Notice of Meeting

Wellbeing and Health Scrutiny Board

Date & time
Thursday, 12 November 2015 at 10.30 am
There will be a private meeting of the Board at 09.30am

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

Contact
Ross Pike or Lucy Collier
Room 122, County Hall
Tel 020 8541 7368 or 020 8541 8051

ross.pike@surreycc.gov.uk or lucy.collier@surreycc.gov.uk

Chief Executive
David McNulty

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This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Ross Pike or Lucy Collier on 020 8541 7368 or 020 8541 8051.

Elected Members

Mr W D Barker OBE, Mr Ben Carasco (Vice-Chairman), Mr Bill Chapman (Chairman), Mr Graham Ellwood, 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

Independent Representatives:

District Councillor Lucy Botting (SCC), Borough Councillor Karen Randolph (Thames Ditton) and Borough Councillor Mrs Rachel Turner (Tadworth and Walton)

TERMS OF REFERENCE

The Wellbeing and Health Scrutiny Board 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 Wellbeing and Health and Scrutiny Board 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.

AGENDA

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

There are no apologies or subsitutions.

2 MINUTES OF THE PREVIOUS MEETING: 16 SEPTEMBER 2015 (Pages 1 - 10)

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

3 DECLARATIONS OF INTEREST

To receive any declarations of discloseable 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 (Pages 11 - 12)

To recieve any questions or petitions.

Notes:

1. The deadline for Member's questions is 12:00pm four working days before the meeting (Friday 6 November 2015)
2. The deadline for public questions is seven days before the meeting (Tuesday 3 November 2015)
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

A public question was received from Bess Harding

5 CHAIRMAN'S ORAL REPORT

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

6 ACCESS TO PRIMARY CARE (Pages 13 - 40)

Purpose of the report: Scrutiny of Services

Following the investigation of the Board's GP Access Task Group NHS

Commissioners, including NHS England South, NHS Guildford & Waverley CCG and NHS Surrey Heath CCG, will be asked to discuss with the Board how the situation can be improved in the future.

7 NORTH EAST HAMPSHIRE AND FARNHAM CCG COMMUNITY BED REVIEW (Pages 41 - 44)

Purpose of the report: Scrutiny of Services

To describe the progress to date on North East Hampshire and Farnham CCG's Vanguard Primary and Acute Care System new models of care project to review its community beds model.

8 SURREY STROKE SERVICES REVIEW UPDATE (Pages 45 - 64)

Purpose of the report: Scrutiny of Services

A countywide review of the stroke pathway is underway and the leaders of the review will present the work undertaken thus far and the next steps for the review

Report to follow

9 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME (Pages 65 - 74)

The Board is asked to review its Recommendation Tracker and Forward Work Programme.

10 DATE OF NEXT MEETING

The next meeting of the Board will be held at 10.30 am on 7 January 2016.

David McNulty
Chief Executive
Published: Tuesday, 3 November 2015

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 **WELLBEING AND HEALTH SCRUTINY BOARD** held at 10.30 am on 16 September 2015 at Ashcombe, County Hall. Kingston upon Thames, KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting on Thursday, 12 November 2015.

Elected Members:

* Mr W D Barker OBE
* Mr Ben Carasco (Vice-Chairman)
* Mr Bill Chapman (Chairman)
* Mr Graham Ellwood
* Mr Bob Gardner
* Mr Tim Hall
* Mr Peter Hickman
  Rachael I. Lake
* Mrs Tina Mountain
* Mr Chris Pitt
* Mrs Pauline Searle
* Mrs Helena Windsor
* District Councillor Lucy Botting
* Borough Councillor Karen Randolph
* Borough Councillor Mrs Rachel Turner

Ex officio Members:

Mrs Sally Ann B Marks, Chairman of the County Council
Mr Nick Skellett CBE, Vice-Chairman of the County Council

9/15 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Rachael I Lake

10/15 MINUTES OF THE PREVIOUS MEETING: 2 JULY 2015 [Item 2]

The minutes were agreed as a true record of the meeting.

11/15 DECLARATIONS OF INTEREST [Item 3]

None received

12/15 QUESTIONS AND PETITIONS [Item 4]

None received

13/15 CHAIRMAN'S ORAL REPORT [Item 5]

It is a pleasure to welcome back Cllr Rachel Turner from Reigate and Banstead Council to serve on the Board for a further 3 years.

Our New Title and Implications for our Work
The addition of 'Wellbeing' to our Board's name gives the opportunity to spread our wings a bit and we will be proceeding as follows:

The **Local Health and Wellbeing Boards** are a forum where many organisations responsible for wellbeing meet. We will be holding a private event with representatives from the 11 District and Boroughs early in 2016 to explore how best Members might become involved in these Health and Wellbeing Boards where they exist.

Transformation Programmes: Our Surrey CCGs are implementing transformation of their health services in partnership with their suppliers using the Models of Care recommended in the NHS 5 Year Forward View. We received an overview of these 5 Models at our Meeting of 21 May, where we also heard of Surrey Heath CCG's intention to explore the Multi-speciality Community Providers (MCP) route. Earlier we had a presentation on the Vanguard Integrated Primary Care and Acute Systems (PACS) programme that is being led by North East Hampshire and Farnham CCG.

We will be asking for involvement when these and other Transformation Programmes are well under way. We have invited the Vanguard PACS programme team back to the Board next year.

Progress on the Better Care Fund
Pauline Searle and I attended the Meeting of the Social Care Services Board on 7 September where we received an update on progress of the Better Care Fund work. Ross will be distributing the Agenda papers and Minutes of that Item to all Members of this Board.

Scrutiny of Mental Health
A number of partners have made a commitment under the Mental Health Crisis Concordats to work together to prevent mental health crises and to ensure that

people get treatment no matter where they make contact. These partners include: Surrey County Council; the Clinical Commissioning Groups; Surrey and Borders Partnership, Surrey Police and South East Coast Ambulance service.
Following a preparatory all Member Seminar on the subject, this Board will be joining with the Social Care Services Board and the Police and Crime Panel in joint scrutiny of mental health in Surrey. Three joint sessions are planned in the remainder of 2015, 2 of which we will be hosting.

CCG Deficits
Several of our CCGs are in deficit or close to it. This Board will need to understand how their financial recovery plans might impact on services for residents. Ross and I will be following up on this issue.
It will be critical for the financial position of the CCGs that attendances at A&E and unplanned admissions are held in check this coming Winter. We will hear more on this topic at Item 6 today.

Merger of Ashford and St Peter's and Royal Surrey County Hospital
Bill Barker reports that the Competition and Markets Authority (CMA) has provisionally cleared the way for the Merger. The CMA's Final Report will be published not later than 7 October 15.

Surrey Downs CCG Review of Community Hospital Services
Tim Hall and Lucy Botting have been deeply involved in this review. We have Item 8 on the subject at this Meeting.

Epsom Hospital Site
Following Daniel Elkeles' presentation at our last Meeting, Members have been invited to visit the Epsom Hospital site. There are two open days:

- Thursday 17 September, 7am to 9pm, at St Helier Hospital
- Wednesday 23 September, 7am to 9pm, at Epsom Hospital

NHS England
Ross and I attended a meeting of the Health Scrutiny Committee Chairmen and Officers for the South East Region. The most interesting points were:
Provision of over £1 billion of **specialised services** for the population of the South East. Costs are rising at 8% mainly due to introduction of high technology treatments.

Forecast **supply of medical professionals**. It appears that across England there will be a continuing shortage in the supply of Doctors, but Surrey is likely to fare better than the England average. On the other hand there is likely to be an over-supply of Pharmacists and the intention is to expand the role of that profession into some work that currently falls to GPs.

14/15 NORTH WEST SURREY URGENT CARE SYSTEM WINTER RESILIENCE [Item 6]

Declarations of interest:

None

Witnesses:

Julia Ross, Chief Executive, North West Surrey Clinical Commissioning Group

Suzanne Rankin, Chief Executive, Ashford & St Peter's Hospitals NHS FT

Shelley Head, Area Director, Adult Social Care

James Kraft, Managing Director, Virgin Care

James Thomas, Head of Urgent & Emergency Care

Key points raised during the discussions:

1. The Head of Urgent & Emergency Care introduced the item to the Board by stating additional resources would be applied this winter and that would include additional GP and Care Home provision. It was added that the CCG has invested £320K in a Care Home Support Team to support care homes in the upcoming winter period. It was questioned whether North West Surrey can provide the resources required, including additional Care Home services and paramedic practitioners, as the demand for skilled staff is so high. The Area Director advised the Board that funding is needed for different types of training and that a campaign to promote and incentivise caring careers in conjunction with Virgin Care had been devised. The Area Director also advised the Board that Adult Social Care were working with the CCG to challenge traditional methods around discharge to assess

2. The Board inquired when the results of the system's actions would be revealed. The witnesses stated that the preparation for winter 2015 is on target and that health and social care providers were in a better position than last year to meet demand. They were able to identify future demand spikes because of an IT system that provided real-time data and allowed for information to be shared between system leaders.

3. Clarification was sought on the Intelligence Based Information System 'IBIS' a patient records system supported by the Ambulance Trust to allow their crews to have patient care records on the ground. Additionally, the Board were advised that a new system - Almanac - that collects outcome data in one place and could show delayed processes across the whole system for example. By using this system it was seen as integrated and developed as leaders could intervene collectively to surges in demand. This system was developed for under pressure systems and is currently being used in Brighton as well.

4. The Vice-Chairman queried whether the system's goal for this winter was to avoid a major incident. It was stated that their intention was to stop system failing in terms of quality and safety and if they had to, leaders would be prepared to declare a major incident again even though that is undesirable. The CCG Chief Executive highlighted to the Board that the system was better at identifying future demand and that the big challenge was quality of service over public holidays. In 2014 pressure fell mostly on hospital and ambulance services, the difference in 2015 was the organisation were partners and have a agreed new process for extreme situations: 'beyond black' this allows the four system leaders to create one command centre to manage the system.

5. The Chief Executive of Ashford & St. Peter's NHS Hospitals advised the Board that there is a strategic shortfall in the supply of clinicians and nursing. The Trust had been recruiting successfully abroad and there was recognition of the quality of Philippine nurses in particular where the Trust had recruited 58 new nurses. However, this route was now unavailable due to Home Office rules on visas. The Board questioned the Chief Executive about the supply from European Union countries and were told that the Trust did recruit from Portugal but 40% returned home. Epsom General Hospital had recruited nurses from Portugal and Spain however they soon left for more specialised roles in London Hospitals. This is similar to staff from Poland and Romania each Trust faced the same problem of diminished supply.

6. The Chief Executive of the CCG advised the Board that caring for frail/elderly residents was the biggest challenge in 2014 and the response was the Locality Hub model for the over-75s which is a proactive service wrapping around the patient. The Trust Chief Executive felt it was important to encourage everyone to have the 'flu vaccination and that the Trust was taking the opportunity to opportunistically vaccinate.

7. The Chair of the Surrey Coalition of Disabled People commented that the Red Cross filled a number of gaps in 2014 and that there was pressure on the wheelchair service. The role of the voluntary sector was recognised by the witnesses and praised for responsive transport service in the period of pressure. It was highlighted that the wheelchair service was being jointly reviewed by Surrey County Council and the CCGs and they were to procure a new integrated community equipment store.

Recommendations:

- The Board commends the system leaders for their efforts in analysing the causes of the pressures in 2014 and the actions taken to ensure the quality and safety of care provided in winter 2015 and beyond.

Board next steps:

- To discuss workforce issues especially the rules around the recruitment of nursing staff from outside the European Union and what action can be taken at its next business meeting.
- Post Meeting Note: The Government has relaxed Work Permit rules for Nurses from outside the EU.

15/15 RESPONSES TO A&E EVIDENCE REQUEST [Item 7]

The responses provided to an information request by the Chairman informed consideration of item 6.

