MINUTES of the meeting of the **WELLBEING AND HEALTH SCRUTINY BOARD** held at 10.30 am on 13 March 2017 at Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting on Friday, 14 July 2017.

Elected Members:

* Present

*	Mr W D Barker OBE
*	Mr Ben Carasco (Vice-Chairman)
*	Mr Bill Chapman (Chairman)
*	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

Ex officio Members:

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

Co-opted Members:

*	Borough Councillor Tony Axelrod
*	Borough Councillor Darryl Ratiram
*	District Councillor Patricia Wiltshire

11/17 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Peter Hickman and Chris Pitt. There were no substitutions.

12/17 MINUTES OF THE PREVIOUS MEETING: 17 FEBRUARY 2017 [Item 2]

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

13/17 DECLARATIONS OF INTEREST [Item 3]

There were no declarations of interests made.

14/17 QUESTIONS AND PETITIONS [Item 4]

There were no questions or petitions submitted to the Board.

15/17 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 5]

The Board reviewed the recommendations tracker. There were no comments.

The Chairman informed the Board that item 7 on the agenda, sexual health integrated services, had been deferred at the request of the Strategic Director for Adult Social Care & Public Health due to sensitive ongoing contract negotiations. The Chairman assured the Board that Members would be informed of the outcomes upon completion of the negotiations, and that the item would be placed on the forward work programme for scrutiny by the Board post election. The Chairman stated that despite the uncertainty surrounding the contract, service provision would be in place from 1 April 2017 in line with the original mobilisation date of the new contract.

16/17 A&E WINTER PRESSURES [Item 6]

Declarations of interest:

None

Witnesses:

Daniel Elkeles, Chief Executive, Epsom & St Helier University Hospitals NHS Trust
Caroline Landon, Chief Operating Officer, Epsom & St Helier University Hospitals NHS Trust
Jim Davey, Director of Service Development, Surrey & Sussex Healthcare NHS Trust
Giles Mahoney, Director of Strategy & Partnerships, Royal Surrey County Hospital NHS Foundation Trust
Dr Jonathan Robin, Divisional Director for Acute Medicine & Emergency Services, Ashford & St Peter's Hospitals NHS Foundation Trust
Karen Thorburn, Director of System Redesign, North West Surrey CCG.
Kate Scribbens, Chief Executive, Healthwatch Surrey.

Key points raised during the discussion:

1. The Chairman began by informing Members and witnesses that two additional documents had been prepared by officers; a comparison of 2015/16 and 2016/17 Quarter 3 (October-December) A&E data by Trust and a tabular comparison of Trust responses to the letter sent by the Chairman in January 2017. These documents are attached to these minutes at annex 1. The Chairman invited each Trust to speak of their performance over the winter period. A response from Frimley Health is attached at annex 2.

Ashford & St Peter's Hospitals NHS Foundation Trust

2. The Director of System Redesign at North West Surrey CCG explained that she was the Chair of the Local A&E Delivery Board (LAEDB) and that its purpose was to work with all system partners in order to own their performance and hold partners to account to deliver the 4-hour standard and a resilient system. It was explained that

North West Surrey system partners, including Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH), had analysed performance from the previous two winters and developed a planning and preparation process with a prepared escalation procedure. Alongside a live data system, desktop planning exercises were used to test resilience and support early discharge.

3. Members were informed that the data presented in the Q3 document for ASPH was not accurate as it was data for St Peter's Hospital only and not the combined data for the Trust. The Director of System Redesign informed the Board that the Trust's Q3 4-hour standard result was 90.7%, an improvement on the previous years' result despite increased demand and attendance.

4. The Board was informed that ASPH saw an additional 9 ambulance attendances per day over the Christmas period compared to 2015/16. The LAEDB was currently preparing for the anticipated surges of demand experienced over the Easter period. Members noted that the CCG had invested in additional GP cover and a weekend X-ray service at community hospitals. The witness also explained that patient flow had been sustained through additional funding to provide Adult Social Care packages via Alpenbest to support discharges over the Christmas period.

5. The Director of Acute Medicine explained that the Trust had declared Opel 3, signifying major pressures which were compromising patient flow, twice since January 2017 however the system response to this escalation on both occasions had demonstrated sound resilience.

