NHS
Surrey Downs
Clinical Commissioning Group

9

Out of Hospital Strategy 2013-2018

Version 1.2

Access | Choice | Experience | Safety | Outcomes

Index

9

1. Vision and context

9

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

1.1 Executive summary

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

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

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

9

1.2 Our role and vision

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

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

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

1.3 How we shaped this vision

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

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

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

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

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

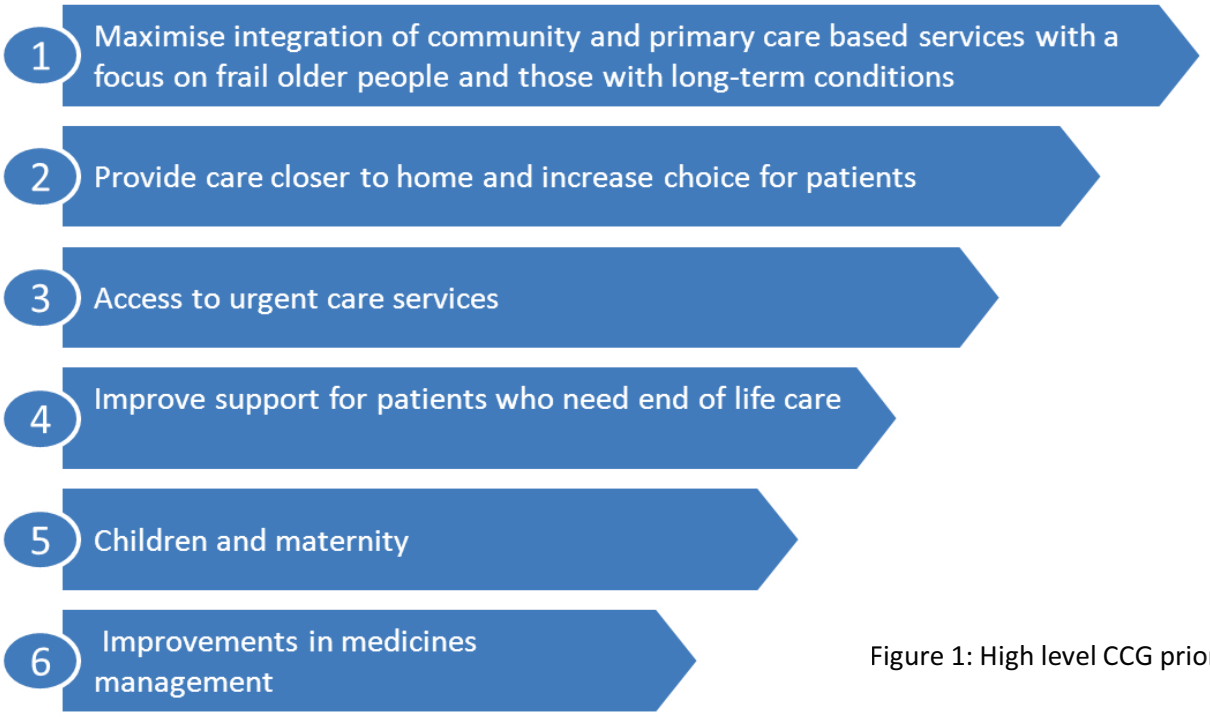


Figure 1: High level CCG priorities

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

1.4 Our clinical journey

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

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

9

1.4.1 Out of Hospital strategic programme

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

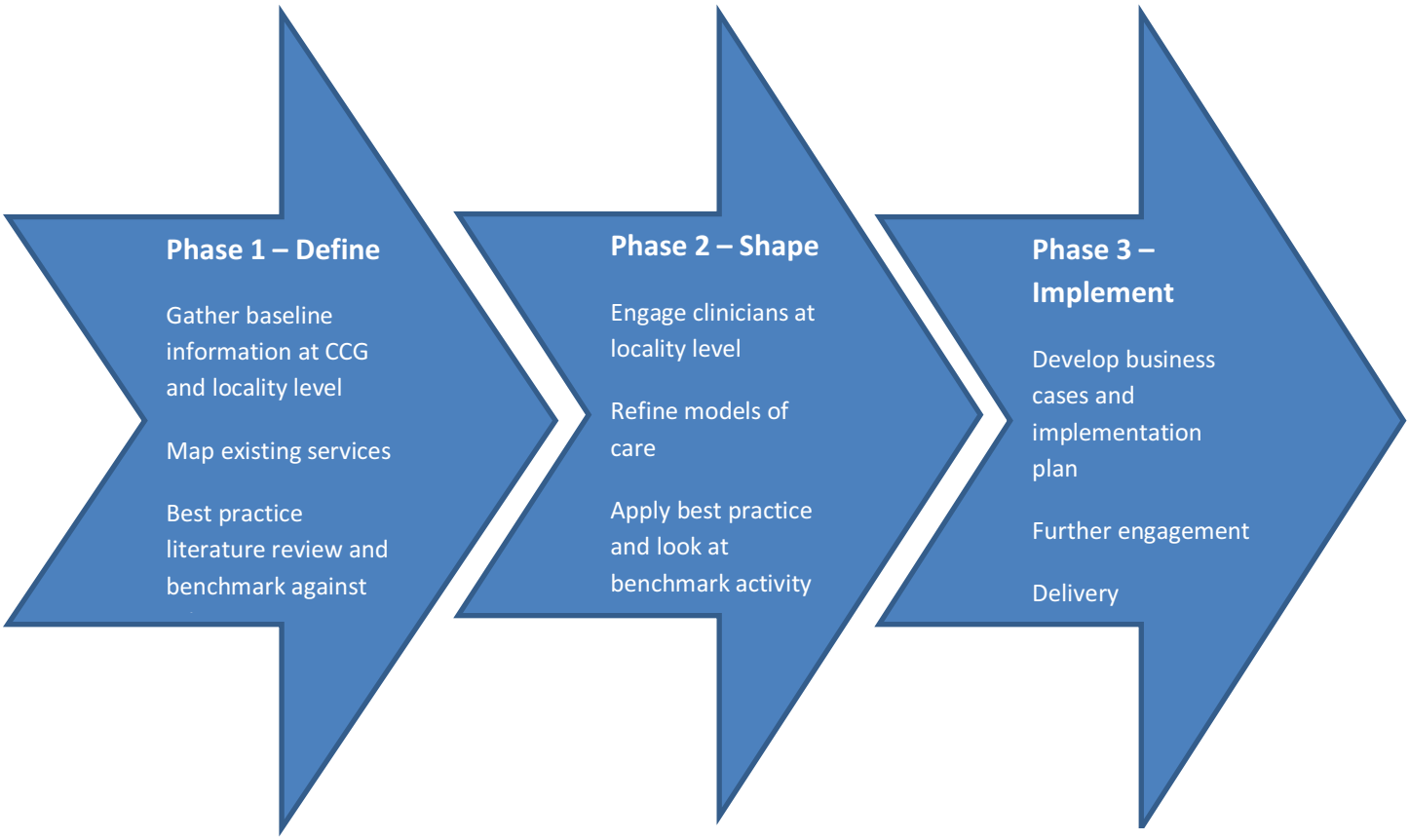


Figure 2: Out of hospital strategy process

1.4.2 Strategic framework

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

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

The framework is described in Figure 3 below:

