MINUTES of the meeting of the **HEALTH SCRUTINY COMMITTEE** held at 10.00 am on 14 March 2013 at Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting.

Elected Members:

Mr Nick Skellett CBE (Chairman)
Dr Zully Grant-Duff (Vice-Chairman)
John V C Butcher
Bill Chapman
Dr Lynne Hack
Mr Peter Hickman
Mr Richard Walsh
Mr Alan Young

Independent Members

Borough Councillor Nicky Lee
Borough Councillor Mrs Rachel Turner

Apologies:

Mrs Caroline Nichols
Mr Colin Taylor
Borough Councillor Hugh Meares

In Attendance

10/13 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies for absences were received from Hugh Meares, Caroline Nichols and Colin Taylor.

11/13 MINUTES OF THE PREVIOUS MEETING: 24 JANUARY 2013 [Item 2]

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

12/13 DECLARATIONS OF INTEREST [Item 3]

No declarations

13/13 QUESTIONS AND PETITIONS [Item 4]

A question was tabled from County Councillor Will Forster.

> "I understand that about 16% of over 75s need emergency readmission to hospital within 28 days of being discharged. This number has doubled in the last 10 years.
>
> "Is the Health Scrutiny Committee aware of this? What discussion has it had with the local NHS on this issue?
>
> "Please could the Chairman tell this Council about work that is planned to lower the numbers of patients, especially elderly patients, being readmitted in Surrey?"

Comprehensive responses were received from all but two of the CCGs by the time of the meeting. These responses were tabled and are attached to these minutes as an annexe. Members were advised to read these at their leisure and any further responses would be circulated upon receipt.

14/13 CHAIRMAN'S ORAL REPORT [Item 5]

Epsom Hospital Meeting
On Friday 1 March I attended a Hospital Summit organised by Epsom & Ewell MP Chris Grayling. We discussed the future of Epsom Hospital in relation to the BSBV programme. The outcome was for a working group to be put together under the Health & Wellbeing Board to look at options for Epsom Hospital going forward.

BSBV decision delayed
You are likely to have seen the news that the BSBV board has delayed the decision on its preferred options for consultation. This is due in part to lobbying by the County Council, local MPs and councillors along with GPs and consultants in Epsom. I am glad that the BSBV team is taking time to look again at all options, avoiding a rush to a decision before the 1 April NHS restructure.

CCG Meetings
Members of the Committee and I have been meeting with the CCGs in readiness for the new NHS structures going live on 1 April. These meetings have been extremely useful to gain understanding of their priorities for the

next year and getting to know them informally. We look forward to welcoming them to our meetings next year.

Healthwatch Tender Outcome
The outcome of the Healthwatch tender has been announced. Surrey Independent Living Council, Citizens Advice Surrey and Help & Care will together be Surrey Healthwatch. The group will take on its role on 1 April and will be able to influence policy, planning and delivery of health and social care services. They will also provide information and advice to help people access and make choices about services.

The Committee thanked LINk officers and volunteers for all their hard work.

Alan Young spoke about the announcement that morning from the Health Secretary regarding the abolition of gagging clauses in NHS severance packages. The Committee agreed this was a welcome change that would bring additional transparency.

He also spoke about a report published that morning regarding the number of CCG board members that were likely to have a conflict of interest in organisations with whom the CCG would be contracting. He indicated that it would be beneficial for the Committee to look into this in future. The Chairman indicated that there would be continuing informal meetings with the CCGs and this could be monitored through these meetings.

15/13 SOUTH EAST COAST AMBULANCE (SECAMB) PERFORMANCE DEEP DIVE [Item 6]

Declarations of Interest:

None.

Witnesses:

Geraint Davies, Director of Corporate Services, SECAmb

Rob Bell, Head of Commercial Services

Lorna Stuart, Senior Operations Manager

Marion Heron, Associate Director supporting Transition, NHS Surrey

Cliff Bush, LINk Chair

Carol Pearson, Chief Executive, Surrey Coalition of Disabled People

Key Points Raised During the Discussion:

1. The Director of Corporate Services provided an overview of the service. The plan is to have three Make Ready Centres (MRCs) at Chertsey, Tongham and Merstham. There are 18 old ambulance stations being replaced by 29 patient led Ambulance Community Response Posts (ACRPs). Across the south east coast , SECAmb performance year to date is 76% of Red 1 calls responded to within eight minutes; however Surrey is just under at 74%. The target is 75%. The service faces several challenges, one of which is reducing emergency hospital admissions. SECAmb uses ‘Hear & Treat’ to try to

deal with patients over the phone when an ambulance may not be necessary. The aim is to reduce pressure on the acute hospitals.