16/15 SURREY DOWNS CCG COMMUNITY HOSPITAL SERVICES REVIEW [Item 8]

Declarations of interest:

None

Witnesses:

Dr Claire Fuller, Clinical Chair

James Blythe, Director of Strategy and Commissioning

Suzi Shettle, Head of Communications and Engagement

Key points raised during the discussions:

1. The Director of Commissioning & Strategy discussed with the Scrutiny Board the CCG Governing Body's recommendation to proceed to public consultation on options for change following the Community Hospital Services Review process. Members of the Scrutiny Board were part of the Programme Board for the review and engaged with the CCG and the public throughout the process. These Members advised the Scrutiny Board that the process was open and transparent and that they were supportive and assured of the review undertaken by the CCG.

2. The Board asked how the council's Adult Social Care Directorate had been involved in the review. The Director of Commissioning & Strategy stated that Social Care representatives had attended engagement events during the review and that Social Care staff will be directly involved in Surrey Downs' community hubs. Additionally, the County Council's Area Director for Mid-Surrey's views had been reflected in the final report.

3. Answers were sought about the future consultation plan for the general public. The CCG stated that the relative strengths and weaknesses of the options for change will need to be discussed with the public. The Board were told that the CCG were happy to reflect feedback and explain the wider context of outpatient services in the Surrey Downs area in the public consultation document as per the Board's advice but that, on the whole, awareness of other out-of-hospital services was high among residents.

4. The Board noted that the CCG currently faced considerable financial pressures and asked whether this had influenced the review. The CCG explained that four community hospital wards were not sustainable for the needs of their population, which is why a three ward model is recommended following the review. The property services budget for the sites was £4.8 million per annum while population growth figures for people over 65 years have reached 6% each year, stretching the financial package. However, the Director of Commissioning & Strategy emphasised that the CCG were not proposing to reduce spend on community hospital services as a result of the review.

Recommendations:

The Board:

- Approves of the review process undertaken by Surrey Downs CCG.

- Requests that it continue to be involved with the review process by scrutinising the CCG's public consultation plans through a sub-group of Members - Tim Hall, Lucy Botting, Karen Randolph and Tina Mountain

17/15 UPDATE FROM SURREY'S HEALTH AND WELLBEING BOARD [Item 9]

Declarations of interest:

None

Witnesses:

Helyn Clack, Co-Chair of Health and Wellbeing Board and Cabinet Member for Wellbeing and Health

Liz Lawn, Co-Chair of Health and Wellbeing Board and Clinical Chair, North West Surrey Clinical Commissioning Group

Key points raised during the discussions

1. The Cabinet Member for Wellbeing and Health advised the Board that there had been vast improvements in working together in the health and social care system in the last two years. The Co-Chairs were asked about the work the Health and Wellbeing Board has done on children's mental health. They referred to current countywide re-procurement of the Child and Adolescent Mental Health Services (CAMHS) which demonstrates the improvement in working together between health and social care. It was suggested that a benefit of having clinical leads involved in the re-specification of CAMHS is the role of GPs is marked. However, they agreed there is a relative low level of support and funding for children and young people with mental health issues including eating disorders.

2. The Board inquired about the involvement of District & Borough Councils and health and social care providers with the Surrey Health and Wellbeing Board. The Co-Chairs advised that the relationship varies with the districts and boroughs, links have often been made through individuals rather than in formal ways. They also stated that the Districts and Boroughs were all represented on the Local Joint Commissioning Groups. Regarding providers, the Co-Chair felt that the Transformation Boards were the best forum to involve providers and outlined the problem of effectiveness if the Health and Wellbeing Board's membership was as numerous as these other Boards – there was a benefit in maintaining a strategic focus.

3. The Cabinet Member for Wellbeing and Health stated that participation was welcomed at the Surrey Health and Wellbeing Board and updated Members that she had been looking at how different boards across the country are working and hopes to convene a group of Chairs through the LGA to discuss best practice.

4. The Co-Chairs were asked about the Surrey priorities for children and young people. Members were advised that the board's strategic plan was taking a overview of the Ofsted improvement plan and were assured of the early years and safeguarding arrangements with the Co-Chair adding that there was more confidence in the operation of children's safeguarding now but that more work was required on the early help offer.

5. Members asked about the success of the Health and Wellbeing Board's prevention activities. It was suggested that the plan focuses on the wider determinants not just ill-health prevention, such as Air Pollution. The Board suggested that the Co-Chairs discuss with the Director of Public Health how to strengthen these plans.

Recommendations:

The Board recommends that:

- It receives a further update from the Health and Wellbeing Board on the progress against its strategic priorities and any possible changes to how it operates in 12 months time.

- The Co-Chairs discuss with the Director of Public Health how the Health and Wellbeing Board can strengthen the focus on the wider determinants of health in CCG prevention plans.

Graham Ellwood left the meeting at 12:55

18/15 JOINT COMMISSIONING OF SPEECH AND LANGUAGE THERAPY SERVICES FOR CHILDREN AND YOUNG PEOPLE [Item 10]

Declarations of interest:

None

Witnesses:

1. Anne Breaks, Head of Children's Commissioning (Community), Guildford and Waverley Clinical Commissioning Group

Key points raised during the discussions

1. The Head of Children's Commissioning introduced the report by updating the Board on the work undertaken to jointly commission speech and language and seeking the Board's view on the level of engagement with stakeholders. A Member expressed views regarding the problems with speech and language therapy in Surrey. They stated that parents often need to get on the ladder early to ensure their children receive the required therapies. The Board was aware of some patients who had waited up to a year to access services. The Board were advised that the changes to the services would see CCGs redirecting funding from schools to early years boosting access and reducing the need for an intervention at school age

2. Regarding the joint commissioning process the Board asked why it has taken two and half years to get to the point of implementation. The Head of Children's Commissioning expressed that she appreciated it had taken a long time. It was explained that there was a long process to organise the joint system and that they hoped to avoid any delays to the implementation of the new model.

3. It was suggested that television could help with speech and language therapy access issues, however, the Head of Children's Commissioning advised that this would not be successful for most children especially those with specialist needs. The Head of Children's Commissioning reassured the Board that staffing in speech and language therapy services was better than in other sectors rather it has been funding that has been the main issue although schools have always been able to buy in therapies over and above their core offer.

4. The Board were advised that they were 4,016 referrals to speech and language therapy in 2014 against a combined budget of £4.1 million which is spent across the Surrey County Council and the CCG. The plan for the future was to make the service more accessible and user friendly for example using a phone hotline to provide parental reassurance about child development and prevent children needing therapy in the future. Therapy is being introduced into schools as a process of education. However it was stated by an officer that the state of Primary Care in Surrey is below average.

Recommendations:

- The Board endorses the engagement work undertaken by the council and CCG and supports the joint commissioning of speech and language therapy.

19/15 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 11]

Declarations of interest:

None

Witnesses:

None

Key points raised during the discussions:

None

Recommendations:

None

Actions/ further information to be provided:

None

Board next steps:

None

20/15 DATE OF NEXT MEETING [Item 12]

The Board noted its next meeting will be held at 10.30 am on Thursday 12 November 2015

Meeting ended at: 1.12 pm

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Chairman

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PUBLIC QUESTION RECEIVED BY THE WELLBEING AND HEALTH SCRUTINY BOARD
Item 4: Public Questions, 12 November 2015

Question received from Bess Harding, on 28 October 2015

Will we have an acute stroke unit at Epsom, what is the plan if we don't? Epsom also has a good rehab unit it is quiet and nurses answer bells quickly.

The alternative is a journey of 45 minutes to East Surrey Hospital. Ambulances and crews cost money – return journey will probably be 3 hours. Ambulances will be returning stroke patients within 72 hours to their home hospital – may not be acute ambulance but it still costs money. Families who do not have transport will be faced with 2 hour bus journeys in each direction. Taxis are £30 each way minimum. How many people can afford that for 3 or more days?

Why can’t this money be used to employ 1.5 or even 2 more extra consultants at Epsom and then it would comply with consultant ward rounds at weekends?

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Strengthening GP services in Surrey

Report for the Surrey Wellbeing and Health Scrutiny Board

12 November 2015

1 Executive summary

General practice is the bedrock of healthcare and local GP surgeries in Surrey and other parts of the country provide valuable services to their patients' day in day out.

Yet these services face a number of challenges. We need to transform the way care is provided in order to address these issues, and to ensure the future delivery of good quality care to patients in a sustainable way.

Across the country, these challenges include:

- An ageing population and an increasing number of patients with complex care needs and multiple long-term conditions, who require more intensive support from GP services
- Increasing pressure on NHS financial resources
- Dissatisfaction amongst patients about the ability to access GP appointments and rising patient expectations about this.
- Variation in the quality and performance of local services and health inequalities
- Growing reports of workforce pressures, including recruitment and retention problems

A clear national strategy for the future of the NHS has been set-out in the NHS Five Year Forward View and this includes plans to address the principal challenges facing GP services. Action is being taken to address workforce and infrastructure issues and changes to the national GP contract have also been made in order to support improvements to patient care. Meanwhile, work is taking place across the country to test potential new models of care, so that services can be designed which will meet the needs of patients, both now and in the future.

In Surrey, NHS England and the local clinical commissioning groups are continuing to work together to address these challenges at a local level and to ensure the ongoing development of sustainable GP services for people in the community.

This paper provides an update on how services are being developed for the benefit of local patients.

1 Overview of GP services in Surrey

1.1 Number of GP practice contracts across Surrey

Across Surrey there are currently 127 GP practices, providing services to 1,180,368 registered patients across 141 surgery sites. Of these, all practices currently have 'open' patient lists and can register new patients.

Name of CCG	Number of GP practices	Registered number of patients across local practices as at 01/04/2015
NHS East Surrey CCG	18	178,184
NHS North East Hampshire & Farnham CCG*	5	47,608
NHS Guildford & Waverley CCG	21	197,047
NHS North West Surrey CCG	42	362,575
NHS Surrey Downs CCG	33	300,899
NHS Surrey Heath CCG	8	94,055
Total	**127**	**1,180,368**

**NHS North East Hampshire & Farnham CCG has a total of 24 GP member practices, the majority of which fall within the Hampshire area. However five GP practices in this area are located within Farnham, Surrey. The local Wessex team at NHS England oversees the delivery of services at these five Farnham GP practices, working closely alongside colleagues from the local South East team at NHS England.*

1.2 Type of GP contracts

There are three different types of contract held by local GP practices. These are:

- **General Medical Services (GMS) contracts.** GMS contracts are nationally negotiated. These contracts run in-perpetuity and provide GP contractors with considerable flexibilities in terms of being able to take on new GPs as partners to the contract. This allows GMS contracts to be handed on from one GP or group of GPs to another, without this requiring the agreement of NHS England as the commissioner (subject to the individuals meeting certain conditions as set out in the national GMS regulations). GMS contracts can only be terminated by the commissioner should there grounds to do so (i.e. fundamental concerns regarding patient safety). GMS contracts cannot be held by public limited companies (PLCs). Across Surrey 64 GP practices hold GMS contracts.

- **Personal Medical Services (PMS) contracts. Personal Medical Services (PMS) contracts.** These are locally negotiated contracts between NHS England and GP practices which allow local flexibility compared to the nationally-negotiated GMS contract. PMS contracts allow the opportunity for variation in the range of services that may be provided by a GP practice, while also ensuring that the core services as required by the national GMS contract are also provided. A total of 62 practices in Surrey hold a PMS contract. NHS England is currently undertaking a review of these contracts and will provide further information about this to the Committee shortly.

- **Alternative Provider of Medical Services (APMS) contract**. APMS contracts vary from GMS and PMS contracts in two key ways. Firstly, they can be held by any form of entity (including PLCs, local GPs and GP consortiums and third sector organisations). Secondly they are for a fixed-term period. There is 1 GP practice in Surrey that currently holds an APMS contract. This is the contract for services at the GP-led health centre which is based at Ashford Health Centre, on the Ashford Hospital site in north-west Surrey. The centre provides both services for registered patients and walk-in services.

