NHS
Surrey Downs
Clinical Commissioning Group

Health Scrutiny Committee:
Surrey Downs CCG Out of Hospital Strategy

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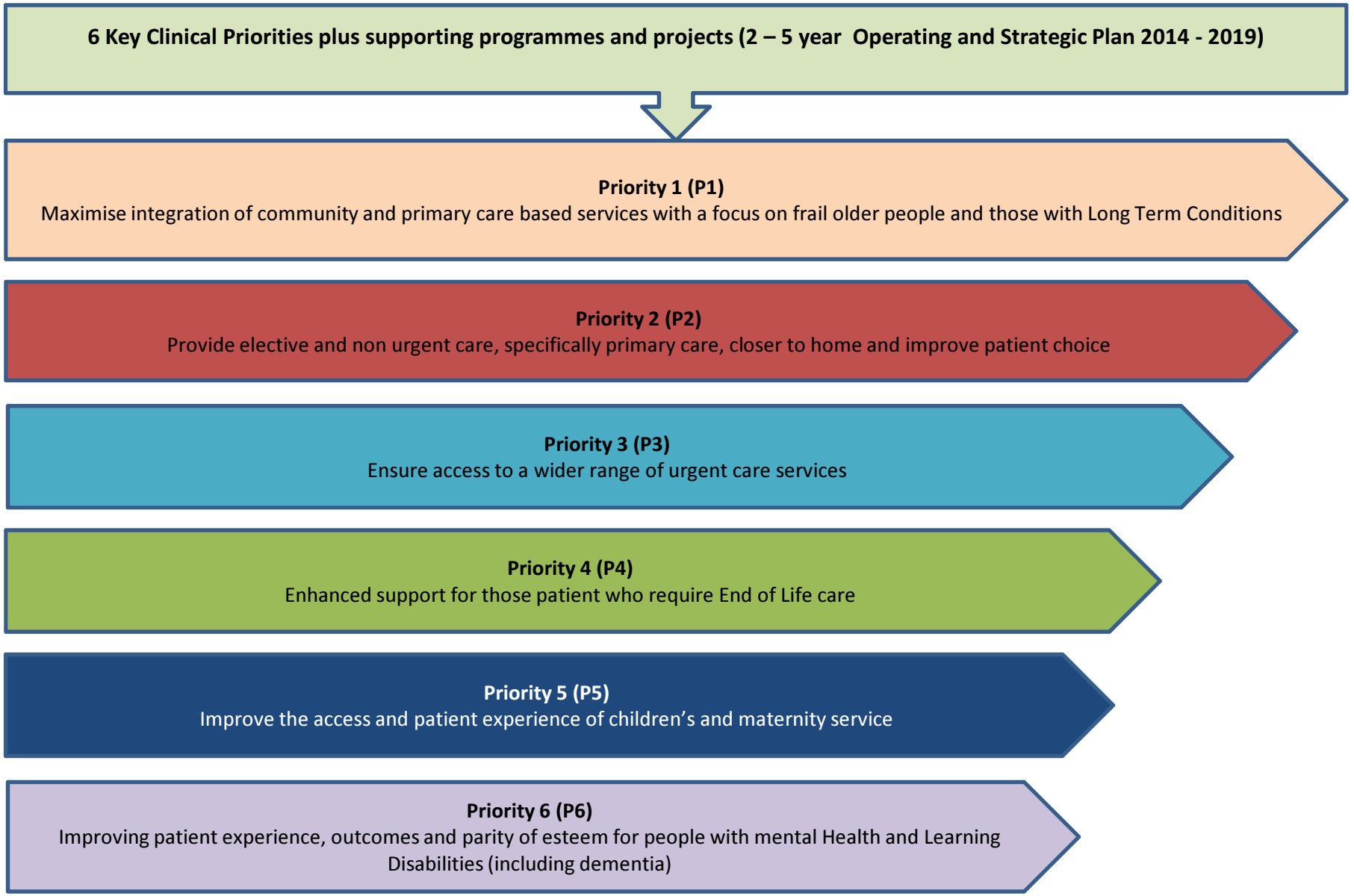
Expanding our Out of Hospital Strategy