6. Members enquired whether the 4-hour standard was for a patient to be triaged or for patients to see a doctor. The Director of Acute Medicine explained that the 4-hour standard was from the point of booking into the A&E system until being seen by a doctor. It was explained that the aim was to get patients to see a doctor within one hour of arrival. Furthermore, Members were informed that most instances where the 4-hour standard was surpassed, this was not patients waiting to see a doctor, but instead, patients waiting for a bed due to the lack of availability.

7. Members suggested that the co-location of GPs on site could reduce the number of attendances to A&E. The Director of Acute Medicine explained that this had been considered, however it was difficult to find suitably qualified GPs who, due to demand could commit to such a scheme. Members were informed that local GPs were supportive of the concept but were reluctant to participate as they were already at full capacity within their own practices. The witness went on to explain that locum doctors had been considered however the Trust was of the view that this was an expensive option and did not represent value for money. Furthermore, he explained that the Trust had set up an urgent care centre where highly skilled care professionals were able to see people and advise them according to their symptoms.

8. The witness suggested that increased out of hours GP provision could potentially reduce the number of attendances at A&E departments but this would not guarantee a decrease in the number of admissions.

The Director of System Redesign explained that North West Surrey CCG had a high number of walk-in centres who see up to 200 patients a day with a low rate of patients seen requiring referral to the acute. In North West Surrey, there were 10 GP practices that were currently offering an extended hours service under a national contract thus providing improved access to appointments. This was in addition to the development of the Bedser hub in Woking, providing proactive and reactive care to the over 65s in partnership with the Trust, Primary Care, Surrey and Borders, Virgin Care, Adult Social Care and the voluntary sector. Members acknowledged that work was aligned across the Surrey Heartlands STP footprint to develop and deliver services and improve patient flow.

9. Members enquired about the process following an ambulance arriving at A&E. The partners explained that upon arrival, the patient would be booked in, triaged and seen by an A&E doctor for an investigation. The doctor would then refer the patient to the relevant teams who would decide whether it was necessary to admit the patient. The witnesses explained that when ambulances arrive and beds are not available, this leads to queues of patients waiting on trolleys until beds become available.

Royal Surrey County Hospital NHS Foundation Trust

10. The Director of Strategy & Partnerships at the Royal Surrey County Hospital NHS Foundation Trust (RSCH) explained that the Trust's performance against the 4-hour standard was disappointing, however it was the view of the system that this was due to a lack of preparedness than in previous years. The Trust was confident that it would learn from its 2016/17 performance and with the implementation of some reactive measures, the dip in performance would be improved for 2017/18.

11. Members were informed that the current results for Q4 were looking strong following the implementation of some reactive responses. Members acknowledged that RSCH had invested approximately £1.4million in order to increase GP provision at weekends and to increase capacity by 18 additional beds until the end of March 2017. Patient flow had been managed by some physical moves within the hospital, and the earlier opening time of the discharge lounge now allowed for beds to be freed up earlier in the day, thus improving patient flow.

12. The witness explained that a streaming nurse had been strategically positioned to ensure patient flow was managed and to avoid ambulance stacking. This, combined with 18 additional beds had made a significant improvement to bed availability.

13. Members were informed that the Trust was looking to invest heavily in the A&E department by the end of the calendar year, as well as investing into the community system to support out of hospital care.

14. The witness explained that the Trust was looking to work with neighbouring partners and that they had been to visit Epsom & St

Helier Hospitals to understand more about their Epsom Health & Care model in order to learn from their best practises.

Surrey and Sussex Healthcare NHS Trust

15. The Director of Service Development began by informing the Board that the Trust was currently testing their resilience plan for the second time this winter. The plan was tested at regular intervals to address blockages within the system and shortages as well as assessing quality, performance and outcomes.

16. The witness explained that Surrey and Sussex Healthcare NHS Trust (SASH) had implemented GP cover from 10am until 8pm seven days a week, and the Trust was of the view that this had made a significant difference to patients. Members acknowledged that GPs were able to assess patients as well as educate them regarding the alternatives to A&E which they felt was important in order to divert unnecessary attendances.

17. The Board was informed that the Trust had set up a Frailty Unit with six trolleys for patients over the age of 76 which was accessible by GP referral, saving the elderly population needing to go through the A&E system. In addition, there was an Ambulatory Care Unit with a larger therapy offer, providing same-day turnaround care and addressing social and health issues.

