds Days			Baseline existing stroke provision with Transformation Boards	Business case to be reviewed by Exec / Transformation Board	Mobilise new pathways	Miles Freeman	All CL Chairs	Emma Jackson
Upgrade/reprocure Dorking X-Ray service	Decrease opportunities to support new community pathways		Service Specification complete (May 13)	Procurement process initiated (July 13)	Mobilisation of new provider (Oct 13) New xRay facilities provided at Dorking Hospital (Nov 13)	Effective implementation of service and performance management	Karen Parsons	Dr Steve Loveless	Steph Isherwood
Upgrade/reprocure Leatherhead X-Ray service	Decrease opportunities to support new community pathways		Service Specification in development (June 13)	Service Specification signed off by Executive Committee (August 13)	Procurement process started (October13)	Mobilisation (January 14) New Xray provision at Leatherhead Hospital (March 14)	Karen Parsons	Dr Claire Fuller	Steph Isherwood
Upgrade/reprocure Molesey X-Ray service	Decrease opportunities to support new community pathways		Service Specification complete (May 13)	Service Specification signed off by Executive Committee (August 13)	Procurement process started (October 13)	Mobilisation (January 14) New Xray provision at Leatherhead Hospital (March 14)	Karen Parsons	Dr Jill Evans	Kate Taylor

Other OoH Projects							Karen Parsons	All CL Chairs	Mark Needham
Diabetes Pathway - Review and introduce new diabetes pathways (including existing diabetes LES)	Inconsistent pathways will reduce impact on health outcomes		CCG notified of high acitivty and capacity levels by ESTH, Provider engagement commenced to diagnose the issues and develop implementation plan.	Business case to be approved by Exec	Initiatie service procurement or contract variation	New service to go live (dependent on procurement option)	Karen Parsons	Dr Andreas P / Dr Stewart Watson	Jack Wagstaff
Dorking Dementia screening pilot implemented							Karen Parsons	Dr Robin Gupta	Diane Woods / Steph Isherwood
IAPT Projects	Inconsistent pathways will reduce impact on health outcomes		Roll out AQP Services and manage transition to new providers	Montor and review services with local GPs	Monitor	Monitor	Karen Parsons	Dr Robin Gupta	Kate Taylor

4.3 Risks to delivery

This is the SD CCG specific Risk Register for our Out-of-Hospital strategy which outlines the anticipated risks at a strategic and operational level for 2013-14 and, where possible, 2014-15. SD- CCG maintains a more detailed risk register as part of the governance framework.

Ref	Risk	Cause and effects	Likeli-hood	Impact	Controls/mitigations
1	Finance Failure to maintain financial balance	Causes: 1. Activity shift to primary and secondary care 2. Demand management for A&E/urgent care 3. Inability to decommission acute care activity 4. Acute activity does not shift to primary and community care within timeframes 5. GPs fail to develop and deliver new pathways 6. Inability to establish new care pathways within time constraints Effects: 1. Overspend 2. Insufficient financial resources to deliver strategic priorities 3. Significant unrecoverable losses 4. Double running of services beyond handover time 5. Loss of reputation	4	4	1. Develop full decommissioning and savings plan 2. Long/medium/short term budget management framework and budget setting process 3. Adequate contingency 4. Implement full programme budgeting Effective management of Commissioning Support Unit Effective governance through Governing Body. Others: Reporting: monthly and board reports; budget reports; commissioning reports
2	Information Failure to secure appropriate information support system to support clinical and performance information	Causes: 1. Poor capture of clinical information 2. Poor sharing of clinical information for smooth patient management 3. Poor efficiency/best value 4. Poor financial control Effects: 1. Inefficient system 2. Poor patient experience and satisfaction 3. Poor performance management 4. Loss of financial control	3	5	The CCG can build on its experience to date but the solutions will also require cross CCG, CSU and National Commissioning Board resolution. Information sharing with Surrey County Council to enable holistic performance management of services