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

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

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

Summary of our priorities for 2014 - 2016



Key Headlines of transformational clinical programmes

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

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

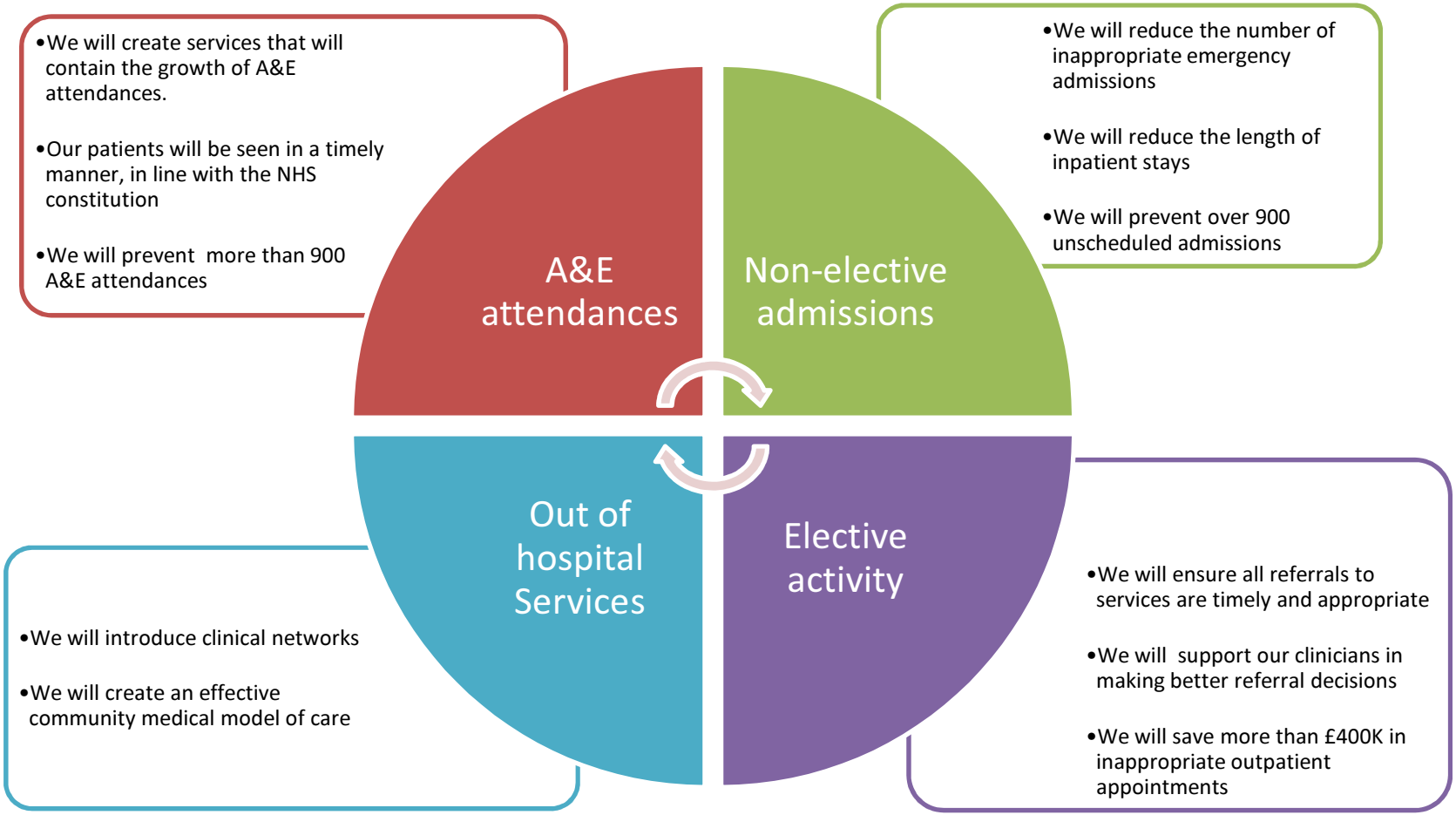
- Developing an Urgent Care and Discharge system that works to enable people to return to a suitable care environment earlier in their recovery pathway **(P3)**