18. The Director of Service Development explained that the Trust's year to date performance to the 4-hour standard was at 94%. The Trust welcomed the announcement of additional government funding into adult social care, given the high level of packages of care required which would reduce the delays of discharge.

19. Members enquired about the length of wait experienced by the ambulances upon arrival at the hospital. The witness explained that, on average, the Trust would receive 300 attendances a day, 100 of which would be ambulance arrivals. The Director of Service Development indicated that no more than one ambulance per day had to wait for more than an hour. The witness explained that fines were imposed on Trusts for delayed ambulance intake, so it was in their best interests to manage them, and they had turnaround nurses in place to support the patient flow process.

20. Members noted that the Trust had pharmacists on wards in order to improve the dispensation process and reduce delays to people upon discharge. The witness explained that they also had a Boots the Chemist on site in order to speed up the process upon discharge. The witness explained that every pharmacist has a formulary list of all the drugs stocked at the site and that it was rare for a patient to be prescribed something that was not on the formulary.

21. The witness explained that the Trust conducted a patient satisfaction survey and there was a feedback section on their website, and that they were committed to responding to all comments, positive or negative. The partner informed the Board that as part of a recent

audit, one of the key questions asked was “why did you come to A&E?” and the most common response was “lack of GP availability”.

22. The Director of Service Development explained that the East Surrey Hospital site had seen an increase of attendance at A&E due to the ongoing redevelopment of the Royal Sussex County Hospital in Brighton. GPs had also been referring patients to East Surrey Hospital for elective surgery and the hospital was currently in dialogue with colleagues in Brighton in order to manage these additional pressures.

Epsom & St Helier University Hospitals NHS Trust

23. The Chief Executive of Epsom & St Helier University Hospitals NHS Trust (ESTH) explained that the Trust was currently performing ahead of the 4-hour standard target at 95.15% year to date. The Board was informed that last year, having missed target for five months in a row, the Trust redesigned the care pathway by applying business thinking to hospital practises.

24. The Board acknowledged that the Trust had set up an integrated care model, Epsom Health & Care, which involved 20 GP practises in Epsom, along with Central Surrey Health as community provider and this council, with a view to providing alternatives to hospital care. The model focused on reducing inpatient stay and had so far reduced length of stays by a day.

25. The Chief Executive of ESTH informed the Board that out of 1000 patients, only 11 experienced delayed discharge and this was usually down to the arrangements surrounding continuing care packages.

26. The Board was informed that as part of planning for the anticipated surge of demand over the upcoming Easter Bank Holiday weekend, the Trust were looking to run the Bank Holiday Monday as if it was a normal working day with a view of analysing how this staffing concept could benefit the Trust going forward.

27. The Chief Executive of ESTH explained that whilst it had previously been difficult to recruit and retain workforce, it was hoped that the positive results delivered by the Trust would allow for a successful upcoming recruitment drive to attract more candidates for vacant consultant roles.

28. The Board noted that the focus of the redesign of the patient flow had enabled a view to be taken in the middle of the day regarding bed availability, allowing for actions to be taken to improve this the same day.

29. The Chief Executive of ESTH explained that multi-disciplinary team meetings were held on wards every day to discuss every patients current care programme and their next steps were noted on a whiteboard. Whilst this could be seen to be a laborious administrative task, it allowed for attention to detail to be given to every patient and for informed decisions to be made regarding their ongoing care needs.

30. Members were informed that the Medically Fit for Discharge ward was for patients for whom the hospital had done all they could do, and their ongoing rehabilitation was dependant on receiving continued care out of hospital. The Chief Executive explained that prior to the creation of this ward, patients at this stage of care were dotted around the hospital dependant on where beds were available, leading to an un-coordinated view on how to appropriately manage the discharge of these complex patients. The Chief Executive of ESTH explained that the Medically Fit for Discharge ward had made a positive impact on reducing length of patient stays and it had been particularly successful at their St Helier site, where the ward was run by GPs and managed by a therapist.

31. The Board was informed that ESTH had a block contract with commissioners rather than a Payment by Results (PbR) contract. This allowed shared control to address nuances and discrepancies and the Chief Executive considered this to be an important element of the ESTH system.