2. Calls to the ambulance service are categorised into Red 1 and Red 2. Red 1 calls are the most critically ill patients and should have an ambulance response within eight minutes. SECAmb receives about 18 Red 1 calls a day.

3. Members queried patient satisfaction with the service. The Director of Corporate Services indicated that a patient satisfaction survey is carried out by the service and that this would be shared with the Committee. Overall, patients indicated they are satisfied with the ambulance service. Where a patient is dissatisfied, a sample of these is followed up with a telephone call. The Director of Corporate Services also indicated that, often, the primary complaint is not receiving an ambulance; however, when the rationale for not sending an ambulance was explained, patients tended to understand better and were then satisfied with the service received.

4. Members queried how the calls were categorised: for example, if a patient is having a stroke that is not severe, a road accident victim or an elderly person collapsing. Witnesses responded that this can be a grey area; however there are keywords that, if heard during the phone call, will inform the call responder to appropriately assess whether the call is a Red 1 or Red 2. Members queried the use of 'Hear & Treat' on patients: for example, someone in severe pain but it is not life threatening. Witnesses responded that, again, it is very dependent on the responses given to the key questions the responder is asking.

5. There was concern amongst Members that calls were being downgraded in rural areas in order to meet performance targets. Witnesses responded that, across Surrey the service is managed on a daily basis to serve the community, be it directly with the patient or through a healthcare professional. SECAmb are transparent on their data and recognise that rural areas do not always receive the same service as urban areas. All calls are assessed clinically, in line with the appropriate pathway, and all calls are categorised accordingly. There are strict criteria for the categorisation and the service is fully audited. SECAmb does not downgrade calls to affect performance as this would be considered fraud. There are clinical pathways that set out specific outcomes for the patient depending on the responses to key questions during the call. Each call is dealt with appropriately and can either be escalated if the situation is life-threatening or downgraded if the responses indicate the need is not life-threatening.

6. The Director of Corporate Services stressed to the Committee the effectiveness of the system. From the second a call comes in, an ambulance is despatched while the call is still ongoing. This can lead to an instance where the vehicle arrives at the address before the call has been completed. If, during the course of the phone conversation, the severity of need is deemed to be less and can either be responded to via 'Hear & Treat' or by directing the patient to other services, the ambulance may be diverted elsewhere. The system is in place to ensure that the call is triaged appropriately according to the responses being given by the patient or caller.

7. Members questioned what the demands are on the service within Surrey. Witnesses responded that it varies greatly, including seasonal demands, and that it is a challenge to ensure the best service is provided regardless of where the patient resides.

8. Members continued to query rural response times, specifically the ability to meet the eight-minute response target. Witnesses responded that vehicles are placed in strategic areas according to the predicted demand on the service. They admitted that travel distance to rural parts can be longer, possibly nine to 12 minutes. The service is keen to develop links and partnerships with other organisations and look at other ways to ensure that there is medical support sooner. The service recognises that this is a challenge and seeks the support of the community to enhance the Community First Responder Scheme. There are also new initiatives, such as public-use de-fibrillator machines in supermarkets and at train stations. The ambulance service must work within its limited resources. An exercise was carried out with its commissioners and it would take an additional £15m per year to fully resource and cover the entire 3000sqm of SECAmb's coverage area. These local schemes must therefore be improved if access for rural areas is to improve.

9. Members then asked if different response targets could be considered for rural versus urban areas. Witnesses responded that, while they agree there is room for improvement, the most important aspect is ensuring the right clinical outcomes are achieved, not simply the quickest response time. The Director of Corporate Services indicated that it would be good to see more debate around clinical outcomes for the service, such as how, by getting a cardiac patient to hospital quickly, it helped him/her to be treated and discharged, that it helped to ensure the longevity of that patient's life.

10. The Chairman indicated that it might be beneficial to consider setting different targets with commissioners, aligned to achieving the clinical outcomes. SECAmb may well be meeting their performance targets across the patch, but ensuring clinical outcomes are appropriate is vitally important and might offer a better way of measuring performance.