1.3 Patient satisfaction with local GP services

1.3.1 Latest national GP Patient Survey results (published in July 2015)

The national GP Patient Survey provides information on patients' overall experience of primary care services across England, and their overall experience of accessing these services.

Details of the headline findings from the national survey are available on NHS England's website at:

https://www.england.nhs.uk/statistics/2015/07/02/gp-patient-survey-2014-15/

The full breakdown of results from the survey, including data by clinical commissioning group (CCG) area is available on the survey's website at: https://gp-patient.co.uk/surveys-and-reports

A summary of some of the local findings from the latest GP Patient Survey, in regards to the experience of Surrey patients and how this compares to national findings, is shown below.

Table 1: Overall experience of GP services

Overall experience of their GP surgery			
	Total number of responses	**Good total (either 'very good' or 'fairly good')**	**Poor total (either 'fairly poor or very poor')**
England total	858,381	85%	5%
NHS North East Surrey CCG	2,025	85%	4%
NHS Guildford and Waverley CCG	2,435	89%	4%
NHS North West Surrey CCG	4,728	82%	6%
NHS Surrey Heath CCG	1,039	92%	3%
NHS Surrey Downs CCG	3,838	85%	5%

Table 2: Ability of patients to get an appointment

Able to get an appointment to see or speak to someone			
	Total number of responses	**Yes total**	**No**
England total	830,142	85%	11%
NHS North East Surrey CCG	2,601	87%	10%
NHS Guildford and Waverley CCG	3,265	91%	6%
NHS North West Surrey CCG	5,367	85%	12%
NHS Surrey Heath CCG	1,405	93%	5%
NHS Surrey Downs CCG	4,446	86%	12%

Table 3: Overall experience of making an appointment

Overall experience of making an appointment			
	Total number of responses	**Good total (either 'very good' or 'fairly good')**	**Poor total (either 'fairly poor or very poor')**
England total	824,865	73%	13%
NHS North East Surrey CCG	2,598	73%	11%
NHS Guildford and Waverley CCG	3,218	78%	9%
NHS North West Surrey CCG	5,322	68%	16%
NHS Surrey Heath CCG	1,383	80%	6%
NHS Surrey Downs CCG	4,400	68%	6%

Table 4: Satisfaction with GP opening hours

Satisfaction with GP surgery opening hours			
	Total number of responses	**Total satisfied (either very satisfied or fairly satisfied)**	**Total dissatisfied (either fairly dissatisfied or very dissatisfied)**
England total	842,965	75%	10%
NHS North East Surrey CCG	2,623	72%	12%
NHS Guildford and Waverley CCG	3,336	72%	13%
NHS North West Surrey CCG	5,416	69%	14%
NHS Surrey Heath CCG	1,417	75%	13%
NHS Surrey Downs CCG	4,482	70%	14%

1.3.2 Surrey Healthwatch survey of GP access

In November 2014 Surrey Healthwatch published the results of its survey of over 1,000 local patients, who were asked about their experience of booking an appointment with a GP.

This reported concerns raised by some patients about their ability to secure an appointment on the day, or time, of their choosing and some other issues of frustration for patients, such as their ability to get through to their GP surgery by phone.

GP practices are responsible for managing their appointments in a way that best meets the needs of their patients, including ensuring that they have appropriate processes in place to offer swift appointments to any patients who need urgent care. Many GP surgeries reserve a number of appointments each day for patients needing an urgent, same day appointment. This is in addition to the appointments that can be booked at the surgery in advance, to assist with continuity of care.

NHS England will however continue to work with the local clinical commissioning groups (CCGs) to encourage local GP practices to deliver the best possible access to services for their patients.

Examples of work undertaken include NHS North West Surrey Clinical Commissioning Group (CCG) investing in extended primary care, to deliver additional access over weekends and outside of core general practice hours. They have also worked with the Primary Care Foundation to support member practices to improve their appointment systems to respond to patient demand.

NHS Surrey Heath Clinical Commissioning Group (CCG) introduced a new scheme earlier this year to increase opening times across its nine local practices. Later appointments are now available for patients until 8pm.

Colleagues in Epsom have also secured national funding to pilot a scheme designed to offer patients access to primary care services from 8am to 8pm Monday to Friday, from 9am to 2pm on Saturdays and from 10am to 1pm on Sundays (see further information in Section 2.5 below about this project which is being supported by the Prime Minister's Challenge Fund).

One issue the Healthwatch survey identified was that not all patients were aware that they had the ability to book appointments online, despite this being a service that a number of Surrey practices provided at the point the survey was conducted last year.

Since that time, national changes have been introduced which mean that all GP practices have been contracted to offer an online appointment booking system since April 2015.

The national Patient Online programme also provides the ability for patients to order repeat prescriptions online and to access summary information from their health records online.

GP practices are responsible for making their patients aware of this service, but we are planning further work to support GP practices to promote the availability of the service.

Further information about the Patient Online service is available on the NHS Choices website at:

http://www.nhs.uk/aboutNHSChoices/aboutnhschoices/find-and-choose-services/Pages/gp-online-services.aspx

2. Developing sustainable local GP services

2.1 The NHS Five Year Forward View

We need to change the way we deliver care to patients, in order to ensure sustainable services that will meet their needs – both now and in the future.

The NHS Five Year Forward View, published on 23 October 2014 by NHS England, sets out a vision for the future of the NHS, including how we can build a firm foundation for the future of local GP services. It was developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the Five Year Forward View is to articulate why change in the NHS is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part to realise the potential benefits, including system leaders, NHS staff, patients and the public.

The Five Year Forward View highlights that the traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. Increasingly we need to manage systems – networks of care – not just organisations.

As such, the NHS of the future needs to be characterised by:

- Out-of-hospital care that is a much larger part of what the NHS does.

- Services which are integrated around the needs of patients. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.

- Applying rapid learning from the best examples, not just from within the UK but internationally.

- Evaluation of new care models to establish which produces the best experience for patients and the best value for money.

With specific reference to general practice, the Five Year Forward View sets out a number of steps to help achieve sustainable services. Some of these key steps are listed below.

NHS England will continue to work with the local Surrey clinical commissioning groups (CCGs), GP practices and other partners to determine how local GP services can be developed and shaped to best meet the needs of local patients.

Most change will be led and shaped locally by GP practices themselves, in conjunction with the CCGs and in dialogue with partners in the local community. NHS England will play a key role in shaping and enabling this change to take place, but sustainable change will need to be clinically- led and locally owned.

2.2 Stabilising core funding for GP services

The NHS Five Year Forward view confirms that NHS England will work with partners to seek to stabilise core funding for general practice nationally over the next two years, while an independent review is undertaken of how resources are fairly made available to support primary care in different areas.

2.2.1 Review of Personal Medical Services (PMS) contracts

Work has also been taking place across the country, including in Surrey, to review the use of Personal Medical Services (PMS) contracts for the provision of local GP services. This is in order to ensure equitable funding for all local practices for the provision of core services.

We want to ensure that PMS funding in Surrey is aligned to services for patients and local strategies to improve patient care. Where this isn't the case, we need to ensure funding is reinvested to where it is needed to help transform local general practice services.

We will be working closely with the local clinical commissioning groups (CCGs) in regards to this to ensure any funds are reinvested in GP primary care services for the benefit of the local population.

We have recently written to local GP practices currently receiving PMS funding about the process for the review and have written to separately to the Chair of the Surrey Wellbeing and Health Scrutiny Board with more detail on this matter.

2.3 Give local clinical commissioning groups more influence

It is intended to give GP-led clinical commissioning groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute care to primary and community services.

The introduction of co-commissioning is an essential step towards expanding and strengthening primary medical care services, helping to drive up quality, reduce health inequalities and put the NHS on a sustainable path for the future.

Co-commissioning recognises that CCGs are harnessing clinical insight and energy to drive changes in their local health systems that have not been achievable before now, but that they are also hindered from taking a holistic and integrated approach to improving healthcare for their local populations, due to their lack of say over the commissioning of primary care services. Co-commissioning will be a key enabler in developing integrated out-of-hospital services based around the needs of local communities. It will also drive the development of new models of care.

In May 2014, NHS England invited clinical commissioning groups (CCGs) to come forward with expressions of interest to take on an increased role in the commissioning of GP services.

Across the South East area, two of the 20 CCGs (Eastbourne, Hailsham and Seaford CCG and High Weald, Lewes Havens CCG) were subsequently granted delegated responsibility for the commissioning of GP services.

The remaining CCGs have been invited to submit their proposals for either entering into joint commissioning arrangements, or taking on delegated responsibility for commissioning GP services. Should their applications be supported then these arrangements would take effect from 1st April 2016.

Any CCGs that do not submit proposals to change their status, or whose proposals are not supported, will retain their statutory responsibility to work with NHS England to develop primary care and support the quality of general practice services provided to patients.

2.4 New models of care

There is a need to transform the way we provide services to patients, in order to ensure the NHS can continue to meet their needs in the future.

Although it is expected that many smaller GP practices will continue in their current form, it is recognised that primary care is entering the next stage of its evolution.

Primary care services of the future will build on the traditional strengths of GPs as 'expert generalists', proactively providing services for patients with complex ongoing needs, such as the frail elderly or those with chronic conditions, and working much more intensively with them. Future models of care will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

However, England is too diverse for a 'one size fits all' care model. Different local health communities will instead be supported to adopt the approach which will work best for their patients.

The NHS Five Year Forward View points towards two new models of primary care provision which local areas could consider adopting in order to develop sustainable local services which will allow them to provide a wider range of care to their patients 1) the multi-speciality community provider and 2) primary and acute care systems.

2.4.1 Multi-speciality Community Provider

This option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care providers, to create a system of integrated out-of-hospital care for local patients. These Multispecialty Community Providers (MCPs) would become the focal point for the provision of a far wider range of care and early versions of this model are emerging in different parts of the country.

Within the South East area GP practices across Canterbury and Whitstable in Kent are one of the vanguard sites across the country testing this new model of care by forming a Multi-speciality Community Provider service.

The establishment of Multispecialty Community Providers could provide the following potential future opportunities to improve patient care:

- These providers could in future begin employing hospital consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.

- GP practices working as part of these providers could transfer the majority of outpatient consultations and ambulatory care out of hospital settings.

- These providers could potentially take over the running of local community hospitals, which could substantially expand their diagnostic services for patients, as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be given authority in some cases to directly admit their patients into acute hospitals,

- In time, Multi-speciality Community Providers could take on delegated responsibility for managing the health service budget for the patients registered with their GP practices. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers, so that they could determine how best to meet the needs of their patients.

- These new models would also draw on the support of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

2.4.2 Primary and Acute Care Systems (PACs)

Another new model being explored nationally to support the delivery of more integrated care to patients is to combine GP practice and hospital services for the first time through the development of new Primary and Acute Care Systems. This will allow single organisations to provide NHS GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals could be permitted to open their own GP surgeries with registered lists. This would allow the investment powers of NHS foundation trusts to kick start the expansion of new style primary care in areas with high health inequalities. Safeguards would be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.

- In other circumstances, the next stage in the development of a mature Multi-specialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

- At their most radical, Primary and Acute Care Systems could take accountability for the whole health needs of a registered list of patients, under a delegated, capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

Primary and Acute Care System models are complex in their nature and will take time and technical expertise to implement. As with any new model there are also potential unintended side effects that will need to be managed.

The intention therefore is to pilot these in a small number of areas across the country to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

Learning from work that is taking place to test these new models of care nationally will be able to inform the ongoing development of services in Surrey.

2.5 Funding to support new ways of working and to improve access to services

Funding, through schemes such as the Prime Minister's Challenge Fund, is also being used across the country to support new ways of working and to improve patient access to services. The scheme has supported over 50 schemes to date across the country, testing a variety of ideas to offer better access to services and appointments for patients, including through offering evening and weekend opening hours and the use of new technology such as Skype to support patient consultations.