Rachael I Lake left the meeting at 11:50am

32. The Chief Executive of ESTH explained that the Trust had a lot of buildings which were not seen to be fit for purpose. The Trust was of the view that the Epsom Health & Care model would enable better availability and accessibility to all care services by locating services of key partners on the Epsom site, creating a modern, purpose-built campus of care services.

33. Members enquired how useful the NHS111 service was in order to divert minor injuries away from emergency departments. The Chief Executive of ESTH explained that NHS111 had two different providers covering the Trust. It was noted that the London provider was better connected to other services and was GP led, allowing for more relevant decisions to be made.

34. Members were informed that North West Surrey CCG was the lead commissioner for the NHS111 procurement and the mandate was to work towards integrated services, with a clinical hub and integrated out of hours provision.

Tim Hall left the meeting at 12:05pm

35. The Chief Executive of Healthwatch Surrey commented that some residents were unaware of alternatives to attending A&E and vulnerable groups had low awareness of the NHS111 service. It was suggested that educating residents via communications campaigns could have a positive impact in increasing awareness and reducing pressures on emergency departments unnecessarily.

Recommendations

That the Chairman follow up the item with Frimley Park and Kingston Hospital and report back to the Board;

That health scrutiny take a future item on the role of the whole system in reducing winter pressures, exploring both:

- The role of GPs, walk-in centres and other initiatives in reducing attendances;
- The role of partners and initiatives to improve timely discharge and create bed capacity across acute services;

That the acute trusts provide a short briefing detailing how they have worked with the ambulance trust to reduce down-time;

That representatives from the acute trusts are invited to attend in autumn 2017, in order to outline how shared learning from 2016/17 has informed planning for 2017/18.

The Chairman thanked the Board, his Vice-Chairman, officers and witnesses for their support over the council term. A Member of the Board offered thanks to the Chairman for the work he had undertaken on behalf of the Board over the past four years.

17/17 INTEGRATED SEXUAL HEALTH SERVICES [Item 7]

The Chairman informed the Board that this item had been deferred at the request of the Strategic Director for Adult Social Care & Public Health due to sensitive ongoing contract negotiations. The Chairman assured the Board that Members would be informed of the outcomes upon completion of the negotiations, and that the item would be placed on the forward work programme for scrutiny by the Board post-election. The Chairman stated that despite the uncertainty surrounding the contract, service provision would be in place from 1 April 2017 in line with the original mobilisation date of the new contract.

Meeting ended at: 12.15 pm

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Chairman

A&E Attendances and Emergency Admissions Annex 1

Please note this covers Quarter 3 – October to December – and does not show admissions for the full winter period

Quarter 3 2016-17

Name	Total attendances	Total Attendances > 4 hours	Percentage in 4 hours or less (all)	Total Emergency Admissions	Number of patients spending >4 hours from decision to admit to admission
Ashford And St Peter's Hospitals NHS Foundation Trust	30,093	3,729	87.6%	6,659	970
Epsom And St Helier University Hospitals NHS Trust	38,393	1,657	95.7%	10,157	237
Frimley Health NHS Foundation Trust	59,810	4,997	91.6%	22,821	959
Royal Surrey County Hospital NHS Foundation Trust	17,656	2,547	85.6%	7,874	0
Surrey And Sussex Healthcare NHS Trust	25,086	1,665	93.4%	9,124	842

Quarter 3 2015-16

Name	Total attendances	Total Attendances > 4 hours	Percentage in 4 hours or less (all)	Total Emergency Admissions	Number of patients spending >4 hours from decision to admit to admission
Ashford And St Peter's Hospitals NHS Foundation Trust	28,337	3,713	86.9%	6,161	745
Epsom And St Helier University Hospitals NHS Trust	38,088	2,291	94.0%	9,830	597
Frimley Health NHS Foundation Trust	57,278	2,513	95.6%	20,936	493
Royal Surrey County Hospital NHS Foundation Trust	16,155	1,216	92.5%	5,379	0
Surrey And Sussex Healthcare NHS Trust	22,883	1,227	94.6%	8,830	555

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ (accessed 8 March 2017)

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A&E WINTER PRESSURES- RESPONSES FROM ACUTE TRUSTS **Annex 1**