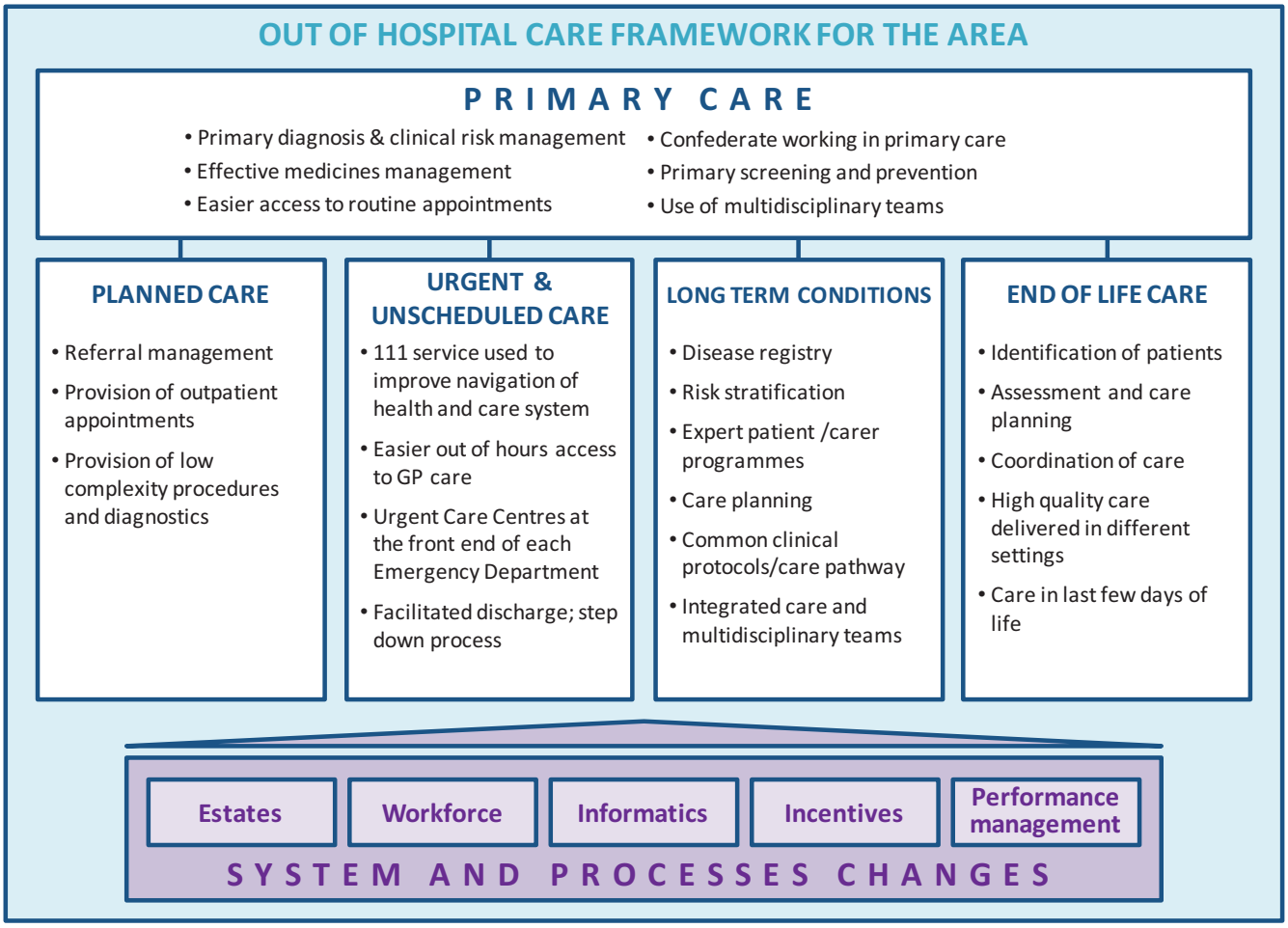


Figure 3: Out of hospital framework

1.4.3 Clinical engagement, workshops and baseline information

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

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

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

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

1.5 Health and Well-being Strategy

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

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

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

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

1.6 Our local population and their health needs

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

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

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

1.6.1 Overview of health needs

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

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

1.6.2 Specific groups in Surrey Downs CCG

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

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

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

1.6.3 Population profile

9

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

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

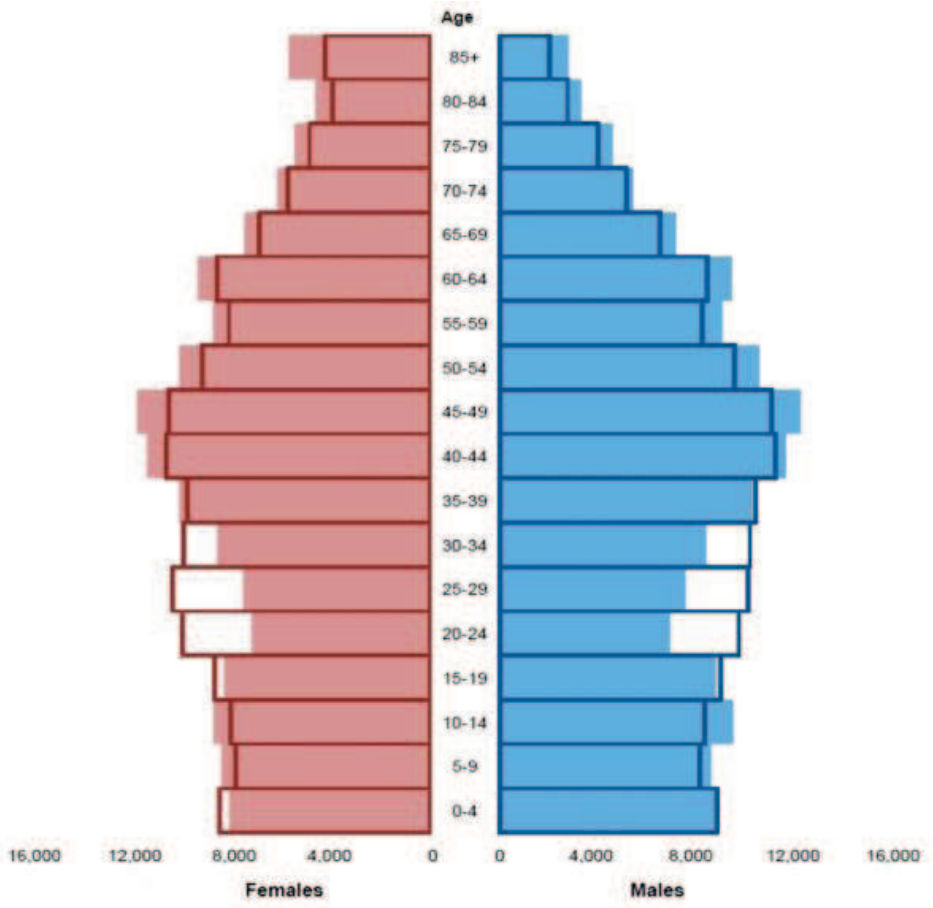


Figure 5: The Surrey Downs population

1.6.3.1 Population projections

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

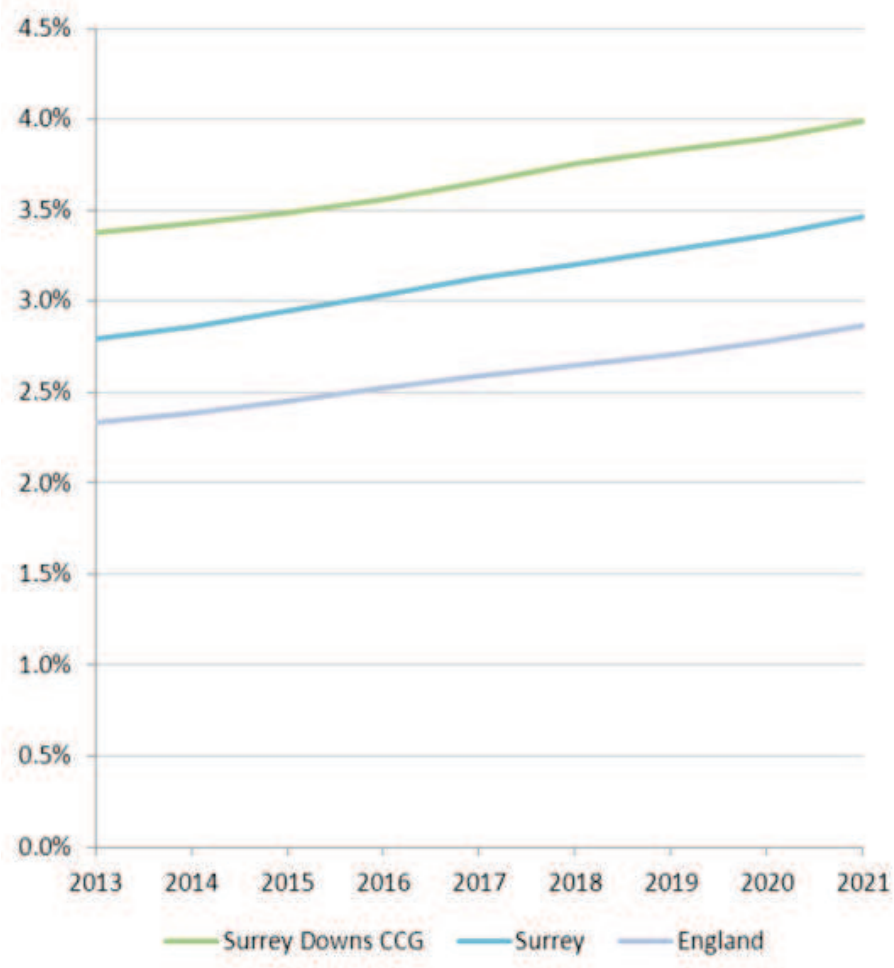


Figure 6: Projected population growth

In summary Figure 6 shows:

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

1.6.4 Health risk factors

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

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

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

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

9

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

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

Table 1: Top ten health risk factors

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

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

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

Table 2: Top ten causes of mortality

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

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

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

Table 3: Top ten causes of morbidity

1.6.5 Admissions

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

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

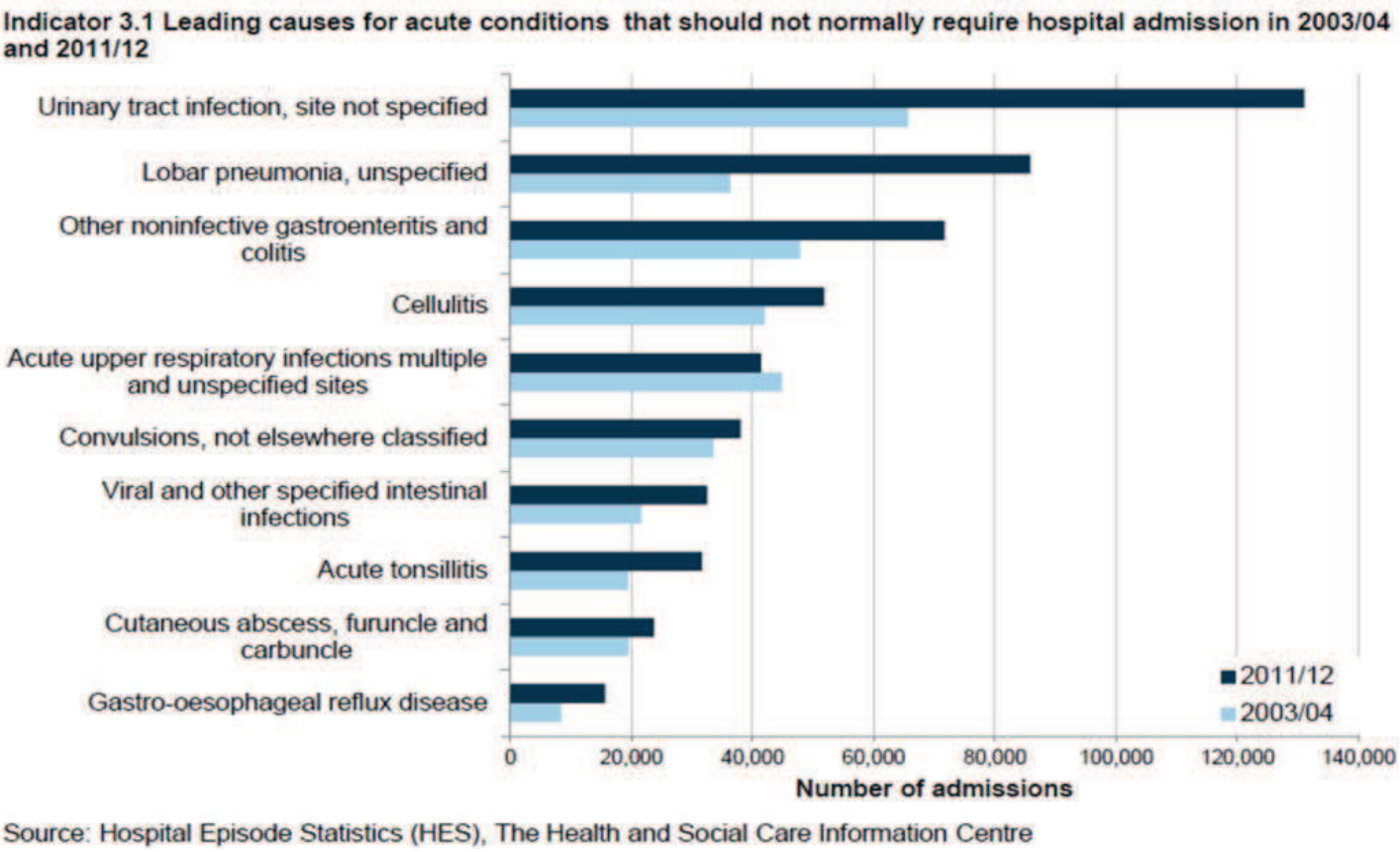


Figure 7: Leading causes for acute admissions that would not routinely require admission

1.6.6 Programme budgeting

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

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

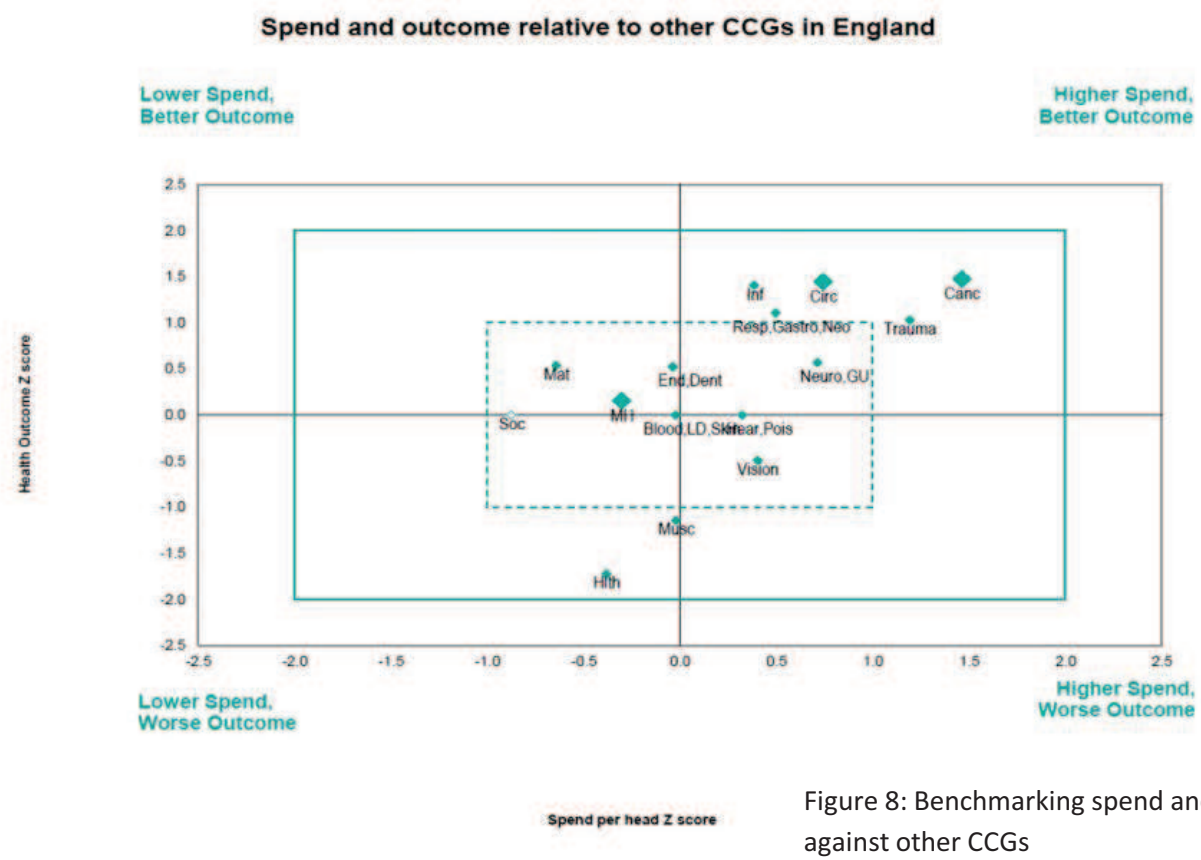


Figure 8: Benchmarking spend and outcome against other CCGs

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

Figure 8 shows the following:

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

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

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

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

1.7 Case for change

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

1.7.1 Admission prevention

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

1.7.2 Earlier discharge

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

1.7.3 Urgent care

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

1.7.4 Elective care

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

1.7.5 Benchmarks and best practice: Surrey Downs CCG and localities

9

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

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

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

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

Opportunities scaled using locality list size and rate for each POD

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

48

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

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

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

Table 5: The 'do nothing' scenario

9

1.7.7 Summary

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

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

2. Out of Hospital Strategy

9

Commissioning intentions and priorities

2.1 Our Out of Hospital Strategy – an overview

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

2.1.1 Aims

To commission high quality services, meeting national standards that:

9

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

2.1.2 Proposed clinical commissioning standards

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

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

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

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

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

2.2 Overview of priorities and proposals

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

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

9

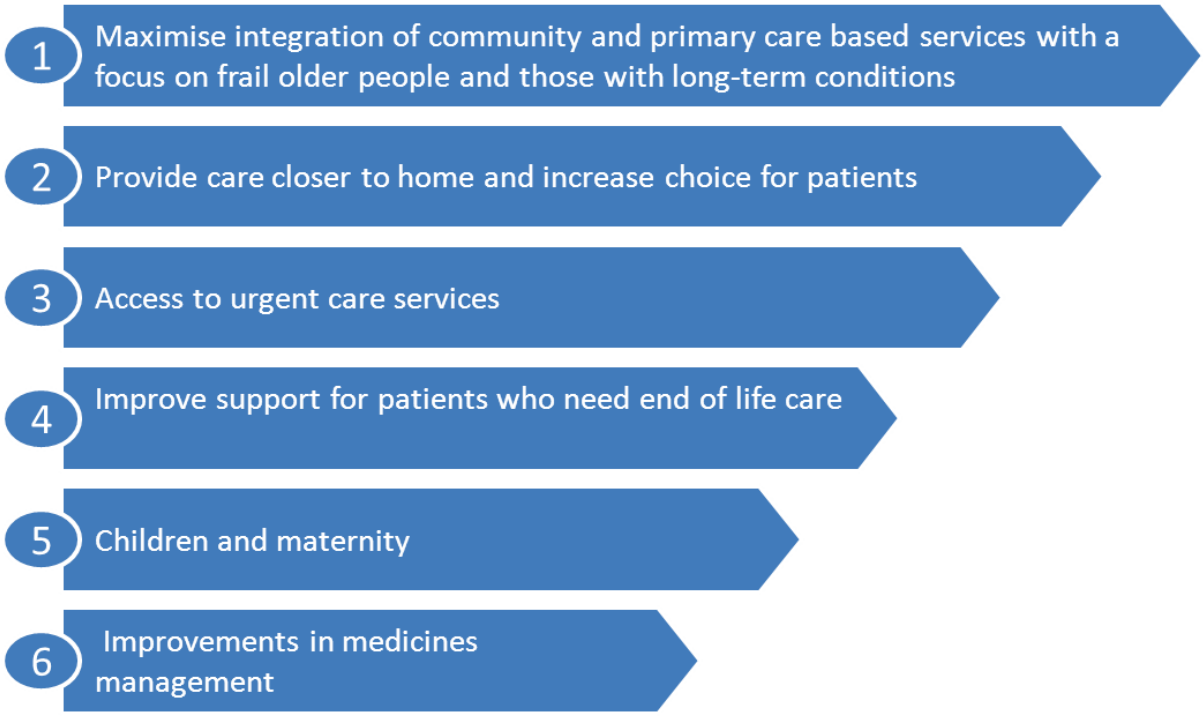


Figure 9: Surrey Downs CCG's high level commissioning priorities

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

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

2.2.1 Maximising integration of care

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

9

2.2.2 Admission prevention

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

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

2.2.3 Timely discharge from hospital

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

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

2.2.4 Our approach to risk stratification

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

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

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

9

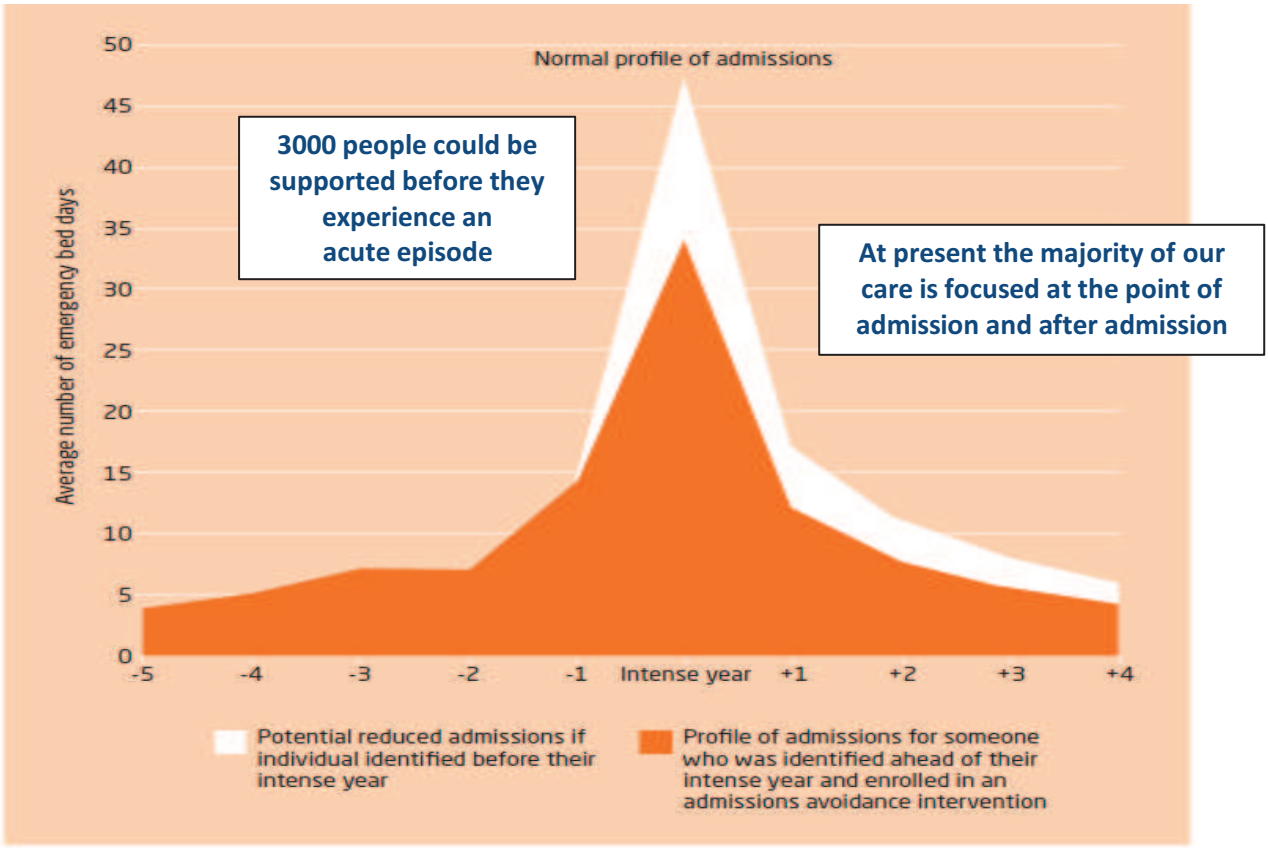


Figure 10: Predictive modelling and benefits

2.2.5 Virtual wards

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

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

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

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

9

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

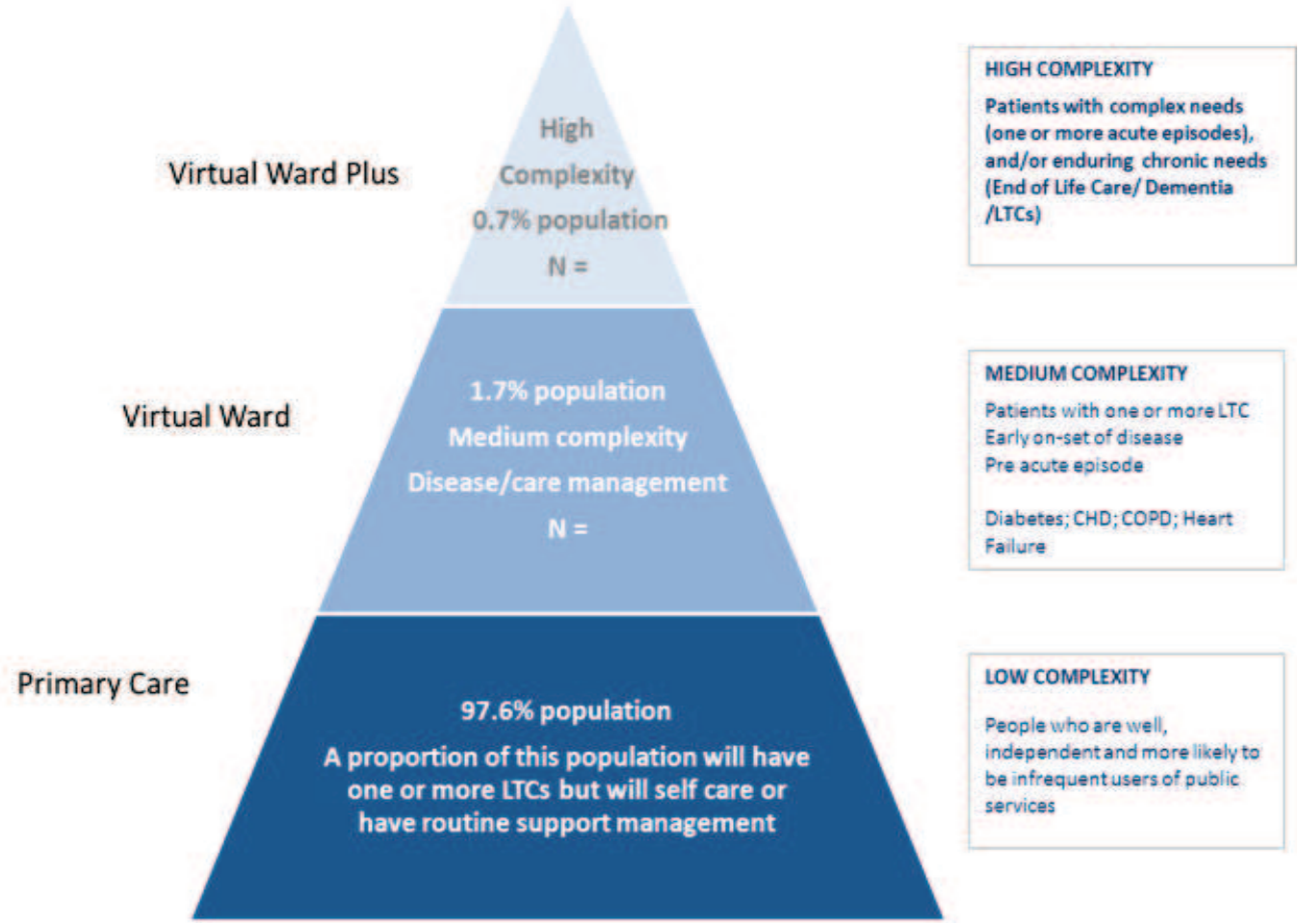


Figure 11: The virtual ward model

2.2.5.1 Our plans for virtual wards

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

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

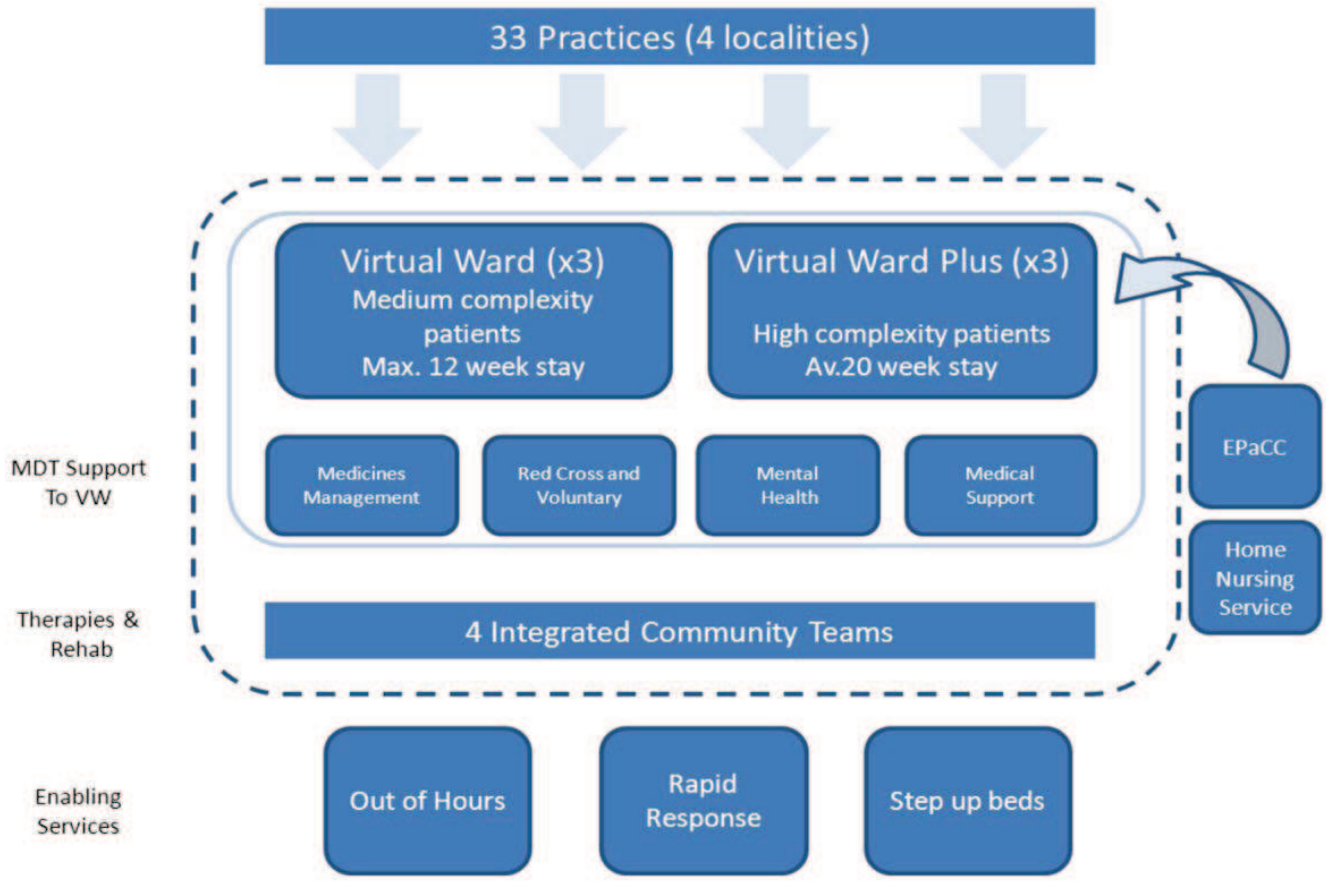


Figure 12: The Two Tier virtual ward model with multi-disciplinary involvement

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

2.2.6 Our plans to improve the discharge pathway

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

9

2.2.7 Investing in community beds

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

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

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

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

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

Figure 13: Community bed capacity

2.2.7.1 Increasing bed capacity

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