		5. Risk of quality assurance and clinical incidents			
3	Workforce Failure to select/procure providers with clinical competencies to deliver services	Causes: 1. Insufficient workforce out of hospital to deliver shift in care settings 2. Professional tribalism rather than competency based approach 3. Inability of providers to secure productivity in out of hospital services 4. Lead-in time beyond our timeframes for education providers to deliver curriculum changes 5. Current NHS staff resistant to cultural change and shift to working outside of hospital 6. Lack of business and project management skills to support change management Effects: 1. Inability to transform system 2. Financial sustainability lost 3. Loss of patient and public confidence 4. Political and reputational risk	3	5	1. London wide work plan to secure change in education commissioning 2. Sector workforce development plan 3. Partnership work with Surrey County Council to increase capacity and capability and enhance potential for effective recruitment and retention 4. Sharing management capabilities with partners at Cluster level
4	Clinical leadership and engagement Failure to secure clinical leadership and engagement, hence not transforming the system	Causes: 1. Change fatigue amongst clinicians 2. Resources to secure clinical time for leadership 3. Workforce changes with fewer full time doctors in General Practice 4. Multiple relationships and complex out of sector flows Effects: 1. Poor pathway design 2. Poor patient experience 3. Potentially poor clinical outcomes 4. Service inefficiency and increased cost	4	4	This challenge will be addressed at borough and sector levels: Borough level: 1. The Governing Body and Clinical Leadership Framework have been established to drive clinical leadership across the pathfinder. 2. Locality GPs are engaged with service redesign at monthly locality meetings Sector level: 1. Clinicians continue to engage with local hospital colleagues on key pathways 2. Clinicians have been engaged with the Better Services, Better Value programme

5	Estates Insufficient quality estate available within required timeframe to enable Out-of-Hospital Care strategy	Causes: 1. Delays to in time for planned transformation of Community beds / hospitals Effects: 1. Impact on service delivery 2. Inability to deliver financial plan as highlighted above	4	4	1. Regular liaison with NHS England Property Services 2. Primary care estate audit 3. Clear commissioning plans and feasibility studies

Appendix A – Methodology and clinical engagement

Literature Review

Overview

Secondary research in the form of a desk top based literature review was carried out; covering Integrated Care principles and success factors and best practice, to establish a priority level for proposed interventions i.e. Urgent Care, Elective Care and Community Hospital Redesign.

The outcomes of the research will describe the key design principles or critical success factors, provide examples of models and pathway flow (where relevant) and include a minimum of three detailed case studies with an additional number of references to further examples of pilots or projects.

Aim of the review

The aims of the literature review were to describe a summary of what is currently done within 'out of hospital care' and to include example case studies both nationally and internationally as relevant to the identified models of care.

There was also a requirement to describe key success factors as evidenced in the available literature for each of the three areas of clinical priority and to describe models of care for groups of activity i.e. unscheduled, planned (outpatients, day case and inpatients) or categories of care and to highlight examples or themes where certain interventions or models of care have not been successful and why.

Methodology

A review of literature in relation to the key areas (urgent care, elective care and care in the community) was carried out over 2 weeks and included:

- Sentinel case studies – highlighting the specific initiatives undertaken by the particular health care organisations, the key success factors and lessons learnt.
- An interpretation of meta-analytical studies and thought leadership articles to suggest achievable target ranges for interventions and set realistic expectations of benefits.
- Extraction of the relevant BSBV strategic frameworks and evidence bases (particularly around urgent care principles and estimates)

The best practice models drew on the literature to include not only the outcomes of different models in existence but also synthesised lessons about effective characteristics of the interventions (e.g. risk stratification, use of a referral management system and case management) and key enablers (shared information protocols and agreed objectives) and also gave consideration to relevant constraints.

The evidence from the review of literature was used to develop an evidence pack which informed locality workshops and interviews.