2.5.1 Prime Minister's Challenge Fund project in Epsom, Surrey

In Surrey, the Prime Minister's Challenge Fund is supporting a pilot project in Epsom to make primary care services available to patients from 8am to 8pm Monday to Friday, from 9am to 2pm on Saturdays and from 10am to 1pm on Sundays. Weekend services will be available via two local hubs and patients will benefit from a greater diversity of consultation types and lengths, including greater use of telephone, online and video consultations.

The project is being overseen by GP Health Partners Limited (the umbrella organisation for the 20 local GP practices in the Epsom area).

The development of Community Medical Teams in collaboration with acute care, primary care, social care, ambulance services, the third sector, NHS111 service and out-of-hours GPs will also support more vulnerable and frail patients. Further work will develop a community based clinical triage system with home visiting services, including to nursing homes and patients that have recently been discharged from hospital. To help empower patients to take an active role in their health care planning, a voluntary personal care record will also be available.

This pilot project is receiving indicative funding of around £1.8 million.

2.6 Addressing workforce challenges

Across the country, including in Surrey, local GP services face workforce challenges.

The Five Year Forward View sets out the need to expand as fast as possible the number of GPs in training, while also training more community nurses and other primary care staff. There is also a need for increased investment in new roles, and in returner and retention schemes, ensuring that current rules are not inflexible and putting off those health professionals considering a potential return to general practice.

At a national level, NHS England, Health Education England (HEE), The Royal College of General Practice, and the British Medical Association's GP Committee are all working together to ensure that we have a skilled, trained and motivated workforce in general practice.

2.6.1 The New Deal for General Practice

All four organisations have jointly developed a new GP workforce action plan called 'Building the Workforce – The New Deal for General Practice'. This is a 10-point action plan, with three broad areas of action around recruitment, retention and returning to general practice. Initiatives set out in the plan to expand the general practice workforce across the country include:

- **To recruit newly trained doctors into general practice** in areas that are struggling to recruit. They will be incentivised to become GPs by offering a further year of training in a related clinical specialty of interest such as paediatrics, psychiatry, dermatology, emergency medicine and public health. This work will be underpinned by a national marketing campaign aimed at graduate doctors to highlight the opportunities and benefits of a career in general practice. Alongside this, pilot training hubs based in GP practices will be established in areas with the greatest workforce needs to encourage doctors to train as GPs in these areas. They will also enable nurses and other primary care staff to gain new skills.

- **To retain GPs** the national plan includes establishing a new scheme to encourage GPs who may be considering a career break or retirement, to remain working on a part-time basis. It will enable practices to offer GPs the opportunity to work with a modified workload and will be piloted in areas which have found it more difficult to recruit. There will also be a wider review of existing 'retainee' schemes.

- **To encourage doctors to return to general practice** Health Education England and NHS England will publish a new induction and returner scheme, recognising the different needs of those returning from work overseas or from a career break. There will also be targeted investment to encourage GPs to return to work in areas of greatest need, which will help with the costs of returning to work and the cost of employing these staff.

NHS England is investing £10million of funding to kick start the initiatives in the plan, which will complement work that is already underway to strengthen the GP workforce and will ultimately benefit all areas.

2.6.2 Engaging clinical pharmacists in the delivery of GP services

As part of work to deliver the 10-point workforce plan for general practice, NHS England also launched a new £15 million national programme on 7 July 2015, designed to engage clinical pharmacists in the delivery of GP services.

Many GP practices already have clinical pharmacists in patient facing roles and the intention is to invest at least £15 million over the next three years to test out extending the responsibilities of their jobs, beyond any current ways of working. GP practices have suggested that this extended role could include the management of care for people with self-limiting illnesses and those with long term conditions and have asked that the new team members have the ability to independently prescribe.

It is anticipated that around 250 clinical pharmacists will be involved in testing these new ways of working over the three-year period, with the ambition of supporting over 1 million patients. The pilot will be evaluated so that successes and learning can be shared and the expectation is that GP practices would continue to support the role of clinical pharmacists after the three-year period of national funding has ended.

Practices and groups of practices were invited to bid to take part in the pilot scheme and encouraged to work together on joint bids, involving pharmacists across a number of surgery sites. These applications are now being considered.

2.6.3 Local Community Education Provider Networks (CEPN)

Across the South East, Community Education Providers Networks (CEPNs) have been also established in each of the 20 local clinical commissioning group (CCG) areas, including in Surrey.

The purpose of the CEPNs is to facilitate educational networks between GP practices, with GP and primary care workforce tutors offering support in education, training and workforce planning. This provides an important local foundation through which to address the workforce challenges facing general practice, with partnerships involving Health Education England, NHS England, CCGs, GP practices and various professions.

2.7 Use of funding to improve primary care infrastructure

2.7.1 Primary Care Transformation Fund

NHS England will be investing an extra £1billion into general practice infrastructure over a four year period commencing 2015/16m, in order to support patient care. The national Primary Care Transformation Fund will see £250 million a year, every year, invested over a four year period.

The first tranche of £250m is being used to improve premises, help GP practices to harness technology and give practices the space to offer more appointments and improved care for frail, elderly patients – which is essential in supporting the reduction of hospital admissions. It will also lay the foundations for more integrated care to be delivered in community settings.

For the first year of funding, GP practices were invited to submit bids in relation to making improvements to existing surgery buildings or the creation of new ones. In the first year it is anticipated that the money will predominantly accelerate schemes that were already in the pipeline, bringing benefits to patients more quickly. Practices were asked to set out proposals that would provide them with more capacity to do more; provide value for money; and improve access and services for the frail and elderly.

NHS England announced details of the next phase of the fund on 29 October 2015. https://www.england.nhs.uk/2015/10/29/primarycaretransfund/

2.7.2 Improvements at Medwyn Surgery, Dorking

One of the first GP practices in the South East to benefit from funding as part of the national GP Infrastructure Fund is Medwyn Surgery in Dorking.

The practice received funding of just over £56,500 from the fund, in addition to funding provided by the practice, to convert space in the building where the surgery is located into four additional consulting rooms, in order to help support the provision of care to the increased number of patients who have registered at the practice in recent years. One of the four rooms is being used by the surgery as a counselling room and the new suite of rooms at the practice opened at the beginning of September 2015.

3. Ensuring the quality of local primary care services

NHS England's vision is to see general practice play an even stronger role in supporting people to keep in good health, as part of a wider joined up system of local health services at the heart of local communities.

As such, it is vital that all GP practices provide the best possible care to all patients, to the highest standards.

Last year, the Care Quality Commission (CQC) began a programme of work to inspect and rate every GP practice in England. This helps ensure the appropriate checks are in place for GP practices, enabling us to make sure patient care is of a high quality and so any issues can be identified and addressed where improvements are required.

Under the new inspection process, the vast majority of local GP practices in Surrey that have been rated as providing a 'good' overall service to patients, with one practice receiving an overall rating of 'outstanding'.

Where a GP practice is rated inadequate this does not mean that it has to close.

Where a GP practice is rated inadequate and placed into special measures, NHS England will work with the local clinical commissioning group (CCG) to support the practice to make sure the necessary improvements are made to support the delivery of safe, high quality care to all patients.

We also work alongside any GP practices that are rated as requiring improvement and monitor their progress in making any necessary improvements for their patients

To date, the CQC has published findings of its inspections of the following Surrey GP services as part of the new inspection process:

CCG	Practice Name	Date of CQC inspection	Overall CQC Rating
Surrey Downs	Ashlea Medical Practice	14.07.2015	Good
Surrey Downs	Ashley Centre Surgery	20.11.2014	Good
Guildford & Waverley	Austen Rd Surgery	07/10/2014	Good
Guildford & Waverley	Chiddingfold Surgery	07/10/2014	Outstanding
Guildford & Waverley	Cranleigh Medical Practice	07.10.2014	Good
Guildford & Waverley	Dapdune House Surgery	07.10.2014	Good
Surrey Downs	Dorking Medical Practice	16.06.2015	Good
Guildford & Waverley	East Horsley Medical Practice	10.08.2015	Good
Surrey Downs	Fairfield Medical Centre	12.05.2015	Good
Guildford & Waverley	Fairlands Practice	31.10.2014	Good
Surrey Downs	Glenlyn Medical Centre	19.05.2015	Good
Guildford & Waverley	Guildford Rivers Practice	29.10.2014	Good
Surrey Downs	Heathcote Medical Centre	11.11.2014	Requires improvement
Surrey Downs	Littleton Surgery	26.11.2014	Requires improvement
Guildford & Waverley	New Inn Surgery	21.10.2014	Inadequate
Surrey Downs	Nork Clinic	14.04.2015	Good
Surrey Downs	Oxshott Medical Practice	11.11.2014	Good
North East Hants and Farnham	River Wey Medical Practice, Farnham	02.10.2014	Good
Surrey Downs	Riverbank Surgery	09.06.2015	Good

Guildford & Waverley	Shere Surgery	16.10.2014	Good
Surrey Downs	Spring Street Surgery	10.08.2015	Good
Surrey Downs	Tadworth Medical Centre	28.07.2015	Requires improvement
North East Hants and Farnham	The Ferns Medical Centre, Farnham	15.10.2014	Good
Surrey Downs	The Old Cottage Hospital (Integrated Care Partnership)	07.07.2015	Good
Guildford & Waverley	Wonersh Surgery	14.10.2014	Good
Surrey Downs	Molebridge Practice	26.08.2015	Inadequate

Copies of CQC reports for each practice are available on the CQC website at http://www.cqc.org.uk/ .

4. Changes to the General Medical Services (GMS) contract to improve patient care

In addition to the developments described above, a number of important changes to the General Medical Services (GMS) standard contract have been agreed between NHS Employers (acting on behalf of the Department of Health and NHS England) and the General Practitioners' Committee (acting on behalf of the BMA) to support improvements in patient care. These have taken effect from 2015/16 and include (but are not limited to) the following:

- a named, accountable GP for all patients (including children) who will take lead responsibility for the co-ordination of all appropriate services required under the contract

- Since 1 April 2015, it has been a contractual requirement for all practices to have a patient participation group (PPG) and to make reasonable efforts for this to be representative of the practice population (with funding to support this as part of the overall resources allocated to individual practices).

- assurance on out of hours service provision has been agreed to ensure that all service providers are delivering out of hours care in line with the National Quality Requirements (or any successor quality standards).

5. Conclusion

This paper describes just some of the work that is taking place both locally and nationally to ensure the ongoing development of sustainable GP services in Surrey.

NHS England will continue to work with local clinical commissioning groups, other partners, patients and the public in regards to the development of these services – to ensure that they meet the needs of our local communities, both now and in the future.

Title of report	GP Access
Name of Meeting	Wellbeing and Health Scrutiny Board
Date of Meeting	12th November 2015
Report Author	Leah Moss, Deputy Director of Clinical Commissioning

All CCGs have a statutory duty to support NHS England (NHSE) in discharging its duty so far as relating to securing continuous improvement in the quality of primary medical services. (NHS England is the commissioner of primary care including general medical, general dental, and community ophthalmology and community pharmaceutical services.)

GPs and practices are under unprecedented pressure. There are about 340 million consultations annually in general practice in England, an increase of 40 million per year from five years ago. This represents the single greatest rise in volume of care within any sector of the NHS. The increase has not been matched by an increase in GP numbers and staff, or by an expansion in infrastructure, against a background of falling or static resource.

There is now a large and increasing gulf between the workload demands on practices and their capacity to deliver essential services to their registered patients. GPs are being overwhelmed by rising workload, particularly from a growing ageing population with complex health needs. At the same time, there is an emerging workforce crisis with shortages of GPs leaving many practices unable to recruit doctors, and evidence that some experienced GPs are considering leaving general practice altogether. Government policy continues to move services into the community, placing yet more pressure on overstretched GP services struggling to provide enough appointments, with consequential delays to see a GP. Cuts in resources to individual practices via a nationally imposed funding review are exacerbating the problem for many.

In a recent British Medical Association (BMA) tracker survey, 74% of GPs described their workload as unmanageable or unsustainable – significantly higher than any other category of doctor. Both the Centre for Workforce Intelligence (CfWI) and Health Education England (HEE) workforce task groups have reported that the current workload demands on GP practices are unsustainable, given current GP workforce levels.