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

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

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

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



Primary Care Case for Change

1. Inadequate **capacity** for rising need

2. **Variation** between areas and practices

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

4. No alignment of **incentives**

5. No economies of **scale**

Transformational Change:
Developing Primary Care offer

Inadequate capacity for rising need

More access within general practice through INCREASED access and IMPROVED access

Variation between areas and practices

Standardised set of services available to ALL patients within a **network of practices**

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

Best practice Chronic Disease Management

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

No economies of scale, No alignment of quality, financial or clinical incentives

Creating and incentivising **working at scale**

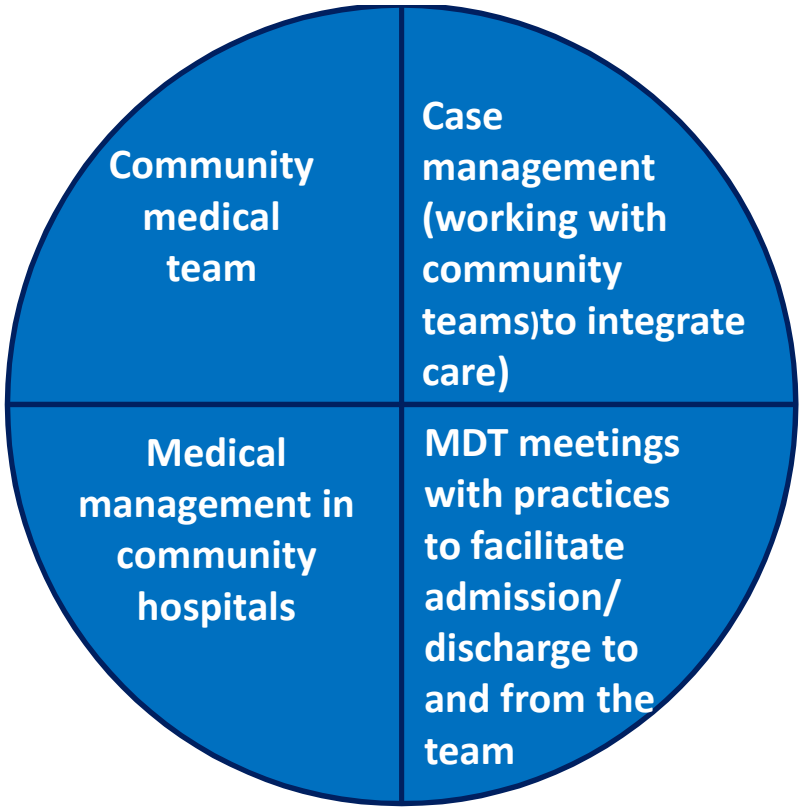
Community Medical Team (CMT)

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

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

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

Out-of-hospital medical care for chronic disease management



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

Referral Support System (RSS)

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

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

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

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

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

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

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

Proposals- Urgent Care System

- The **out-of-hours service** will be procured this year, with a centre co-located with A&E and weekend bases across all localities.

- We are working towards weekday extended access (8-8) service provided by our practices as it works better for patients; including dialogue on standardising appointments across practices.

- **Our Community Assessment Unit** at Leatherhead has been co-located at Epsom to ensure a more resilient model of care with A&E

- We have also launched an Ambulatory Care Unit at Epsom so that more patients can receive day care and be returned home with support from community services (and in future the community medical teams) as an alternative to admission.

- A similar unit has been co-funded at Kingston Hospital for East Elmbridge residents

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

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

End of Life Care

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

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

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

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

Dementia

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

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

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

Children's and maternity commissioning priorities 2014/2015

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

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

Reviews in process (community services):

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

For review:

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

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

"No health without Mental Health"

- Mental Health Strategy for England 2011

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

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

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

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

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

Summary and Next Steps

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