Baseline performance and benchmarking

Overview

This section included a baseline of Surrey Downs CCG current performance along a number of agreed key activity metrics which are expanded upon below. The aim of the this section was to be familiar with the landscape and have an agreed position by locality and practice (where data is available) in order to then benchmark against where the CCG needs to be within five years and the implications of this on the out of hospital sector.

The Current 'as is' performance

The baseline analysis focused on how the CCG, localities and practices are performing in 2012/13 and will cover

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- Activity
- Current performance
- Tariff related financials for comparison

The supporting narrative evaluated the trends in performance over the "past three years" particularly focusing on shifts in point of delivery (POD), rises in activity, changes in disease prevalence taking into account Long Term Conditions and Top 10 electives, and assess relevant outcomes by POD. Referral patterns were also be analysed to identify any trends and associated outcomes. The impact of changes to provision of care between primary and secondary will also be assessed both in terms of activity and financial.

Specific analysis included current performance and trends within the following areas at CCG, locality and practice level:

- **Emergency activity**: A&E attendances (broken down to practice, severity of condition and age), non elective admissions – LOS <1, ratio of discharged without investigation, A&E attendance by route of referral, A&E activity split by in hours and out of hours
- **Unplanned admissions**: attendances split by specialty, LOS and route of referral, readmission rates by practice and excess bed days split by practice
- **End of life**: Numbers by practice on 'end of life care register', admissions analysis of those discharged as dead including age, gender, day discharged and numbers dying 'out of hospital'
- **Community care**: bed utilisation by practice and acute provider, LOS
- **Elective activity**: number of outpatients and trend analysis across specialties, admissions and LOS, plus activity by location and broken down by provider
- Specifically for the top 10 specialties – GP first and follow up referral by provider and practice, consultant to consultant referrals by specialty and provider
- Patients using Rehab and therapy services by practice, patients using private providers by practice and specialty

Benchmarking

The benchmarks were a mixture of regional, national and peer comparison at locality level where appropriate data is available (such as NHS Information Centre Indicators). Metrics such as A&E admission rate, referral rates and admission rates for certain conditions, will be used to assess current practice.

Where identifiable, specific benchmarks, stretch targets and realistic assumptions for the future model of care were provided. This work was informed by 2020 Delivery, who were responsible for data collation and Analysis.

Informing the Models of Care; Stakeholder Engagement and Workshop Outputs

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Overview

The purpose of this section was to provide a brief overview of the process for engaging key stakeholders within the out of hospital strategy development and to detail the involvement at locality level with the models of care. An underpinning principle of the strategy development is to involve all key stakeholders and work with the localities to ensure that the proposed models are viable and broadly supported.

Purpose of workshops

To test the ideas generated through the baselining, benchmkarking and literature review with the locality stakeholders to then inform further development of the proposed models of care for the CCG.

To start having discussions regarding the gap between the future picture and where the localities are now, what the possible solutions might be, the anticipated levels of activity and the implications for workforce and estates. These discussions informed the final proposed models within the strategy.

Methodology

- Build the current 'as is' picture using baseline information, benchmarked performance and service map for out of hospital care. Use these sources to have a locality based discussion on the current position of the CCG, locality and practices will be inform opportunities for change and the potential impact of achieving the stretch targets
- Use the literature review material to evidence practice carried out elsewhere and what initiatives are underway and provide a conceptual base upon which to inform thinking at the CCG whole system level and then the locality specific considerations and variations.
- Hold facilitated workshops (one per locality) to gain stakeholder input and capture thoughts and ideas regarding the future out of hospital care initiatives
- Formed Clinical Reference Groups for each area, used to test ideas and assumptions and keep the communication between the CCG and the localities

Where relevant, interviews were carried out to provide more detailed insight into proposed solutions. The interviews were with GPs, service providers, or other CCGs.