Q18. Overall experience of making an appointment Base: All		
	%	N
Very good	39	1251
Fairly good	39	1264
Neither good nor poor	13	414
Fairly poor	7	216
Very poor	2	73
Total		3218

In July 2014 Surrey Healthwatch published a report[1]: Getting an appointment with your GP: Experiences of the People of Surrey, containing views about primary care services and recommendations for improvement in a range of areas.

Having elicited comments from over 1,100 members of the public and groups, the report stated:

> *"**Prioritising Access:** People generally understand the importance of prioritising access to GP appointments according to need, but are frustrated at what they perceive to be inefficiencies and barriers within many GP appointment booking systems."*

Surrey Healthwatch made a number of recommendations and the CCG have in response to this established a Primary Care Co-Commissioning Group working in collaboration with NHS England Area Team to improve access and establish practice development plans that build on the good practice that already exists in the area and supports practices to redesign their systems to improve access, in its broadest meaning, for all.

A more recent G&W patient survey[2] reported in July this year, completed by 2435 patients of which 71% had seen or spoken to a GP in the last six months, included the following reported findings:

- 27% said it was very easy to get through to the surgery by phone 48% said fairly easy;
- 44% said receptionists were very helpful, 44% said they were fairly helpful;
- 84% of patients book appointments by phone 24% in person, 12% booked online;

[1] http://www.healthwatchsurrey.co.uk/sites/default/files/healthwatch_booking_a_gp_appointment_report_v6.pdf

[2] CCG report (July 2015 publication)

- 45% were aware that they could book appointments on line and 34% were aware that repeat prescriptions could be ordered online. 43% didn't know what on-line services were available;
- 72% of patients said that they were satisfied or fairly satisfied with the opening times and 69% said that opening times were convenient;
- Only 2% of patients said that extended opening hours would make it more convenient to see someone, the majority of patients stated that evenings – after 6.30 and Saturdays would be most convenient for them;
- 89% said that the experience was good and the majority would recommend their surgery to someone else.

This survey shows that the majority of patients surveyed were able to easily book an appointment and were happy with the service received. However more could be done to raise awareness of online resources and opening times could be extended beyond the current times for certain individuals. G&W CCG continue to work with NHS England to support NHS England's vision to see general practice play an even stronger role in supporting people to keep in good health, as part of a wider joined up system of local health services at the heart of local communities.

There are a range of factors that contribute to whether patients feel they have good access to general practice care, including practice location, opening times, ease of appointments and speed of access. Performance by access criteria is now part of the quality monitoring system for general practice, which is currently the responsibility of NHSE. This relates to access to primary care during core hours (8am to 6.30pm on Monday to Friday inclusive).

This paper briefs the Wellbeing and Health Scrutiny Board on how the CCG review access to general practice care, outlines initiatives in place to improve patient access to services and describes how the CCGs are supporting the provision of additional capacity in primary medical care.

Key elements

The CCG review patient and carer experience of health care services using a variety of sources.

- Feedback from patients and carers via NHS Choices, Patient Advice and Liaison Service (PALS), Patient Network Groups, Patient Participation Groups, Healthwatch and complaints received into the CCGs.
- The national GP survey undertaken twice a year by Ipsos MORI. (Also used by NHSE).

Convenient Access

Evidence suggests that the majority of patients want more convenient access to GP appointments.

All GP practices in Guildford and Waverley have the opportunity to deliver extended hour's access scheme (DES). The scheme requires practices to offer routine appointments at times outside of practices core contracted hours (08:00 to 18:30) to allow patients to attend the practice at a time when it is more convenient for them (e.g. at weekends, early mornings and evening). Currently, 14 of the 21 GP practices in Guildford and Waverley offer an extended hours service, meaning that 158,471 patients have access to a GP in the evening or on a Saturday morning.

It was clear from the survey that people would like to be able to book appointments in a variety of ways. As a result, available booking methods in practices have been looked at to ensure different ways of booking an appointment are available to meet the requirements of all patients.

The online booking service and SMS has been publicised and is an option for the majority of patients. Offering online booking as an option relieves pressure on telephone booking and is a viable option to improve access. Special provision is given to babies and young children, elderly patients and those with complex health needs. Same day and extended appointments for these patients are a seen as a priority.

A campaign to help patients get the most from their GP appointment will be promoted to raise awareness of current available services and what to expect. Patient Participation Groups (PPGs) made up of a group of volunteer patients and staff from the GP practices, have been encouraged to discuss the services on offer, and how improvements can be made for the benefit of patients and the practice.

Conclusion

Access to GP practices is considered an important aspect of good patient care; patients need to know they can access their health services at the point of need, using a variety of options. The CCG is committed to working with the primary care providers to establish accessible GP services as described in the Healthwatch Surrey report.

The CCG continues to develop alternative options that extend and improve access to population groups who may have experienced difficulty in accessing GP appointments.

Supporting GP Access in Surrey Heath

- Context
  - Everyone Counts: Planning for Patients 2014/15 to 2018/19" - requirement for Commissioners and Providers to work together to deliver 7 day services.
  - Public responses from the NHSE "Call for Action" initiative in 2013 included feedback on improving access to extended services across 7 days.
  - Integrated Care Team implementation 2015. Community, Mental Health and Social Care staff working in partnership in locality teams.
  - Encouraged all Practices to use EMIS which enables data sharing and potential link to community and other services in the future

NHS
Surrey Heath
Clinical Commissioning Group

National GP Experience Survey

	Surrey Heath CCG	National Average	NHS England South (SE)
Overall GP experience good	92%	85%	86%
Overall experience in getting an appointment good	80%	73%	74%
Satisfied with opening hours	75%	75%	72%

GP Extended Opening

- GP Practices funded to support Monday – Friday 8-8 opening (excluding Bank Holidays)
  - Extended core General Medical Services / Personal Medical Services contract to deliver additional 15 hours per day across Surrey Heath GP Practices
  - Additional GP, Practice Nurse and Health Care Assistant resource
  - Mix of individual practice based and collaborative cover
    - Formal Information Sharing Agreements set up and agreed across sites delivering the service in collaboration

GP Access

- In Quarter 1 2015/16 the extended hours resulted in an additional 1378 GP hours and 1397 Practice Nurse/Health Care Assistant hours made available to the Surrey Heath CCG population
- CCG offering funding to practices to open for 4 hours on Boxing Day and New Years Day.

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North East Hampshire and Farnham Vanguard:
working together for a healthy population

Wellbeing and Health Scrutiny Board
Date of meeting: 12 November 2015

Vanguard New Models of Care – Review of Community Beds Model in North East Hampshire and Farnham Clinical Commissioning Group

Purpose of the report: To describe the progress to date on North East Hampshire and Farnham Primary and Acute Care System Vanguard project to review its community beds model.

1. Introduction

1.1 North East Hampshire and Farnham are one of 50 sites across the country selected to pilot the new models of care as outlined by the NHS England Five Year Forward View, known as a Primary and Acute Care System Vanguard. The Vanguard programme is enabling health and social care professionals in North East Hampshire and Farnham to speed up plans to develop new ways of providing and commissioning health and care services with local people.

1.2 The Vanguard proposal is to introduce a fundamentally different model of service delivery, co-designed with local people. The new model is intended to:

- Redesign fragmented pathways of care;
- Reduce the number of people who are admitted to hospital – with particular focus on locally identified priorities of reducing the number of people who fall, and improving care for people with respiratory problems and heart disease;
- Eliminate delayed transfers of care, in particular by eradicating waits in hospital for assessment or for decisions about ongoing care needs, leading to a substantial reduction in the overall number of emergency bed days for North East Hampshire and Farnham patients at Frimley Park Hospital;
- Ensure that the mental as well as physical health needs of individuals are fully addressed at every stage of care pathways.

1.3 As part of this programme of work there is a project focused on reviewing the current community bed model in North East Hampshire and Farnham. The aim being to streamline and improve peoples' experiences and make best use of the beds and facilities we have to meet local needs.

1.4 The project includes Fleet and Farnham Community Hospital beds, residential and nursing care homes and hospice care.

2. Work underway

2.1 A clinical working group (CWG) has been formed to consider options for proposed new models of care for community beds. The CWG comprises of representatives from the League of Friends of Fleet and Farnham community hospitals, North East Hampshire and Farnham CCG, Hampshire and Surrey County Councils, Southern Health Foundation Trust and Virgin Care, Surrey and Borders Partnership, local GPs and Frimley Park Hospital.

2.2 The CWG have commissioned a clinical utilisation review (CUR) audit of all patients in both community hospitals, reablement beds in two local authority nursing homes in the area and Frimley Park Hospital.

The aim of the audit is to ascertain:

- The proportion of people whose admission could have been avoided if enhanced integrated community services had been in place;
- The proportion of people who could be cared for at a 'lower level of care' either in a community bed or at home by enhanced integrated community services;

The audit results are expected during November. The audit will only form one part of the information considered to determine next steps.

Timelines for this project are flexible to ensure wider engagement with the community and all partners across the health and care system. It is important that this project fits in with other work-streams ongoing within the Vanguard programme.

2.3 Engagement with the community and partners will continue over coming months to consider options.

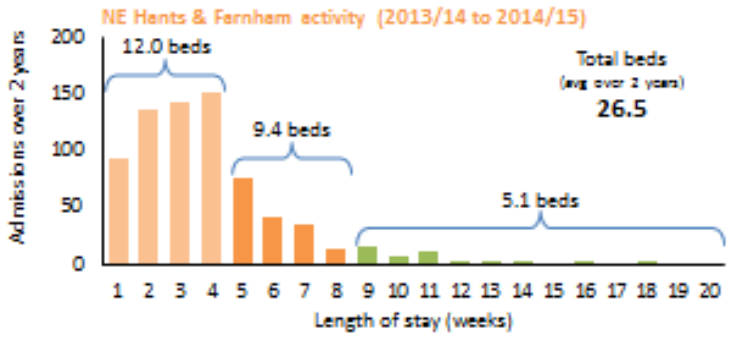
2.4 If deemed necessary during next year, a formal wider public consultation of changes will take place.

3. Information gathered to date

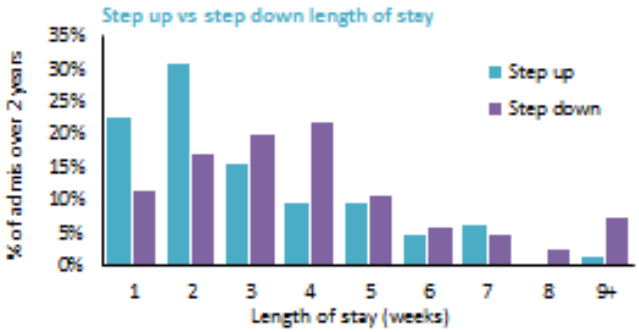
3.1 A detailed analysis of the data from the community hospitals shows certain findings:

3.2 The beds are mainly used for 'step down' purposes, meaning that people often use these beds after a stay in the acute hospital before they return home for their onward care as they require. Fewer people use the beds for 'step up' reasons to help avoid an acute admission to hospital.

3.3 When considering information about how long people stay in community beds over the last two years, the data suggests that approximately 13% of people stay for a week or less. Approximately 87% of people stay for 6 weeks or less and approximately 13% of people are in a community hospital bed for more than 6 weeks.