2.2.7.2 Key issues

9

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

2.2.8 Improving dementia care and support

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

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

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

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

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

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

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

9

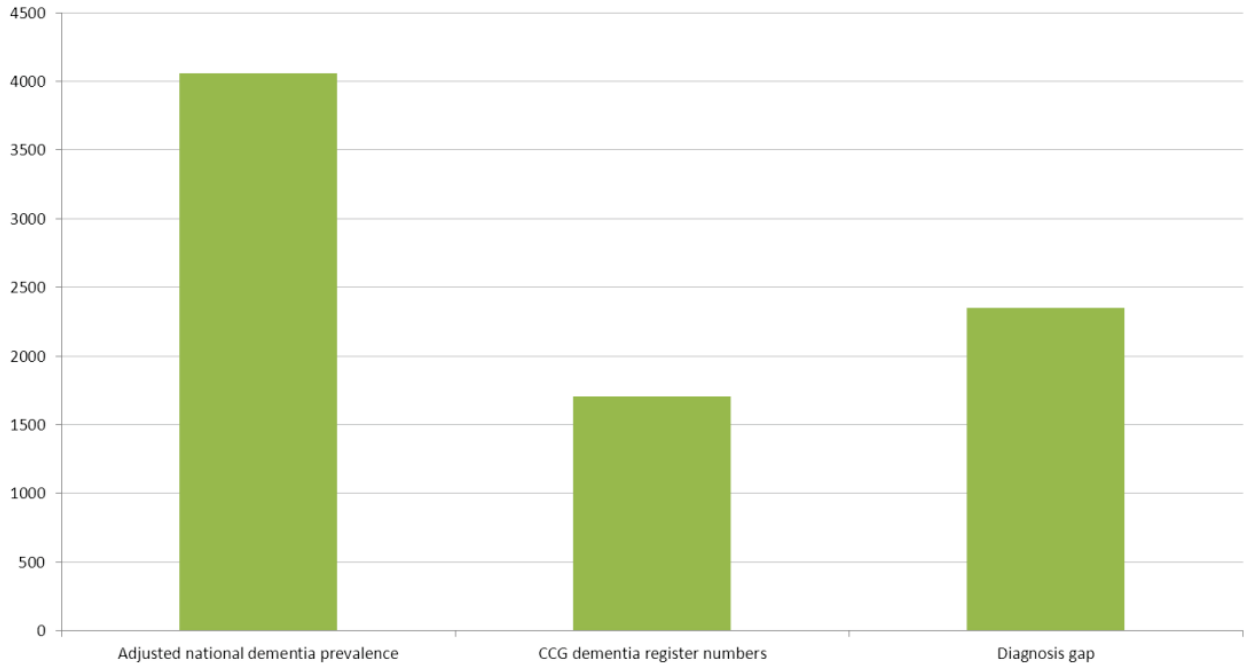


Figure 14: The dementia diagnosis gap

2.2.8.1 Our plans to improve dementia care

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

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

2.2.8.2 Patient benefits

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

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

9

2.2.8.3 Clinical benefits

Our plans also offer the following clinical benefits:

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

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

2 Provide care closer to home and increase choice for patients

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

9

2.3.1 Increase choice for patients in elective care

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

2.3.2 Key issues

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

The key issues and drivers for change are summarised below:

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

2.3.3 Our plans for a referral support service

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

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

2.3.4 Referral support system: Developing a new model of care

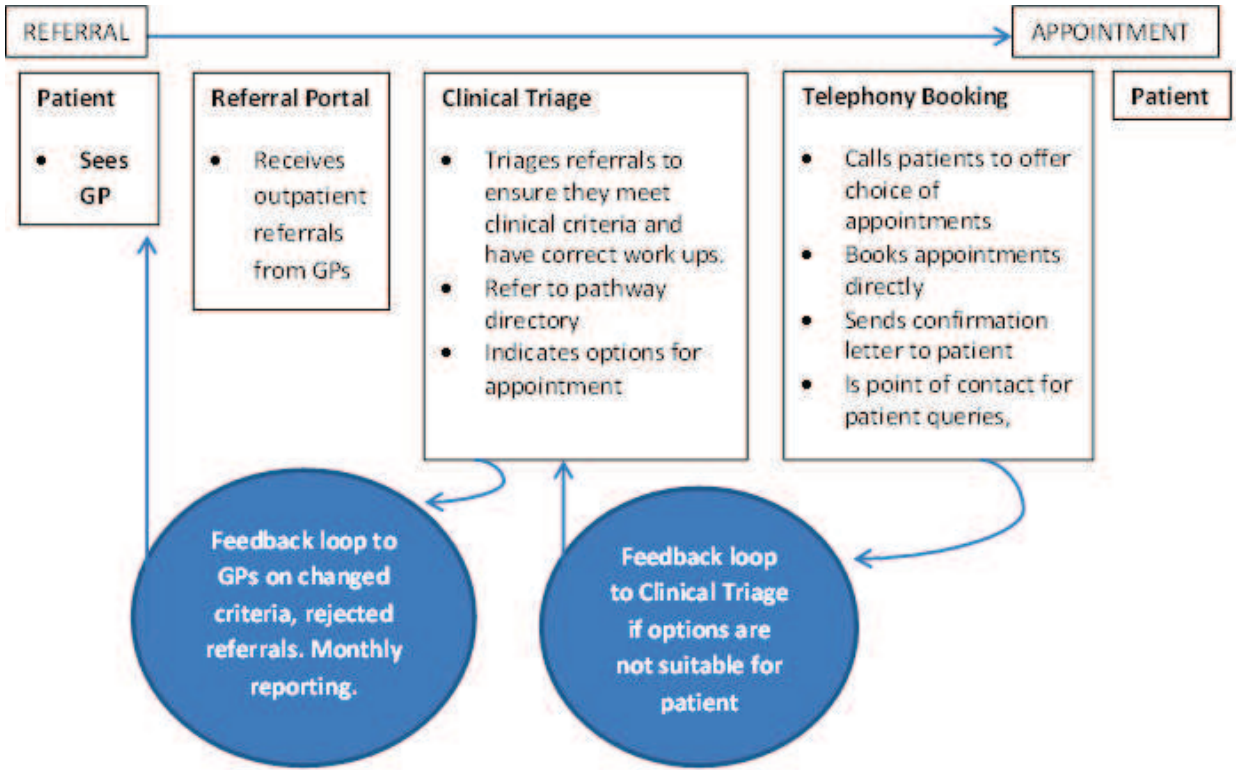


Figure 15: The referral support model

2.3.5 Benefits of a referral support service

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

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

3 Access to urgent care services

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

9

2.4.1 Our plans to improve access to urgent care

Our plans to improve access to urgent care include:

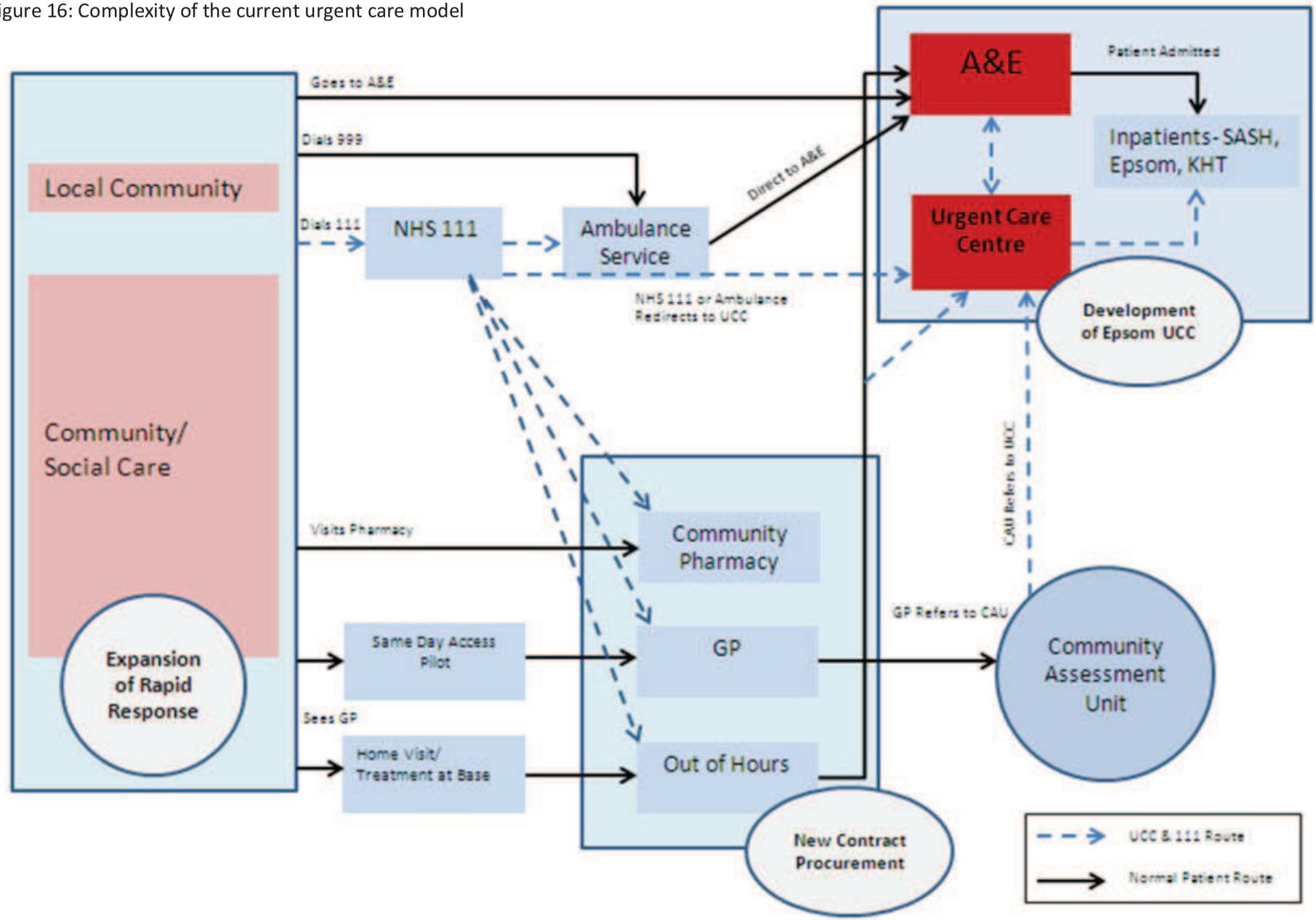
- Establishing an Urgent Care Centre at Epsom to improve access to urgent care
- Same day access in primary care to improve access to GP services
- Re-procuring Out-of-Hours GP services (2014) to ensure patients have access to high quality GP services outside of working hours

2.4.2 Overview

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

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

Figure 16: Complexity of the current urgent care model



4 Improve support for patients who need end of life care

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

2.5.1 End of Life Care - Case for change

- In an ageing population, the number of deaths in England is set to rise from 500,000 to 590,000 over the next 20 years increasing pressure on the quality of EOLC services.
- EOLC is one of the 12 national QIPP work streams and is a national priority. Combined with the EOLC strategy (2008)) the focus is on early identification of patients, integration of services and patient centred care.
- Nationally 70% of people would prefer to die at home, yet 51% die in hospital. In areas using EPaCCS, 76% of people die in their preferred place & 8% die in hospital- a significant improvement in quality of care
- Research shows that (after friends & family) people turn to GPs for information about EOLC- education, training and professional support are key to the EPaCCS

2.5.2 Our plans to improve end of life care

Our plans include:

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

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

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

End of life care pathway

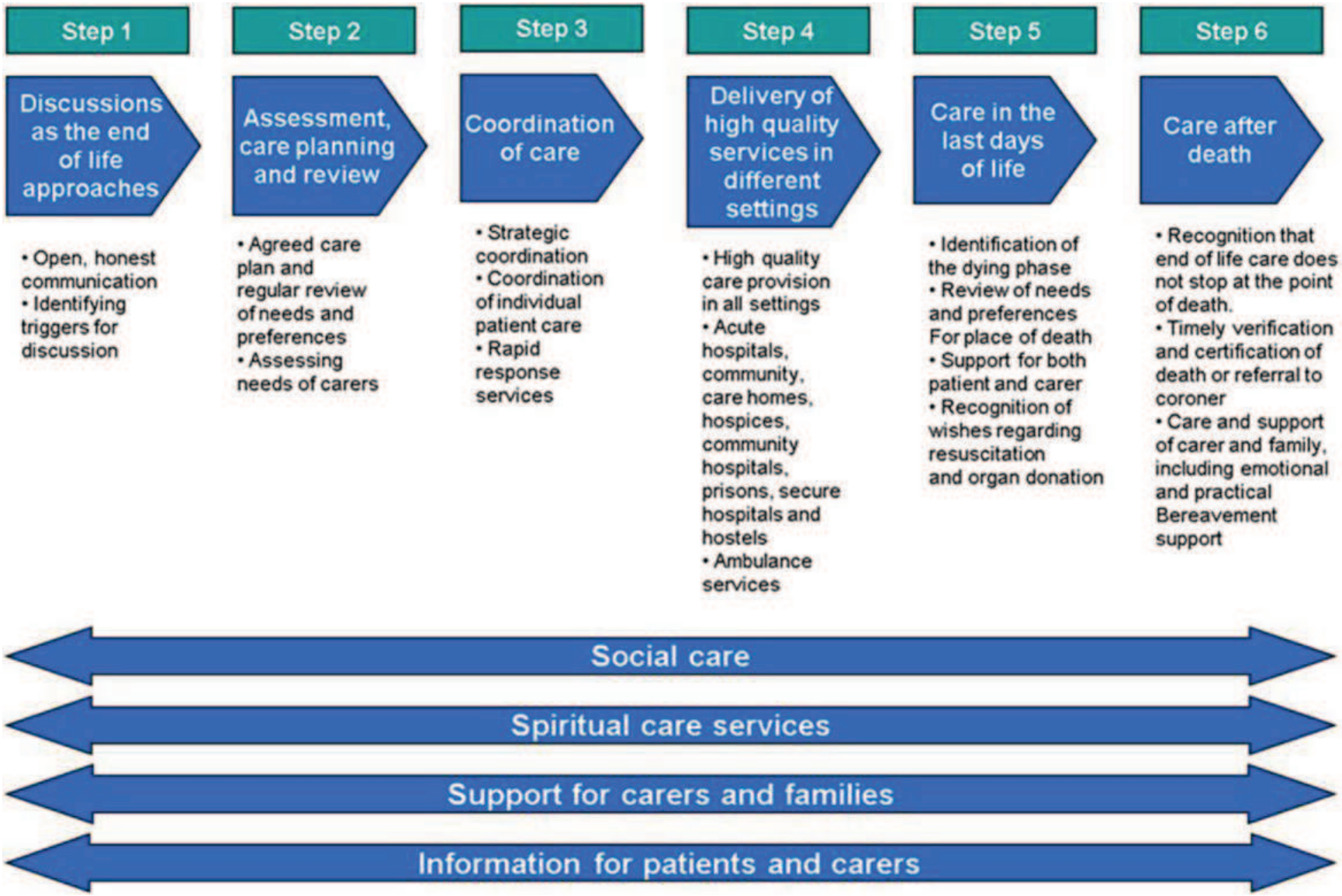


Figure 17: The end of life care pathway

5 Children and maternity

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

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

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

9

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

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

6 Improvements in medicines management

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

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

9

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

Our plans in this area involve:

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

2.7.2 Our plans for managing medicines better

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

3. Financial Strategy and opportunities

3.1 Our Out of Hospital Strategy and our financial forecasts

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

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

9

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

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

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

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

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

BASE CASE

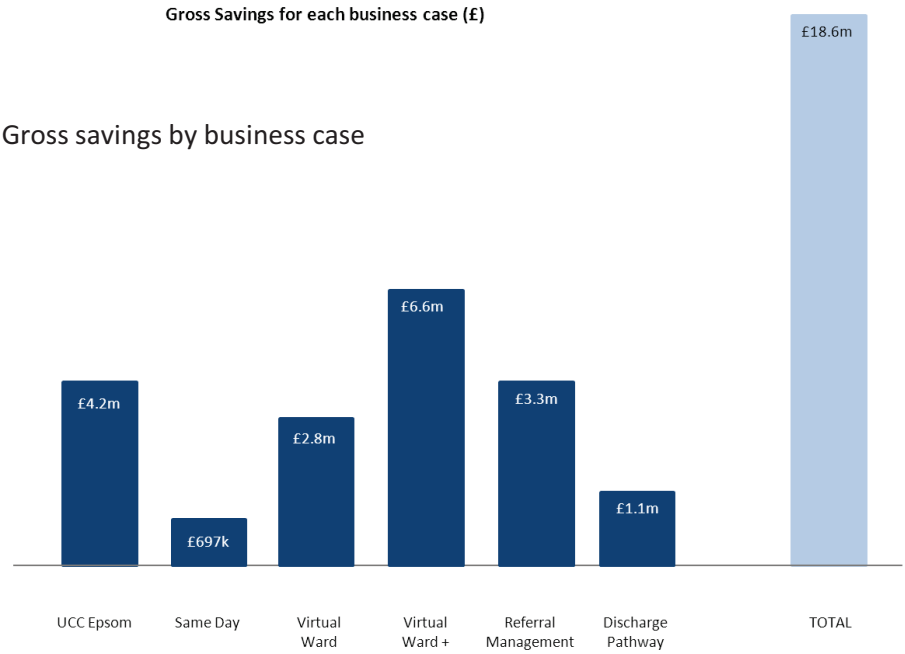
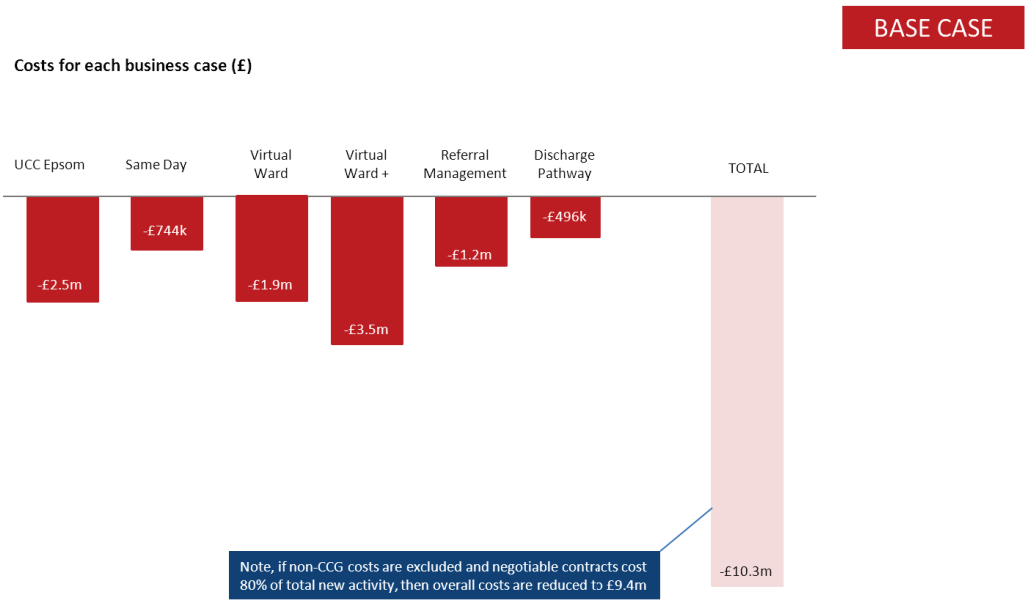


Figure 17: Gross savings by business case

Source: SDCCG / CSH cost modelling



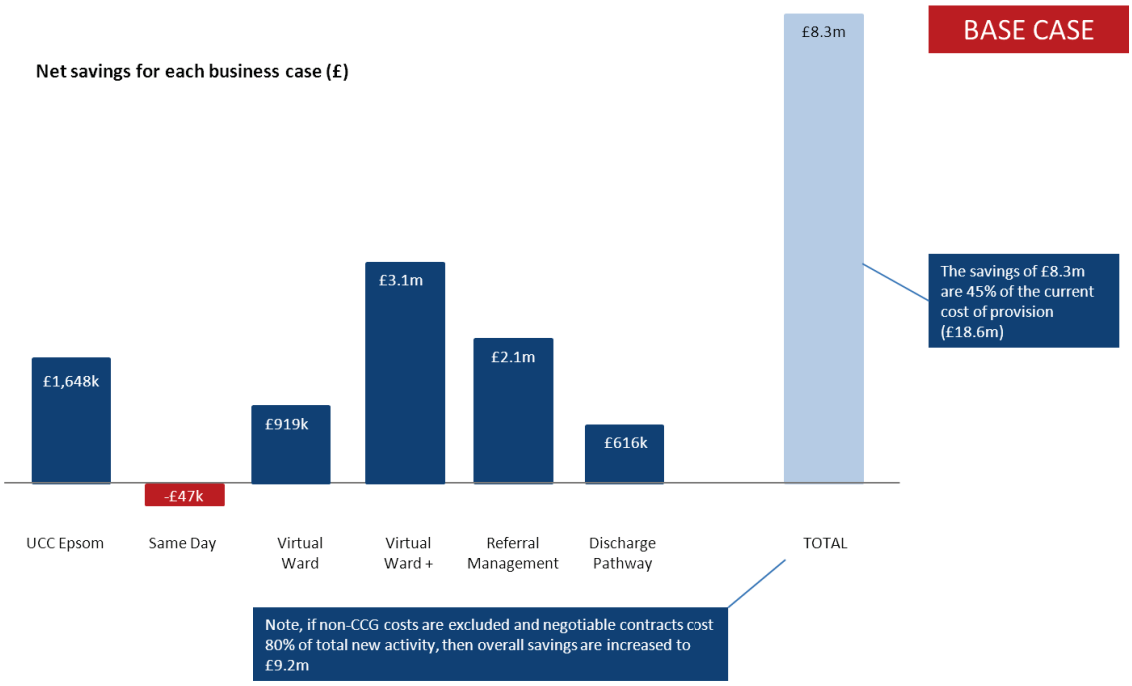
9

Source: SDCCG / CSH cost modelling

37

Figure 18: Cost of business cases

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



Source: SDCCG / CSH cost modelling

38

Figure 19: Net savings by business case

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

9

Table 6: Alternative acute growth rates

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

3.1.1 Summary

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

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

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

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

3.2 QIPP (Quality, Improvement, Prevention & Productivity)

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

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

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

N.B. The above schedule represents gross savings only

Table 7: QIPP savings by sector

3.2.1 Delivering on our QIPP targets

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

Table 8: QIPP schedule A

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

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

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

Table 9: QIPP schedule B

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

4. Delivery

9

4.1 Organisational requirements and enablers

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

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

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

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

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

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

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

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

4.2 Timeframes for delivery

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

9

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

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

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

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

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

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

4.3 Risks to delivery

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

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

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

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

Appendix A – Methodology and clinical engagement

Literature Review

Overview

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

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

Aim of the review

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

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

Methodology

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

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

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

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

Baseline performance and benchmarking

Overview

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

The Current 'as is' performance

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

9

- Activity
- Current performance
- Tariff related financials for comparison

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

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

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

Benchmarking

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

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

Informing the Models of Care; Stakeholder Engagement and Workshop Outputs

9

Overview

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

Purpose of workshops

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

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

Methodology

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

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

Appendix B - Finance assumptions used in Surrey Downs projections

From Commissioning Board, Dec 2012 and monitor guidance

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

Source: SDCCG

5

Continuing care and mental health growth estimates

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

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

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

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

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

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

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

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

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

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

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

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

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

CCG Peers in Southern England

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