Appendix B - Finance assumptions used in Surrey Downs projections

From Commissioning Board, Dec 2012 and monitor guidance

		13/14	14/15	15/16	16/17	17/18	18/19	19/20	
Funding levels	SDCCG	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	
Pay Inflation	SDCCG	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	
Non-pay inflation	SDCCG	2.80%	2.80%	2.80%	2.80%	2.80%	2.80%	2.80%	
Tariff inflator/deflator	SDCCG	-1.30%	-1.30%	-0.20%	-0.20%	-0.20%	-0.20%	-0.20%	
Non-Acute Deflator	SDCCG	-1.30%	-1.30%	-0.20%	-0.20%	-0.20%	-0.20%	-0.20%	
Contingency	SDCCG	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	
Surplus	SDCCG	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	
Non recurrent investment reserve	SDCCG	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	
Prescribing inflation	SDCCG	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	From Kevin Solomans
Other Continuing Care growth (activity)	SDCCG	0.30%	0.30%	0.30%	0.30%	0.30%	0.30%	0.30%	From Andy Simmonds
Other Continuing Care growth (price)	SDCCG	0.90%	0.90%	0.90%	0.90%	0.90%	0.90%	0.90%	From Andy Simmonds
Mental Health Growth (activity)	SDCCG	11.00%	7.50%	4.50%	4.50%	4.50%	4.50%	4.50%	From Andy Simmonds
Mental Health Growth (price)	SDCCG	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	1.90%	From Andy Simmonds
NEL - overall activity growth: BASE	SDCCG	1.22%	1.22%	1.22%	1.22%	1.22%	1.22%	1.22%	From SUS
A&E - overall activity growth: BASE	SDCCG	2.76%	2.76%	2.76%	2.76%	2.76%	2.76%	2.76%	From SUS
OP - overall activity growth: BASE	SDCCG	4.05%	4.05%	4.05%	4.05%	4.05%	4.05%	4.05%	From NHS comparators
EL - overall activity growth: BASE	SDCCG	6.51%	6.51%	6.51%	6.51%	6.51%	6.51%	6.51%	from SUS
Community Expenditure Projection	SDCCG	-1.30%	-1.50%	-1.50%	-1.50%	-1.50%	-1.50%	-1.50%	from Alun Shopland (CSH)
Non-growth related inflation	SDCCG	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	From Keith Edmunds

Source: SDCCG

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Continuing care and mental health growth estimates

Activity Growth							
	13-14	14-15	15-16	16-17	17-18	18-19	19-20
Mental Health	11.0%	7.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Frail Elderly	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Learning Disabilities	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ABI	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
YPD	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Neuro-rehab	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Palliative	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Mental Health	**11.0%**	**7.5%**	**4.5%**	**4.5%**	**4.5%**	**4.5%**	**4.5%**
Other Continuing Care	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**0.3%**
Total	**3.5%**	**2.5%**	**1.6%**	**1.6%**	**1.6%**	**1.6%**	**1.6%**

Price Growth								Total Spend 12-13
	13-14	14-15	15-16	16-17	17-18	18-19	19-20	
Mental Health	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1,551,504
Frail Elderly	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	798,156
Learning Disabilities	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1,284,328
ABI	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	427,133
YPD	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	491,477
Neuro-rehab	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	158,852
Palliative	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	652,242
								5,363,692
Mental Health	**1.9%**	**1.9%**	**1.9%**	**1.9%**	**1.9%**	**1.9%**	**1.9%**	
Other Continuing Care	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**	
Total	**1.4%**	**1.4%**	**1.4%**	**1.4%**	**1.4%**	**1.4%**	**1.4%**	

TOTAL Growth							
	13-14	14-15	15-16	16-17	17-18	18-19	19-20
TOTAL GROWTH MH	12.9%	9.4%	6.4%	6.4%	6.4%	6.4%	6.4%
TOTAL GROWTH other CC	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
TOTAL GROWTH All	4.9%	3.9%	3.1%	3.1%	3.1%	3.1%	3.1%

High mental health activity expected over the next 12-24 months, then steady at 4.5%
Low Frail elderly growth

Surrey Downs CCG acute growth rate used in 5-year forward projections is 3.56%. This shows the methodology used to determine this growth

Activity by POD	2009/2010	2010/2011	2011/2012	2012/2013
NEL	28,875	29,170	29,841	29,942
Day + EL	25,420	25,374	29,086	30,719
A&E		76,585	80,475	80,869
OP (all OP, inc non-PbR)	From NHS comparators			

Activity was obtained from SUS datasets between 2009-10 and 2012-13. However, this data excludes any 'private' out of hospital activity in outpatient or elective categories.