11. Members queried how coherent responses could be from frantic patients or family members or those for whom English is a second language. Witnesses responded that there are resources that can be called upon to assist with people who do not speak English and that the call responders are trained to treat each call with caution to ensure that it has been triaged accordingly to ensure patient safety.

12. Members queried how well-equipped ambulance teams were to lift heavier patients. Witnesses responded that all units have access to various equipment that can be used as required to ensure that a patient is lifted safely. If additional assistance is required, they can also call upon additional crew or support.

13. Members asked about the use of volunteer ambulances and whether they had the same equipment as SECAmb ambulances. Witnesses

responded that all volunteer ambulance crews are staffed and equipped to the same standard as SECAmb. They receive the same training and have the same medical knowledge and competence to enable them to respond to the patient's needs appropriately.

14. The Director of Corporate Services then provided an update on the new NHS 111 service, which went live the previous day, 13 March. He indicated that things were going well, that there had been peaks and troughs during the time he'd spent observing. The service is supporting out of hours GP cover as well. Members queried the link-up between NHS 111 and the NHS Direct service. Witnesses indicated that NHS Direct would be ceasing, that NHS 111 replaces NHS Direct. Further information on this would be provided at a future meeting. A wider advertising campaign for the new service will be coming out soon.

Recommendations:

1. SECAmb is thanked for their attendance today;

2. The Committee would welcome further information and cooperation on developing the Community First Responders Scheme and placement of de-fibrillators in rural areas, particularly on where there are areas of joint working with the local authority; and

3. The Committee would also welcome working with SECAmb on how to use clinical outcomes to continue to work to improve performance across the County.

16/13 PATIENT TRANSPORT SERVICES [Item 7]

Declarations of Interest:

None.

Witnesses:

John Furey, Cabinet Member for Environment & Transport

Geraint Davies, Director of Corporate Services, SECAmb

Rob Bell, Head of Commercial Services, SECAmb

Tracey Coventry, Transport Co-ordination Team Manager

Marion Heron, Associate Director supporting Transition, NHS Surrey

Carol Pearson, CEO, Surrey Coalition of Disabled People

Cliff Bush, Chair, LINk

Key Points Raised During the Discussion:

1. The Cabinet Member attended the meeting and gave an update on the contract. He recognised that there had been several issues with the delivery, since the contract had gone live in October 2012. One of these key issues was the transfer of G4S staff into SECAmb, assessing their skills and competence. Many had to be retrained to

ensure that they were in line with PTS and SECAmb requirements. The second issue was the age of some of the vehicles. He advised that the new vehicles had not been delivered in time but that they had begun to be rolled out in mid-February 2013. The service is now delivering 18,000 transports a month within Surrey. It was reported that 85% of journeys were on time and that 91% of patients were on the vehicle for less than one hour. There is work currently being done to ensure that the eligibility criteria are clear for all groups and there are plans to roll out the booking solution.

2. The Committee was advised that the contract had still not been signed but that it should be done within the next week, before the end of the financial year. There had been concerns regarding the Director appointed by NHS Surrey but this has now been resolved. The Cabinet Member indicated that Surrey County Council was fortunate to have such a good working relationship with SECAmb that ensured the service was delivered effectively without a contract. He indicated that SECAmb had worked closely with the Transport Coordination Centre to ensure a smooth PTS transition. He continued by saying that it was due to good will on all sides that ensured patients had not suffered and it should be acknowledged and applauded that these groups had worked together well.

3. LINk, providing a patient perspective, stated that the patient experience had not been good; however the various groups have worked together to resolve and take forward a better service for the patient.

4. SECAmb's Head of Commercial Services informed the Committee that they were seeking feedback regarding the patient experience and this will be reported back in due course.

5. Surrey's Transport Co-ordination Team Manager reported that there is a centralised booking service that had initial problems, but these have now been resolved. Patients will soon be able to access one telephone number, which will then have options for the centralised booking service or for SECAmb.

6. The Chief Executive of Surrey Coalition of Disabled People stated that the problems had arisen due to lack of clear direction and this had been disappointing. She indicated that the Cabinet Member and his team have tried to resolve the problems along the way. The Coalition is aware that there is still quite a lot to be sorted; however it looks forward to the future improvements.

7. The LINk Chair stated that it had been frustrating to all concerned. He had wished for it to be noted that some patients were missing their hospital appointments due to late arrival of transport. Obtaining these appointments is difficult and when they are missed, there is often a long wait for a new appointment.