	RESPONSE TO Q.1	RESPONSE TO Q.2	RESPONSE TO Q.3	RESPONSE TO Q.4	RESPONSE TO Q.5	STRATEGIC BODIES
ASPH	• Local A&E Delivery Boards (LAEDBs) dedicated to undertake exercises to test resilience, resulting in updates to the whole system surge and escalation plan. • Two "Ready for Winter" days held at the hospital • LAEDBs scheduled weekly during December and January. • Daily system calls scheduled over weekends and bank holidays over Christmas and New Year. • A number of resilience initiatives were agreed (details in annex 2) • Public communications campaign, covering social media, online	• LAEDB interim review to identify immediate improvements required. • A comprehensive review of the winter period to be undertaken in due course	• Increase in national communications around winter pressures, self-care information and support. • National patient education programme to support the public to self-care • Investment in primary care services to facilitate improved access to urgent appointments as an alternative to A&E	• Recruitment and retention difficulties within A&E and the wider hospital. • Current A&E infrastructure is not conducive to managing peaks in attendance at current levels of demand. • Managing social care demand within existing funding is extremely challenging • Change in Community Services provider from 1st April 2017 likely to disrupt the system.	• Continued strong partnership working and engagement from all system partners.	• Local A&E Delivery Board- comprising senior representatives from all health system partners.

	ads, local paper ads.					
ESTH	• Developed an enhanced @home service within Epsom Health & Care alliance to provide over 65s at risk of admission to alternatives to inpatient stay. • Re-designed site-specific bed meetings to ensure whole-hospital engagement • Twice daily director-led cross-site conference calls to implement actions to support effective patient flow. • Established an Urgent Care Board with wide clinical involvement • Additional consultant and junior doctor support implemented over weekend period to	• Changes to managing patient flow will allow for successful management of future increased demand. • Continuing to work closely with health and social care partners to further develop existing systems to better manage admission		• Likelihood of increased demand throughout 2017/18	• Continued focus to further improve existing systems and processes • Continued partnership working with health and social care partners.	• Epsom Health & Care- comprising of GP Health Partners, CSH Surrey, SCC & the Acute Trust. • Urgent Care Board

	support assessment of patients for discharge.					
FPHT	• A number of initiatives were implemented to try to improve bed availability. • New Ambulatory Care facility opened to reduce inpatient admissions • New service introduced, working with Hants Social Care to provide packages of care	• 22 additional beds at Frimley to rebalance workload and capacity • Restructure of consultant rotas to allow for improved weekend and evening cover to best match patient flow. • Integrated care teams to be implemented across Hants, which should result in a decrease of workload as more patients will be managed at home.	• Implementation of 8-8 service (currently operating in Surrey Heath) across the STP and roll-out of integrated care teams in order to reduce inpatient admissions as they seek alternatives to ED. • Re-education of general public around the alternatives to A&E	• Increased demand throughout 2017/18 would be a risk • Timely discharge-delays will affect bed-availability. • The availability of experienced ED doctors is low and it is becoming increasingly difficult to staff the rotas	• Additional funding announced in the Budget should provide a shot in the arm for social care services. • Scope for joint venture approach in providing nursing home care • Continued partnership working across the system.	
RSCH	• Extra meetings were called by the Guildford & Waverley LAEDB to determine what responses could be made to the significant increased demand. • Daily operational phone calls and	• Challenge of having effective plans in place to meet the annual spikes of demand in winter (detail in annex 2) • Funding arrangements should be retrospective and	• National and local regional communications informing patients of the alternatives to A&E. • Investment in community services to support people staying within the community.	• Lack of community health and social care capacity to keep people in their own homes. • Lack of flexibility in patients ability to access community beds • Processes for the	• Support all assessments for care outside of the hospital, including CHC.	• Part of the Guildford and Waverley Local A&E Delivery Board- comprising of all local health and social care partners.

	usual contact between practitioners.	secondary to patient safety which isn't currently the case.	• Assessment of need in residential homes for escalation to nursing care to prevent homes using A&E as a place to shift pressures.	management of continuing care are cumbersome and result in delays		
SASH	• Active within the South East Coast System Resilience group, undertaking the assurance of service delivery and performance. • Urgent Care and Emergency Care Delivery Board has been active throughout the year, planning for capacity required to ensure delivery. • Winter plan in place (see annex 2 for component detail)	• The Delivery Board has adopted the mandated initiatives as outlined by the National Delivery Improvement Plan • Streaming at the front door • Ambulance response programme • Discharge • NHS 111 • STP new priorities (see annex 2 for detail)	• Easily recognisable and consistent provision and labelling of non acute care centres to discourage attendance at A&E as the relied upon default. • Better promotion by the NHS 111 service of alternative centres for minor injuries and advice (pharmacies)	• Ambulance conveyancing not being centrally co-ordinated to spread demand after dispatch. • Delays to discharge that impact on flow and number of acute beds available	• Discharge to assess models • KPIs should be agreed across the health and social care system that are consistent and not conflicting. • Gap analysis should drive provision.	• Member of the South East Coast System Resilience Group- comprising of all local health and social care partners.