Growth by POD	2009/2010	2010/2011	2011/2012	2012/2013	CAGR
NEL		1.0%	2.3%	0.3%	**1.2%**
Day + EL		-0.2%	14.6%	5.6%	**6.5%**
A&E			5.1%	0.5%	**2.8%**
OP		4.0%	4.0%	4.0%	**4.0%**
Weighted Average (based on current spend per POD)			**6.49%**	**2.79%**	**3.56%**

Compound Annual Growth Rate (CAGR) over the last three years was calculated and shows that activity has been growing by 3.56%.
Year-by-year analysis shows that growth was 6.49% between 2010-11 and 2011-12, but it then slowed to slowed to just 2.79% between 2011-

2012-13 Forecast spend[2]		
	NEL	£58,996.94
	Day + EL	£43,312.54
	A&E	£ 9,499.04
	OP	£36,769.27

CAGR for each POD is weighted by 2012-13 forecast spend to give an overall 'acute' growth

Summary
Given that the most recent growth in acute services (between 2011-12 and 2012-13) was 2.79%, but that the 'private' out of hospital providers are excluded from the analysis, the 3 year **growth of 3.56%,** was chosen as being most appropriate[1] for the 5-year projections.

Source: SUS data 2009-10 to 2012-13, OP (1st, FU and procedures, inc non PbR) growth obtained from NHS Comparators 2007-2011 for Surrey PCT
[1] / [2] 2012-13 Forecast spend is from 2020 Delivery analysis of UNIFY report and 'private' OOH spend

CCG Peers in Southern England

Prospering Southern England ONS Cluster	
NHS Aylesbury Vale CCG	NHS North East Hampshire and Farnham CCG
NHS Bracknell and Ascot CCG	NHS North Hampshire CCG
NHS Chiltern CCG	NHS North West Surrey CCG
NHS East and North Hertfordshire CCG	NHS Surrey Downs CCG
NHS East Surrey CCG	NHS Surrey Heath CCG
NHS Guildford and Waverley CCG	NHS West Essex CCG
NHS Herts Valleys CCG	NHS West Kent CCG
NHS Horsham and Mid Sussex CCG	NHS Windsor, Ascot and Maidenhead CCG
NHS Newbury and District CCG	NHS Wokingham CCG

Health Scrutiny Committee
30 May 2014

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. The Work Programme for 2014 is attached at **Annex 2.** The Committee is asked to note its contents and make any relevant comments.

Recommendations:

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

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Sources/background papers: None