8. NHS Surrey have recognised that there was a lot of learning for the lead individual and were hoping for improved commissioning of services in the future. She personally offered her apologies on behalf of NHS Surrey.

9. The Vice-Chairman queried assurances that there was reliable digital technology in place to ensure that all patients could access the service (i.e. deaf or hard of hearing and visually impaired patients). Witnesses responded that various media, such as SMS text, had been put in place but this can be inappropriate when attempting to answer eligibility criteria questions so other alternatives are being looked at.

10. Members queried the eligibility criteria being finalised. Witnesses responded that these were being looked at and claimed that the eligibility criteria had not changed but the questions being asked had. The service would also assist those that were ineligible by giving out details for alternative transport organisations. Many people wrongly believe they are entitled to patient transport, thinking it is an open service. It is only available to those who have a genuine medical need. The Chair of LINk indicated that there is an outstanding issue about the eligibility of an advocate or chaperone riding with the patient.

11. Members queried whether the databases were sharing information between organisations. Witnesses indicated that information is transferrable and can be easily accessed. They also said that the booking system has been designed to ensure that any additional information on specific patient needs is in place to inform PTS staff for appropriate action.

12. Members queried when the Committee Chairman or Scrutiny Officer became aware of this issue, concerned about the ability of the Committee to recognise when problems are occurring and act appropriately. The Scrutiny Officer responded that she became aware in October and November 2012 of issues around the age of the vehicles and, with the support of the Chairman, had raised this informally with SECAmb. The Vice-Chairman also indicated that she was aware of issues with the SMS number in October 2012 and, with the help of the Scrutiny Officer, had raised this with the Transport Coordination Centre and SECAmb.

Recommendations:

1. Officers from Surrey County Council, SECAmb and the Surrey Coalition of the Disabled are thanked and commended on the joint working to improve the delivery of this contract;

2. The Committee was concerned that the new PTS contract has not offered the best patient experience to date but welcomes assurances that most problems have now been dealt with and looks forward to a report back in six months by SECAmb, Surrey County Council and the Surrey Coalition of Disabled People.

17/13 LINK STROKE REHABILITATION PROJECT FINAL REPORT [Item 8]

Declarations of Interest:

None.

Witnesses:

Jane Shipp, Development Officer, LINk

James Stewart, Patient Carer, LINk

Cliff Bush, Chair, LINk

Marion Heron, Associated Director supporting Transition, NHS Surrey (representing Maggie Ioannou, Director of Nursing and Quality, NHS Surrey)

Key Points Raised During the Discussion:

1. The Chair of LINk indicated that the report had been produced by volunteers who had worked many hours to gather and compile evidence. The Development Officer indicated that they had collected many patient stories that were unfortunately similar to the carer's story.

2. Witnesses highlighted three of the recommendations in the report to be addressed. First, for the struggling carers what is offered or available is not always clear. Sometimes there is no written no care plan nor any indication of what is happening and a genuine lack of available support. The second is to work with commissioners on engaging with patients and carers to deliver the best service after leaving acute care. Finally, therapy for stroke patients after leaving hospital. When patients are in a rehab hospital, they often receive daily therapy, seven days a week, but this then drops to sometimes less than five days a week. The report also highlighted inequity of provision in the east of the County. The report recommends a review of services county-wide, ensuring that patients are receiving rehabilitation and focusing on gathering evidential stories to back up what patients' needs are.

3. The Carer thanked the Committee for allowing him to share his story and raise the systematic issues that he and his wife had faced post-stroke. He stated that their concerns had been highlighted in many of the stories. He praised the work of the volunteers and thanked the Stroke Association for their support. He also encouraged organisations to work together to ensure that the patient is the central focus. He stated that strong leadership would ensure these improvements.

4. The LINk Chair was grateful for the Carer bringing the story to his attention. There is pressure on hospitals to discharge quickly but there needs to be quantifiable investment to ensure that stroke patients are provided with relevant therapy. He mentioned that the cost of early discharge may be not cost effective in the long run due to other impositions on the patient, such as cost of long-term therapy.

5. Members questioned impartial assessments of the person undertaking the Milford Hospital visits given the volunteer's involvement with the hospital pressure group some years earlier. Witnesses advised that the individual was a volunteer and that the group had used all of the resources that were available to them at the time. The enter and view reports were shared with the providers prior to inclusion in the report, giving them an opportunity to address any issues.