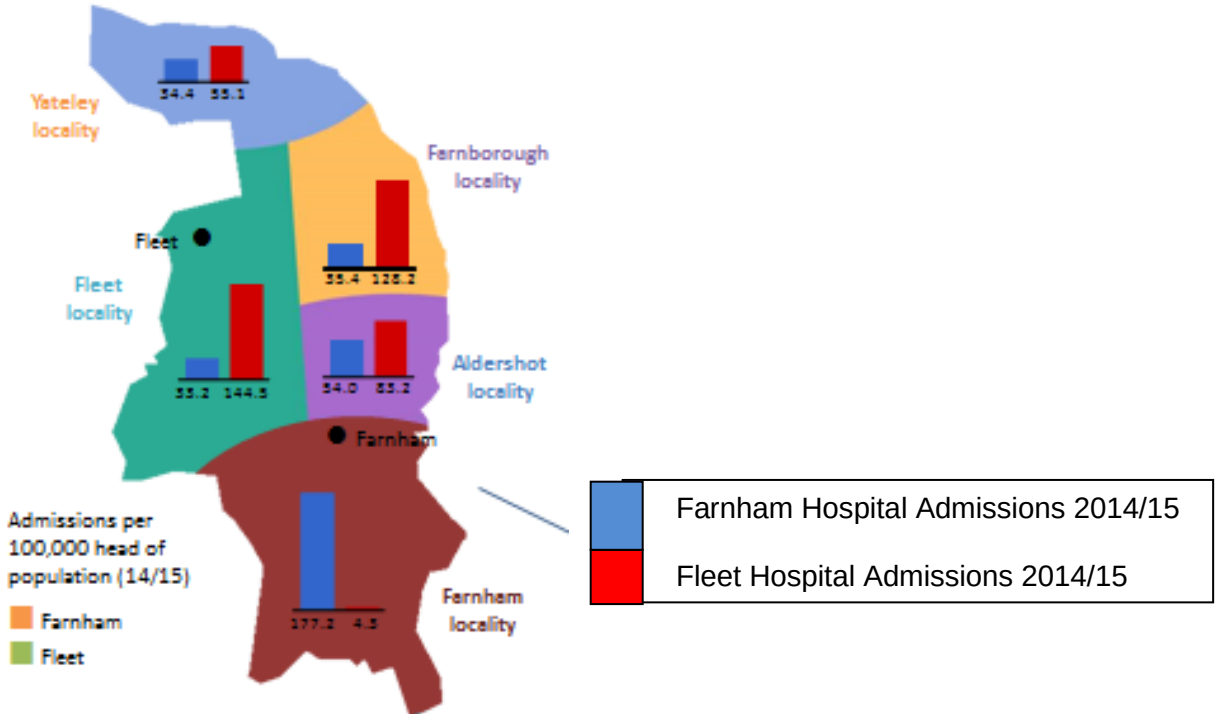
LoS (wks)	13/14 admis	14/15 admis	Total admis	Total (%)
1	43	51	94	12.7%
2	71	66	137	18.4%
3	80	64	144	19.4%
4	74	77	151	20.3%
5	41	36	77	10.4%
6	27	15	42	5.7%
7	19	16	35	4.7%
8	10	5	15	2.0%
9+	32	16	48	6.5%
Total	397	346	743	100.0%



LoS (wks)	13/14 admis	13/14 (%)	14/15 admis	14/15 (%)
1 to 4	268	67.5%	258	74.6%
5 to 8	97	24.4%	72	20.8%
9+	32	8.1%	16	4.6%
Total	397	100%	346	100%

LoS (wks)	13/14 Est beds	14/15 Est beds	13/14 to 14/15 Av beds
1 to 4	12.3	11.7	12.0
5 to 8	10.9	7.9	9.4
9+	6.9	3.3	5.1
Total	30.1	22.9	26.5

3.3 Both hospitals are mainly used but people living in the immediate vicinity of Fleet and Farnham hospitals:



3.4 Finally, some data suggests that the use of community beds does not lead to a reduction in the use of acute beds; there appears to be no correlation between the use of acute and community beds days per weighted head of population.

4. Conclusion

Further research and engagement is required to better understand how community beds in North East Hampshire and Farnham are currently being used to meet the needs to the local community. It is essential that this project links with the other work-streams ongoing in the Vanguard programme to ensure a joined up model of care for the future is developed with local people.

5. Public Health Impacts

As the work progresses and any options for the future develop, an Equality Impact Assessment and a Deprivation Impact assessment will be undertaken to analyse the effect these changes will have on local health of the population.

6. Recommendations

The Scrutiny Board notes the project.

7. Next steps

To develop and coproduce options for the new models of care through wider public engagement and with the other work-streams within the Vanguard programme.

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Wellbeing and Health Scrutiny Board
12 November 2015

Surrey Stroke Services Review Update

Purpose of the report: Scrutiny of Services

The six Surrey Clinical Commissioning Groups in partnership with people who have had a stroke and health & social care organisations are reviewing the current stroke services offered in the county.

Summary:

1. The leaders of the Stroke Services Review met with the Wellbeing and Health Scrutiny Board before its September 16 meeting to brief Members on the rationale for the review and the initial work that had been started.

2. The review work undertaken so far and the possible next steps will be reported in early November to a Committee in Common created to make decisions in Surrey. Following this meeting papers will be made available to the Scrutiny Board.

Recommendations:

3. The Scrutiny Board is asked to review the report from the Stroke Change Board once it is made available and agree its next steps at its November 12 meeting.

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Sources/background papers: Stroke Review – HOSC September 2015 Update

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Surrey Stroke Services Review

Commissioning next steps

October 2015

Effective commissioning of the whole pathway: the Surrey stroke services vision

Context

Following the publication of national guidelines and strategies, regions throughout England are reviewing whether stroke services meet the criteria for providing good stroke care. A review across Surrey is underway. Feedback has been sought from local people, clinicians, voluntary and community groups, an expert panel of national experts and other stakeholders. Data has been collected about the number of people using stroke services and the quality of the services provided.

The Review is being led by the Stroke Change Board, which is made up of general practitioners, clinicians and managers from the acute sector, representatives from community health services, service user and carer representatives, voluntary groups such as the Stroke Association, clinical commissioning groups (CCGs) and other interested parties. The group is chaired by Dr Claire Fuller, a GP and Acting Clinical Chief Officer of Surrey Downs CCG. Julia Ross, Chief Officer of North West Surrey CCG is the Senior Responsible Officer.

About 2,500 people in Surrey have a stroke each year. There are pockets of good practice and people are generally satisfied with the care they receive, particularly in the immediate acute phase. However the Review has found that services could be improved to provide even better care and to make sure that wherever in Surrey people live they have access to the same good quality care. Mortality rates are high in comparison to areas such as London that have streamlined their services, and commissioners and health service providers in Surrey want to ensure that Surrey residents have better outcomes.

With the support of local clinicians and national experts such as Tony Rudd and colleagues and considerable engagement from people using services, carers and the Stroke Association, the Stroke Change Board has compiled evidence about what comprises good stroke care. Alongside the South East Coast specification for stroke services, there is extensive evidence about what local people feel would improve care and what they would like to see in an improved pathway.

The Review has shown that it is important to consider the entire pathway of care, from prevention through to acute care through to recovery and rehabilitation in hospital and the community. Ongoing follow-up and support when people return home is a priority.

A summary of key information collected in the Review, and the processes used is provided in ‘The Story So Far.’

Planned next steps

At this stage in the Review, the Stroke Change Board believes that there is sufficient information regarding what 'good' care looks like and what a whole pathway of care should comprise for people suffering a stroke/TIA. The consensus is clear regarding high volume pathways, seven day working and the workforce required to deliver the benefits achieved in London and elsewhere.

The Stroke Change Board knows that elements of the current pathway in Surrey are disjointed, with delays and poor communication across acute and community care. To deliver changes across the pathway there needs to be an increase in workforce across all therapies, consultants and nursing care. All of the changes in delivery will require the Surrey stroke system to work together. Providers already offer a telemedicine network solution to increase OOH (out of hours) provision of thrombolysis, and greater integration will be required moving forwards to ensure the service specification can be delivered.

The Review suggests that HASU provision needs to be offered at three sites in Surrey to ensure appropriate volumes of activity and expertise. The data available regarding sustaining five ASU sites is more challenging, but suggests that there will not be the workforce available to support five sites. There are potential efficiency gains from co-location and reduced costs due to the need for reduced staffing, the ability to use beds flexibly, shorter length of stay and no repatriation costs.

For the whole pathway to work effectively community services need to be integrated and responsive. Community services in England achieving community SSNAP level A are integrated with acute care, have a push method for ESD (not a pull model) and their staff rotate between community and hospital.

Surrey commissioners wish to work with health systems to develop the best approaches for delivering the whole pathway of care. By 'health systems' we mean groups of acute, community and other providers working together across geographic areas. The plan is for commissioners to issue a Request for Proposals in January 2016, asking health systems to work together to plan how to achieve the outcomes required within a specified financial envelope (to be determined). The requirements would be clearly laid out regarding the 'must dos' for pathway delivery and an appropriate timescale agreed.

The system will be asked to develop around the three HASU sites (Frimley, St Peters/RSCH and SASH) and deliver the care pathway for the whole community in their 'system'.

Advantages of this approach are that:

- the system would be designed by those providing the care
- the whole pathway would be easier to performance manage and challenge
- the financial envelope would be clear, without the need for tariff disaggregation
- the public will be assured that any changes to stroke services are driven by clinicians
- an improved pathway may be delivered faster

However there are acknowledged challenges:

- the system may overstretch the available workforce to ensure local stroke provision
- the system may wish to continue with ASU-only sites for longer
- changes may not happen quickly enough
- providers may try to cut corners regarding workforce and not meet the requirements, for example of twice daily ward rounds and seven day working

To minimise these challenges, the commissioners plan to set out a specification for service. This already exists in the form of the South East Coast Stroke Service Specification, plus additional principles of what good care looks like gained from the Surrey Stroke Review (see appendices 1 and 2).

To this specification, the commissioners will add the conditions, criteria, outcomes and quality requirements to be achieved. This will include some of the important principles that the Stroke Review has established as important. Examples *may* include providing a fully integrated end-to-end pathway, greater emphasis on follow-up care in the community, six month reviews, preference for having a co-located model, achieving workforce standards, achieving SSNAP Level A within 18 months and so on.

The commissioners will set out the financial envelope available based on a capitated payment model and clarify how the risks will be managed. A model that shares the risk is likely to be proposed, but the specifics of this are not finalised.

Providers will be invited to work collaboratively to propose how they would deliver the requirements by working differently together. Where appropriate, an Alliance Contract or Lead Provider arrangement or similar could be considered.

The commissioners will engage in dialogue with the systems as they develop proposals, so aspects of the system are working together to focus on how to get the best outcomes for people affected by stroke.

This would be a dialogue process to establish most capable providers.

The commissioners will ensure the process meets Monitor's criteria by ensuring that competition between providers was encouraged, that the nature of benefit to people using services is highlighted and that the benefits could not feasibly have been achieved through other means (such as by providers acting independently).

Commissioners have engaged with the local authority (HOSC and Health and Wellbeing Board) throughout and have meetings scheduled to discuss the proposed way forward.

To be clear, if substantial variations to services are proposed, CCGs and providers may need to undertake some level of public consultation in due course. Extensive engagement has already been undertaken as part of the review, as outlined in the Story So Far. CCGs have a statutory duty to ensure people are informed of and invited to offer views about changes, and these views must be considered as part of the decision-making process.

The *Duty to involve service users in development of proposals*, contained at 13Q and 14Z2 HSCA 201 and associated guidance widen the scope for fulfilling the duty to consult to include providing the public with the information or using feedback gained during ongoing engagement activities rather than solely formal consultation routes. However, if there is a potential significant variation in acute services, some type of consultation or ongoing engagement may be required.

Rather than expanding into a full public consultation at this stage, the commissioners believe it is first better to have clarity about the exact service configuration being proposed. Instead of commissioners specifying the form this will take, the plan is for commissioners to specify the outcomes and constraints, and for systems to respond with solutions.

Table 1 lists the broad timeline.