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ANNEX 1

HEALTH SCRUTINY COMMITTEE
ACTIONS AND RECOMMENDATIONS TRACKER – UPDATED 26 MARCH 2014

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
SC040	Health & Wellbeing Board Update [Item 9]	The Committee requests an update from the Health & Wellbeing Board in six months on the Board's key priority strategies and progress against these strategies.	Health & Wellbeing Board Scrutiny Officer	Update scheduled for May 2014 from the Health & Wellbeing Board	*May 2014*
SC044	Patient Transport Service [Item 7/14]	The Commissioner must ensure that hospital discharge planning improves across Surrey. Member Reference Groups will follow-up on this work with the acute hospitals.	North West Surrey CCG Member Reference Groups Acute hospitals	The Lead Commissioner for the PTS contract has changed to NW Surrey. More time will be needed to allow for changes in management. NW Surrey have been briefed on these recommendations.	*May 2014*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SC045	Patient Transport Service [Item 7/14]	The Commissioner will report on how they will ensure the viability of the Patient Transport Service and the chosen provider for the future through its contracting arrangements. They should assure the Committee that any new service specification includes realistic and achievable KPIs.	North West Surrey CCG Scrutiny Officer	The Lead Commissioner for the PTS contract has changed to NW Surrey. More time will be needed to allow for changes in service. NW Surrey have been briefed on these recommendations.	*November 2014*
SC046	Patient Transport Service [Item 7/14]	That there is an effective complaint handling system that allows this Committee to scrutinise individual outcomes.	SECAmb North West Surrey CCG		*November 2014*
SC047	Sexual Health Services for Children and Young People [Item 8/14]	The team returns with further information on completion of its Sexual Health Needs Assessment and Strategy in early 2015.	Public Health Services for Young People Scrutiny Officer		*March 2015*
SC048	Sexual Health Services for Children and Young People [Item 8/14]	The Committee is included in the consultation on the Sexual Health Strategy,	Public Health, Scrutiny Officer		*September 2014*
SC049	Sexual Health Services for Children and Young People [Item 8/14]	The commissioning plans that emerge from the review of School Nurses is brought to a future Committee meeting.	Public Health, Scrutiny Officer		*September 2014*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SC050	Surrey and Sussex Local Area Team [Item 9/14]	That the Area Team works with Healthwatch to analyse the Annual Declaration from GPs and returns to this Committee on its completion for further scrutiny.	Local Area Team Healthwatch Scrutiny Officer		*September 2014*
SC051	Surrey and Sussex Local Area Team [Item 9/14]	The Area Team keeps the Committee informed of the plans for consultation on the future of the Ashford Walk-in Centre and involves when appropriate.	Local Area Team Scrutiny Officer		*September 2014*
SC052	Surrey and Sussex Local Area Team [Item 9/14]	Publicity is devised to promote the helpline that advises the public about the availability of NHS dentists.	Local Area Team		*September 2014*
SC053	Surrey and Sussex Foundation Trust Consultation [Item 10/14]	The Trust should emphasise the quality of its leadership when publicising their FT application.	Surrey and Sussex NHS Trust		*January 2014*
SC056	End of Life Care [Item 19/14]	That there is review of capacity and funding of hospices in Surrey (as part of the Better Care Fund work) including private and voluntary providers of End of Life care.	CCGs		
SC057	End of Life Care [Item 19/14]	Request for a Surrey-wide implementation of an Electronic Patient Coordination System (or systems with inter-operability) that integrates primary, community and acute end of life care.	CCGs		

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
		Update from CCGs in six months.			
COMPLETED ITEMS					
SC043	Integration Transformation Fund [Item 6/14]	The Committee requests a further update post sign-off at its meeting on 22 May 2014.	Assistant Chief Executive Interim Strategic Director for Adult Social Care Scrutiny Officer	Member Reference Group formed to monitor, the now Better Care Fund, plans. Meeting with Co-Chairs in June 2014	*May 2014*
SC054	Surrey and Sussex Foundation Trust Consultation [Item 10/14]	Encourage the participation of the younger cohort (14 years+) for the mutual benefit of public services.	Surrey and Sussex NHS Trust.	The Committee wrote to SASH's CEO to this effect offering support for its FT application. The consultation has now closed.	*February 2014*
SC058	Surrey & Borders Partnership Update [Item 20/14]	Request a report on the improvements identified and actions taken in response to CQC inspections in 2013 and comment on where this would leave performance versus aspirations and comparable benchmarks.	Surrey & Borders Partnership	SABP attended the March meeting of this Committee.	

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SC055	Better Care Fund [Item 18/14]	Instigate a Joint MRG to liaise with Surrey Better Care Fund Board on a quarterly basis. Taking the Better Care Fund as a starting point with a long-term aim to investigate wider health and social care integration in Surrey.	Scrutiny Officer Better Care Fund Board	First meeting is set for 27th June in Weybridge.	