Received by email
9th March 2017

Dear Bill,

Please accept my apologies for the delay in responding to you. Unfortunately I mislaid your letter. It has certainly been the most challenging winter that I have experienced since the 4hr standard was introduced and the staff have worked tirelessly often under the most difficult of circumstances to do their best for patients. We have traditionally prided ourselves on delivering the 4 hr standard and while our performance for the financial year has been 91.7% year to date, Trust wide it did dip to 84.7% in January. I will respond to your points in the order you have listed them.

1. While we continue to work collaboratively with all of our partners across several counties, the combination of increased activity and a spike in the acuity of patients did give significant operational problems and the process of getting people out of hospital who were medically fit compounded matters. There were delays in securing timely packages of care and social care and continuing care placements. Also we had particular challenges in expediting discharge with private funders for nursing home care. A cohort of patients spent longer in hospital than they should have, which resulted in delays in admitting the incoming patients. All of our partners worked hard to support us but the constraints on funding and not having sufficient capacity to move patients was a constraint.

We did improve our flow through the ED with a number of initiatives to try and turn around patients we could treat relatively easily and we have just opened a new Ambulatory Care facility on the Frimley site which is geared to avoid inpatient admissions for a number of conditions. We also introduced a new service with Hants Social Care to provide packages of care. We now employ 10 care assistants to provide packages of care which has proved to be successful as hitherto Hants could not identity sufficient providers to offer a service at the Hants rate. We also have the Community integrated care teams who focus on pulling patients out of hospital and supporting people at home which has been successful in Surrey and Hants. These teams have also been focussed on keeping the high risk patients out of hospital.

We also took on the community services in NE Hants and have merged the hospital and community teams to help keep patients out of hospital and support high risk patients at home. This service is currently looking after 85 people.

2. We are keen to work more closely with social care to joint manage the discharge plans of complex patients. We have also opened 22 more beds on the FPH site to rebalance workload and capacity. The integrated care teams are to be implemented across Hants which should, over time, reduce hospital workload as they are focussed to managing high risk patients at home. We are restructuring our

consultant rotas to have a greater presence at weekends and evening so that there are more senior decision makers in duty to better match the inflow of work.

3. We have experienced a slow-down in the growth of attenders in ED since the start of this year, and the message of keeping away from ED unless you are very sick seems to have had an impact. Also Surrey Heath GPs have started to offer an 8 to 8 service Mon to Fri which has helped and NE Hants are about to do the same during 2017. Some people attend ED because they can't get an appointment quickly and if we can offer this enhanced service across the Trust's catchment which is in our STP, It should have a positive impact. We have a massive re-education process to undertake with the general public around using alternatives to ED.

4. The main risks to our ED performance are increases in workload and delays in getting medically fit patients out of hospital. We have enough beds if we can maintain a good patient flow through the hospital. Also, the supply of experienced ED doctors is a risk as most hospitals are finding it increasingly difficult to staff the rotas.

5. The extra money just announced in the Budget should be a shot in the arm for Social Care but I believe funding will still be tight. We need to continue the good work with social care to speed up the discharge process for patients who need packages of care and nursing home support. Also there may be some scope for a joint venture approach in providing nursing home care for patients and care packages. We can recruit care assistants quite easily and we do not seek to make a profit from such activity.

The STP is keen to roll out the 8 to 8 offering from GPs to divert activity from ED and the roll out of integrated community teams should provide more care at home and avoid admission. By working together more closely with all partners we can make better use of a pooled resource. I think there is much more we can do with the voluntary sector to collectively help us.

I hope these comments are useful in your deliberations.

Kind regards

Andrew

Sir Andrew Morris
Chief Executive,
Frimley Health Foundation Trust
Frimley Park Hospital.