Table 1: Potential timeline

Month	Key milestones
November 2015	Clinical Senate Review Legal review and risk assessment HOSC review Notification of providers of planned approach
December 2015	Finalise specification, financial envelope and other materials Incorporate initial feedback from Clinical Senate Committee in Common meeting to agree next steps
January 2016	Final Clinical Senate report Issue Request for Proposals Issue documentation relating to engagement in the Review
February 2016	Discussions with market
March 2016	Proposals received
April 2016	Evaluation
May 2016	Ongoing dialogue
June 2016	Confirmation of provider(s), scope and next steps
July 2016	Mobilisation which may include consultation

Support from Clinical Senate

South East Coast Clinical Senate has agreed to review some of the information collected as part of the Review and to provide feedback about the following question:

> **To what extent will Surrey's planned approach and materials give health systems the information they need to develop clinically robust stroke services across the pathway?**

The Review has drawn heavily on the advice provided by the South East Coast Clinical Senate to other areas regarding key issues to prioritise, gaps to fill and interdependencies. A South East Coast service specification is in existence and there is a clear steer from local people about priorities. Therefore the Stroke Change Board feel that it would add less value for Clinical Senate to repeat advice given to other areas or explore the clinical effectiveness and evidence-base of the specification. Instead, the Stroke Change Board believes that Clinical Senate could provide significant insight into whether the proposed approach and materials available to date (as documented in the Story So Far and embedded files) are sufficient to help health systems and teams to develop clinically robust services across the whole pathway of care.

It is important to note that Stroke Change Board acknowledge gaps in the information available to date. There is a lack of detailed information about the workforce or finances in community care, and the interfaces between hospital, community care and voluntary sector and primary care services. These are things that the Review team is currently actively pursuing. Details about preventive services are also being sought. More detailed financial information and benchmarking is due by the end of November 2015 and work is also underway to validate further SSNAP data. The Board would like Clinical Senate to bear in mind this ongoing work when commenting on the material.

Early in January 2016, commissioners plan to issue health systems with:

- the South East Coast service specification (appendix 1)
- additional outcomes that health systems are expected to fulfil (draft at appendix 2)
- background information (draft material in the 'Story So Far' which will be updated and revised in light of new information due over the next month)
- a request for health systems to develop strategies to meet the specification and outcomes (ie Request for Proposals and outline of dialogue approach)
- criteria against which health systems will be evaluated (draft at appendix 3)

The Board is interested to hear whether Clinical Senate feels this approach is appropriate and to receive any suggestions about the draft documentation, particularly in terms of how the information could be made more useful for health systems being asked to develop strategies for next steps.

Appendix 1
SEC Service Specification

Embedded here is the South East Coast Stroke Service Specification.

SE Stroke Service Specification.pdf

Appendix 2
Additions to the SEC Service Specification

Outputs to be delivered

The SESCN service specification is in the final stages of agreement and has received input from the Surrey stroke community. It is a comprehensive document describing the service to be delivered from acute presentation to community rehabilitation, six month reviews and beyond.

Commissioners are inviting health systems in Surrey to work collaboratively to design a system to deliver the optimum whole pathway of care for stroke. Systems will be asked to demonstrate how they will deliver all of the components below:

1. Delivery of the South East Coast service specification
2. SSNAP level A across the whole pathway and all domains within two years
3. Sustainable delivery of the national standards within SSNAP and the local SE SCN quality standards
4. Integration across the whole pathway including ESD and community care
5. Repatriation of specialist care that can safely be delivered within Surrey (including for example spasticity management and video fluoroscopy, but excluding thrombectomy)
6. Clear plans for linking with specialist care outside the area, such as thrombectomy
7. Sustainability and resilience regarding the workforce
8. Consistency and equity for the Surrey population
9. Demonstrate that the recommendations from the ‘expert panel’ who have supported the Surrey review, the SEC Clinical Senate, recommendations from Surrey redesign events with service users and clinicians, feedback from the RCP peer review and other evidence have been taken into account when designing the whole pathway of care
10. Delivery of services within a fixed financial envelope

Appendix 3
System assessment criteria

Health systems will submit proposals regarding how they will meet the SEC service specification for stroke and the additional criteria outlined in Appendix 1. Commissioners will assess these proposals based on criteria similar to those outlined below.

Note that these are DRAFT criteria. They are currently being refined. They are provided here as an example to show that a structured assessment process will be used. The criteria have been adapted by those used successfully within the Midlands. Tony Rudd has provided advice about their use and adaptation.

The criteria will be assessed by a panel including local commissioners, service user and carer representatives, the Stroke Association, representatives from the national stroke team and expert panel of clinicians.

General quality of service

	Description	Evidence
1.	Please provide a concise summary of clinical structure to support delivery of a high quality Hyper Acute Stroke Unit to promote continuous measurement and improvement of the HASU service.	A diagram outlining the clinical structure of the institution (and partnering institution) may be submitted if appropriate.
2.	Demonstrate all clinical services take responsibility for all aspects of data collection, keeping stroke register, and participating in national stroke audit (SSNAP) either directly of via upload of equivalent local data that enables comparison with regional and national peers)	Please provide details of your current rate of data entry to the SSNAP and your future arrangements to ensure 100% submission of data and how this would be used to monitor and feedback on clinical outcomes to Multi-Disciplinary Teams and individuals Evidence needs to demonstrate consideration across all three service areas (HASU/ASU and TIA) (Activity numbers will be provided for Trust to support the submission of evidence): Evidence of historical achievement of stroke targets to demonstrate good track record supporting the delivery of high quality care Evidence a sustainable system of coding for stroke patients is in place. Evidence of local guidance should be in place to support the collection of data between community and across service providers Evidence of accurate and explicit records of patients are recorded and shared using agreed protocols between all hospital, community and social care practitioners and individuals in a timely way

	Description	Evidence
3	Demonstration of a stroke management group to oversee service delivery and improvement review of performance standards, impact of new guidance and methods for improvement of service	Evidence of management group including TORs, minutes and action plans. Schedule of meetings
4	Please describe your approach to continuous quality improvement including, ensuring that the evidence base of clinical practice is reviewed and where necessary guidelines and protocols updated e.g. with NICE guidance, national and local audit reports etc. and how this contributes to delivery of QIPP and value for money.	Evidence of protocols to review clinical evidence including implementation of action plans Please describe your priorities and processes to review, update, implement and monitor practice of all relevant guidelines and protocols ensuring consistency and co-ordination between Trust and interface with other provider pathways. Evidence of length of time it takes to implement change IT/management infrastructure
5	Please describe how your systems for clinical risk management and investigation will be applied to Stroke services including reviews of morbidity and mortality and identification and investigation of adverse incidents using root cause analysis methodology. Please provide details of any complaints or material litigation i.e. previous, pending or threatened litigation or other legal proceedings, relating to stroke service. This statement should include any remedial steps subsequently taken	Please provide information on of any complaints and quality issues including SI or never event RCA's regarding stroke services for 2012/13 & and 2013/14., Data should be not be patient identifiable Number of complaints/RCA's and summary of complaints including action plan and lesson learnt SSNAP Mortality figures 2014/15 mortality figures (available from Autumn/Winter 2014)
6	A Quality Account. □ Any external reviews that may have taken place from outside organisations such as CQC, Patient Experience, Royal Colleges, HEE. □ A National Clinical Audit and Patient Outcomes Programme (NCAPOP) report.	Evidence of reviews and reports
7	Please provide details of how your standard policies on Infection Control, HCAI's, Management of Clinical Waste, Medicines Management, Data Handling, Dignity Privacy and Confidentiality of service users and other relevant policies, will be applied to the services described in the specification.	Evidence of polices and application Evidence of local audits

	Description	Evidence
8	Please describe how staffs are trained to assess the needs for end of life care including discussions with relatives. (Specification	Evidence of training Evidence of pathway
9	Please provide your proposal high level overview of your plans to ensure that patient records and patient information are accessible at Hub & Spoke sites if part of proposal	Current information protocols and proposal of future plan to ensure seamless care across Trust and out of area pathways
10	Please describe arrangement for evaluation of implementation phase to ensure that there is a clear plan to evaluate the new service for all sections	Evaluation process

Clinical quality

	Description	Evidence
1.	Please define your current stroke management patient pathway form ambulance handover to assessment and admission	Basic pathway for the management of stroke patients highlighting where patients are seen and if there are any joined up pathways
2.	Provide evidence that the service has a pre-alert pathway and process for transferring stroke patients form A+E to HASU	Ambulance protocol for FAST track Evidence of protocol to manage pre-alert Evidence of clear pathways between A+E and acute care
3	A radiology service responsible for the following: CT scanning 24/7 CT reporting by radiology/stroke consultant 24/7 A contingency plan for scanner breakdown	Evidence of access Evidence of protocols (including prioritisation) Evidence of reporting of scans by radiology/stroke consultant 24/7 Rota as evidence for CT scanning and reporting Evidence of CT interpretation skills
4	Thrombolysis pathway	Evidence of effective pathway
5	Evidence of appropriately trained staff in assessment and administration of thrombolysis	Rota to demonstrate 24/7 care Training records to demonstrate competency Evidence of identified clinical lead (i.e one A+E and one radiology) Evidence of A+E staff training/knowledge of pathway
6	Evidence of 24/7 availability of appropriately trained staff in assessment of suspected stroke patients for thrombolysis tx	Evidence of training and rota to support availability Evidence of achievement of target e.g SSNAP Rota to demonstrate 24/7 on-site availability of staff trained in assessment of suspected stroke who are ineligible for thrombolysis Training records to demonstrate competency
7	Evidence of provision of 24/7 consultant cover provided by at least 6 consultants on a rota able to make thrombolysis and hyper-acute treatment decisions	Evidence of trained staff and 24/7 rota to support access to thrombolysis and tx decisions

	Description	Evidence
8	Evidence of daily assessment of all TIA pts by stroke team Anticipated throughput high/low risk TIA admissions per year	Evidence of training and rota to support availability Activity levels for high and low risk admissions Assumption on activity for increased levels of HASU activity Evidence of referral to 24/7 access for high risk patients and 7 days for low risk patients
9	Protocol to manage HASU bed capacity to ensure is accessible and pts are transferred as quickly as possible and patients are stepped down to ASU as appropriate	Bed capacity protocol Evidence of management of system pressures while protecting HASU beds
10	Evidence of time of senior review after admission	Evidence of rotas SSNAP data
11	Urgent access to essential investigations e.g echo etc	Access to investigations and waiting times
12	Evidence of consultant led HASU team to meet the requirements of the service volumes the trust is offering to provide	Evidence of rota outlining ward schedules
13	Evidence of consultant 7 day ward rounds for HASU and ASU – twice daily	Evidence of rotas to support
14	Proposals to support arrangement for timely repatriation to appropriate local stroke unit if required	Protocol for transfer – if required to ASU or community bed
15	Evidence of sharing information between HASU and ASU if not co-located	Evidence of information sharing protocols – notes/scans etc
16	Clear access to tertiary centres	Protocols and pathways in place and waiting times to transfer available
17	Access to brain imaging (MRI and CT), carotid imaging (including ultrasound, MRA, CTA) CEA should be undertaken as soon as possible and within 7 days of symptoms	Pathways for the specific investigations Evidence of protocols for acces Waiting times
18	100% of appropriate patients to receive continuous physiological monitoring by trained staff as per the service specification	Protocols in place Training records available
19	Evidence of timely discharge from ASU site with appropriate packages	Evidence of audit plans
20	Achievement of SSNAP level A across all domains (acute and community)	SSNAP data

ASU criteria

	Description	Evidence
1.	Plan to support timely admission and discharge from HASU > ASU > home	Proposed pathways
2.	A radiology service responsible for provision of the following: CT scanning and reporting MRI reporting Ultrasonic angiography	Details of on-site service availability Protocols and access times
3	Evidence of 7 day consultant ward rounds	Named lead clinics and and remit Details of availability of staff to deliver these services
4	Evidence of MDT working	Details of meetings and MDT
5	Availability of supporting services e.g orthoptics, podiatry, orthotics, dietetics	Protocols and waiting times
6	Availability of rehab facilities e.g access to physio gym, OT kitchen, SALT equipment	Details of availability
7	Evidence of effective referrals to ESD for 40% of stroke patients	Activity levels Response times SSNAP data
8	Evidence of effective pathways for non ESD patients (CNRT)	Activity levels Response times
9	Evidence that patients not requiring therapies can still access nursing advice and psychological support if required	Activity levels for non-therapy patients
10	Plan for management of average LOS	Current LOS and plans to improve
11	Information sharing	Protocols in place and evidence available: GP Stroke Association support worker Community teams
12	Evidence of consultant led ASU team including dedicated junior medical team trained in stroke	Evidence of cover and junior doctor complement
13	SSNAP action plan to be developed to ensure that any domain not achieving SSNAP A has an action for improvement	Action plan developed
14	Evidence of the use of outcome measures e.g Rankin score	Evidence of use of rankin scores
15	Evidence of a protocol to initiate suitable secondary prevention measures in all appropriate patients	Evidence of protocols
16	ASU has support to all appropriate diagnostics	Evidence of pathways