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Health Scrutiny Committee Work Programme 2014-2015

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
May 2014				
30 May	Frimley Park Hospital NHS FT merger with Heatherwood & Wexham NHS FT	Scrutiny of Services – The Committee will review the rationale behind the merger and examine the plans for the foundation trusts and the possible impacts on Surrey residents.	Andrew Morris, Chief Executive and Dr. Timothy Ho, Medical Director – Frimley Park Hospital NHS FT	
30 May	Surrey Downs CCG Out of Hospital Strategy	Scrutiny of Services – Pressure on A&E departments continues with non-emergency admissions. The committee will scrutinise the plans of Surrey Downs CCG to provide more community based care to meet local needs in their Out of Hospital Strategy.	Surrey Downs CCG representative	
30 May	Rapid Improvement Event – Acute Hospital Discharge	Policy Development – the committee will review the progress and impacts of the actions identified in the October Rapid Improvement Event.	Sonya Sellar, ASC CCG representative Acute Trust representative	
30 May	Care Quality Commission	Scrutiny of Services – the CQC has recently changed how it inspects health and social care services. The committee will receive an update on the organisation's new inspection methods including 'deep dives' and how it will involve the Committee in this work.	CQC regional manager	
30 May	Review of Quality	Policy Development – The Committee will review the MRG's comments	MRGs/Scrutiny	

Health Scrutiny Committee Work Programme 2014-2015

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
	Account Priorities	on priorities for the next year's QA for those Trusts submitting priorities since the last meeting.	Officer	
July 2014				
3 July	Acute Hospitals Collaboration	Scrutiny of Services – the performance of acute hospital are of the utmost interest to the Surrey public and they have been widely reported to be under more pressure than in the past. The performance of the hospitals also effects the whole health system. The Committee will consider plans of Ashford & St. Peters and Royal Surrey Trusts to work together.	Ashford & St Peters and Royal Surrey Acute Trusts reps Guidlford & Waverley and NW Surrey CCGs Health Watch	
3 July	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.	Helen Atkinson, Acting Director of Public Health Guildford & Waverley CCG Children, Schools & Families representative	To be joint with C&E Select

Health Scrutiny Committee Work Programme 2014-2015

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
			Healthwatch representative	
3 July	Healthwatch Strategy Review	Scrutiny of Services – To consider the Healthwatch strategy and priorities which were agreed by the Board at the beginning of the year and their performance in the first year of operation	Healthwatch Business Manager, Stephen Hughes	
3 July	2014/15 Forward Plan	Members to consider and approve items for the 14/15 forward plan	Scrutiny Officer	
To be scheduled				
	Transformation Board Update	Scrutiny of Services/Policy Development - Transformation Boards are made up of NHS commissioners and providers and SCC. The Boards centre on the Acute Trusts and have the entire health economy of that area as their scope. They solve problems and strategise on thematic terms. The Committee would benefit from understanding the outputs of an exemplar board and their role in the health system	Board representatives	
	Renal Services	Scrutiny of Services/Policy Development – St Helier Hospital, which is 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.	Epsom & St 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	

Health Scrutiny Committee Work Programme 2014-2015

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
			representatives	
	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 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	
	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, ASC	To be joint with ASC Select
	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 Scrutiny Committee Work Programme 2014-2015

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
			Health representative	

Task and Working Groups

Group	Membership	Purpose	Reporting dates
Alcohol	Karen Randolph, Peter Hickman, Richard Walsh	The health effects of alcohol are well known however its use remains prevalent among Surrey residents of all backgrounds. The group should investigate public perceptions on safe drinking and the effect on statutory services. The group may also develop strategies for managing alcohol intake, raising awareness and contribute to Public Health's Alcohol Strategy	
Better Care Fund (Joint with Adult Social Care)	Richard Walsh, Tim Evans	To monitor and scrutinise the plans and investment in services in terms of impact and risk for existing services in Surrey and patients.	
Primary Care	Ben Carasco, Karen Randolph, Tim Evans, Tim Hall	To investigate the risks and issues faced by primary care and service users. *To be further defined.*	

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