TIA

	Description	Evidence
1.	Provide a concise summary of clinical structure to support delivery of a high quality TIA service	A diagram outlining the structure may be submitted
2.	If developing hub and spoke model – provide evidence of your plans to ensure that patient records and patient information are accessible at hub and spoke sites	Current information protocols and proposal for future plans
3	Evidence of pathways to support identification of TIA as per the service specification	Evidence of pathways and protocols
4	Evidence of 7 day outpatient high risk TIA clinics – inc. collaborative working assumption to enure services can be maintained	Rotas for 7 day working
5	Information on internal audit data collection	Activity and response times
6	Evidence of TIA patients receiving secondary prevention	
7	Evidence of information sharing with GP	
8	Evidence of patients satisfaction across whole pathway of care	Patient experience

ESD onwards

	Description	Evidence
1	Describe how the community pathway will be delivered for all patients leaving the stroke unit including ESD, non-ESD, community bed based care referrals and patients transferred directly to care homes	Detailed description of whole pathway of care: Description must include all clinical quality markers to be delivered

Workforce criteria

	Description	Evidence
1	Evidence and completion of leadership training for key members of the stroke team to support stroke service improvement Evidence of appropriate training offered to stroke clinical team Provision of and attendance at MDT stroke training governance programme	What is the training plan for the clinical team and how many days are allocated to training needs Evidence of appropriate training offered Evidence of study leave Evidence of provision of structure training plan for new and rotational staff Evidence of annual appraisal Evidence of completion of mandatory training
2	Detail the workforce as required to deliver the service specification and outcomes required and where there are gaps what are the plans to support delivery Demonstrate approaches to support the pathway delivery, such as band 4 in-reach support workers for ESD, rotational posts with the community and use of A+E/Elderly care/neurology consultants to support the national stroke consultant gaps	To be evidenced by increasing activity levels and as per the specification across the HASU/ASU , ESD and community care Specifically including numbers of WTE's per health professional
3	Describe how the system will work collaboratively to deliver the whole pathway	Integration with acute and community care demonstrated Close working with social services and the voluntary sector Mentorship policies Evidence of collaborative plans
4	Describe your proposals for HR and employment arrangements for staff	Evidence of current workforce gaps and plans to address vacancies Evidence for plans to increase activity volumes Evidence of collaborative working with the whole 'system'
5	Describe how the service will participate in research for stroke	Evidence of involvement in research
6	Describe how the system will respond to the potential growth in thrombectomy	Clear plans for increased activity Evidence of discussion with St George's for tertiary referrals
7	Describe how the system will work to maximise recruitment and retention across all disciplines	Evidence of workforce plan Links with HEE evident
8	Describe how the voluntary services will be linked in to provide stroke care	

Deliverability

	Description	Evidence
1	Submit a detailed mobilisation plan of all actions to be taken during mobilisation – for the whole system including the development of a stroke network	Plan
2	Provide evidence that the trust can support the following activity per annum XXXX stroke admissions XXXX TIA admissions XXXX Stroke mimic admissions And the ESD teams can increase by X numbers/yr	
3	Provide evidence of proposed bed capacity for HASU/ASU care and for community bed based care (if required)	
4	Provide details of any infrastructure developments that may be required to deliver the xxxx activity volumes and any interdependencies with other projects such as urgent care	High level summary to support activity levels predicted including costs
5	Provide detail on the care of mimic patients	Evidence of protocol
6	Provide a contingency plan to support a sustainable service	Draft plan
7	Describe your service proposals strengths – for the whole pathway of care	
8	Describe the key challenges and areas in need of development to deliver the whole pathway of care	

Improved strategic fit

	Description	Evidence
1	Evidence of an effective system wide response, And that this has been considered alongside the other 2 stroke 'systems' in Surrey	Evidence that the proposal was jointly developed with the community teams
2	Demonstrate an understanding of the impact on other services and inter-dependencies	Evidence to support increased activity
3	Demonstrate that all the work of the stroke review including the expert panel event has been taken into account when designing the local system	Evidence of the stroke review

Costs

	Description	Evidence
1	Demonstrate an effective business case based on the financial envelope provided to provide the whole pathway of care	Concise business plan Any economies of scale demonstrated Capital costs to be included
2	Evidence of sustainable operational processes to support the most cost effective service delivery: Activity v workforce Throughput of bed capacity Reduction in readmission of stroke Evidence of pooled resource has been considered	

Access

	Description	Evidence
1	Please describe current and future plans to ensure the stroke service delivers optimum patient experience and outcomes, Ensuring patients and their carers are informed throughout the care pathway on a regular basis	Provide evidence of any stroke specific patient satisfaction services used to monitor and improve quality of services Evidence that 100% of appropriate patients and carers receive high quality information and care plans
2	Describe the process of involving patients in the re-design of stroke services for your stroke 'system'	Evidence that local patients have been involved in the discussions and their feedback is represented
3	Please demonstrate that the system review has assessed the proposal to ensure there are no negative impacts on the proposed service on people who have protected characteristics (as listed in the Equality Act)	Evidence of an equality impact assessment Evidence of any action plans arising from this Evidence that patient leaflets will be available in different languages
4	Formal links exist with patient and carer organisations such as the stroke association	Evidence that all relevant local stroke groups have fed into the proposal and appropriate pathways in place, including voluntary organisations such as: TALK Dyscover Connect
5	Please provide details of how you will ensure education of service users presenting with conditions that can be self-managed and referral to health promotion and lifestyle services	Evidence of health promotion
6	Availability of car parking for HASU sites	Describe how an increase in activity will be managed
7	Provide an outline communications plans	Communication plan

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Wellbeing and Health Scrutiny Board
12 November 2015

Recommendations Tracker and Forward Work Programme

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

The Board 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 Board is asked to review progress on the items listed.

2. The Work Programme for 2015/16 is attached at **Annex 2.** The Board is asked to note its contents and make any relevant comments.

Recommendations:

3. The Board 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

WELLBEING AND HEALTH SCRUTINY BOARD
ACTIONS AND RECOMMENDATIONS TRACKER – UPDATED NOVEMBER 2015

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.

Scrutiny Board Actions & Recommendations

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SCO66	Patient Transport Service Update	The Committee requests that, along with Healthwatch and user-groups, it is included in the re-tendering of the patient transport service contract in 2015. This is to include the service specification and complaint-handling procedures.	NW Surrey CCG MRG	Karen Randolph is part of the Patient Advisory Group working on this project.	*September 2015*
SCO68	Better Care Fund Locality Hubs	That the Committee reviews the financial and quality outcomes of the three locality hubs throughout 2015 and 2016. Mr Tim Evans, Rachael I Lake and Borough Councillor Karen Randolph to take part in stakeholder engagement with North West Surrey CCG and report back to the Committee as appropriate.	Head of Communications and Engagement, NW Surrey CCG		*2016*
SCO70	The Healthy Child Programme in Surrey including Health Visiting and School Nurses [16/15]	The Committee requests that Public Health share information collected by the present commissioner – NHS England – on the current performance of Health Visiting in Surrey; and	Public Health Principal	Circulated	*Complete*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
		The Committee recommends that it receive a further report from Public Health on performance, benchmark data and Surrey specific targets in 2014/15 in this area and the commissioning plans for the complete 0-19 service at its November meeting.		Scheduled now for January to accommodate priority items	*January 2015*
SCO71	Epsom and St. Helier University Hospitals NHS Trust [6/15]	1. The Board supports the Trust's investigation into future estate strategy and recommends that it emphasises the improvements it can make to its services and its wider contribution to the management of the total health system finances and; 2. That the Board is involved as part of future public engagement on this issue.	ESTH Chief Executive		
SC072	Surrey Downs CCG Community Hospital Review [Item 8]	Approves of the review process undertaken by Surrey Downs CCG. Requests that it continue to be involved with the review process by scrutinising the CCG's public consultation plans through a sub-group of Members - Tim Hall, Lucy Botting, Karen Randolph and Tina Mountain	Head of Communications and Engagement		

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SC073	Update from Surrey's Health and Wellbeing Board	The Board recommends that: It receives a further update from the Health and Wellbeing Board on the progress against its strategic priorities and any possible changes to how it operates in 12 months time. The Co-Chairs discuss with the Director of Public Health how the Health and Wellbeing Board can strengthen the focus on the wider determinants of health in CCG prevention plans.	Scrutiny Officer Co-Chairs of HWB		*September 2016*

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Wellbeing and Health Scrutiny Board Work Programme 2015-2016 **ANNEX 2**

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
November 2015				
12 Nov	Access to Primary Care	Scrutiny of Services – Following the investigation of the Board's GP Access Task Group Commissioners will be asked to discuss with the Board how the situation can be improved in the future.	Sarah McDonald, Director of Commissioning NHS England South Dominic Wrigh, Chief Executive, G&W CCG	
12 Nov	Surrey Stroke Review	Scrutiny of Services – a countywide review of the stroke pathway is underway and the review leaders will present the work undertaken thus far and the next steps for the review	Julia Ross, NW Surrey CCG Claire Fuller, SD CCG	
12 Nov	Community Bed Review	Scrutiny of Services – NE Hants & Farnham CCG along with its system partners in Surrey and Hampshire is beginning a review of its community beds and wishes to brief the Board on the scope and purpose of this work	Francesca White, Vanguard Project Manager NE Hants CCG Jean Boddy, Area Director	

Wellbeing and Health Scrutiny Board Work Programme 2015-2016 **ANNEX 2**

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
January 2016				
7 Jan	Working Together – Integration of Health and Social Care	Scrutiny of Services – the Board will consider the progress made by the Working Together Pubic Service Transformation Programme on health and social care integration		
7 Jan	Surrey Community Services Procurement	Scrutiny of Services – The Board will receive a report on the planned procurement of community health services including timelines.	Julia Ross, NW Surrey CCG	
7 Jan	Children's Mental Health	Scrutiny of Services – the Board will consider the current performance of the Child and Adolescent Mental Health Service in Surrey, the plans for its future and the transformation of children's mental health more broadly	Sheila Jones, Head of Countywide Services Ian Banner, Children's Commissioning Sarah Parker and Diane McCormack, Guildford and Waverley CCG	
7 Jan	Public Health 0-19 Commissioning	Scrutiny of Services – it was recommended that the Board receive a further report from Public Health on performance, benchmark data and Surrey specific targets in 2014/15 in this area and the commissioning plans for the complete 0-19 service at a future meeting.	Harriet Derrett-Smith, Public Health Principal	

Wellbeing and Health Scrutiny Board Work Programme 2015-2016 **ANNEX 2**

Task and Working Groups

Better Care Fund (Joint with Adult Social Care)	Bill Chapman, Tina Mountain, *Vacancy*	To monitor and scrutinise the plans and investment in services in terms of impact and risk for existing services in Surrey and patients.	Quarterly
GP Access Task Group	Ben Carasco, Karen Randolph, Tim Evans, Tim Hall	Working together with partners in the NHS Surrey and Sussex Area Team and Healthwatch Surrey, this group aims to gather evidence on the availability of appointments, the barriers to improved access and to offer solutions and support in improving availability for residents.	March 2015
CCG Reference Groups	All Members	To liaise with CCGs and monitor activity and plans across the county, and provide patient and public voice where appropriate.	As appropriate

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