6. Members queried if there was additional information regarding how post-stroke rehabilitation impacts children. Witnesses responded that there was no specific data within Surrey around post-stroke rehabilitation for children. They also advised that there are now stroke patient registers and, going forward, this information may become available. Further work is being done with the local GPs and other providers to ensure that duplication is avoided when collecting and collating stroke patient data.

7. The Development Officer stressed that the work of the volunteers was vitally important to the success of the project and report. She thanked them for their support and commitment to the project and recommended that such groups be used in future. She also thanked the Committee for providing a voice for patients.

8. The Vice-Chairman thanked LINk for the report and indicated that this was the right time to share this report with Jeremy Hunt, the Secretary of State for Health, for action to be taken going forward.

9. Members queried whether Clinical Commissioning Groups (CCGs) had been involved yet and what their response had been. Witnesses responded that the CCGs had not yet been involved but would be in future. The NHS Surrey witness assured the Committee that Stroke Services had been discussed with all Surrey CCG Directors of Nursing (DONs) as part of the Quality Assurance Process. The DONs meet monthly so NHS Surrey would ensure that the Development Officer would be invited to a future meeting to discuss the report .

10. The Chairman thanked LINk and the volunteer network and the Committee endorsed the report unanimously.

Recommendations:

1. LINk and its volunteers are thanked for bringing this issue to the attention of the Committee and for their dedication and work on this project and the production of a comprehensive report;

2. The Committee endorses the report and the development of an action plan to be passed to Healthwatch to be taken forward; and

3. The Committee will monitor Healthwatch's progress on the plan and request a report in around six month's time on this.

18/13 PERFORMANCE AND QIPP UPDATE [Item 9]

Declarations of Interest:

None.

Witnesses:

Marion Heron, Associate Director supporting Transition, NHS Surrey

Key Points Raised During the Discussion:

1. Members noted the mixed sex accommodation breaches and asked if there were any further details, specifically those at Epsom & St Helier Hospitals. The witness did not have any specific information but would be able to find out and report back via the Scrutiny Officer. The Scrutiny Officer also responded that, in the past, Epsom & St Helier had been affected by mixed sex accommodation breaches primarily at Epsom Hospital and mainly when the patient had been moved from the High Dependency Unit onto a regular ward. Nonetheless, further clarification would be sought from NHS Surrey.

2. Members also sought clarification regarding Healthcare Acquired Infection breaches within the limit and whether Epsom & St Helier hospitals had now been fined for this. The witness stated that the target had been met, meaning there had been a fine. It was noted that, from a previous conversation, this would be a £5.7m fine.

3. Members queried why Ashford & St Peter's A&E were not meeting their waiting times targets. The witness responded that Ashford & St Peter's is reviewing its A&E pathways as well as the services outside of the hospital. The CCG will be setting quality targets and reviewing the overall performance of the hospital.

4. Members queried why Frimley Park Hospital and Royal Surrey County Hospital were on amber for their A&E waiting times. Were recent events the cause for the drop in performance? The witness stated that she didn't have specific data but that there has been pressure on all acute hospitals in the last few weeks.

5. Members questioned if the provision of Health Checks had stopped. The witness indicated that, previously, targeted groups of individuals received invitations for a health check, but that this would be opened up further going forward.

6. Members questioned what the current situation was with the Jarvis Centre and other providers taking its breast cancer work. The witness indicated that Virgin Healthcare and Royal Surrey County Hospital will be managing the additional demand for the time being. The mobile units will be used for assessing and the Royal Surrey County Hospital will be used for further investigation.

7. Members sought clarification on the Improving Access to Psychological Therapies (IAPT) target of 15% but only showing as 2.4%. The witness advised that the aim of 15% is for March 2015 and that procurement is currently being reviewed by CCGs.

Recommendations:

1. The officer from NHS Surrey is thanked for attending and providing the performance information.

19/13 REVISED HEALTH SCRUTINY REGULATIONS [Item 10]

Declarations of Interest:

None.

Witnesses:

Leah O'Donovan, Scrutiny Officer

Key Points Raised During the Discussion:

1. The Scrutiny Officer updated the Committee on the key changes to regulations governing health scrutiny that had been amended and recently published.

2. Members questioned the requirement for a 20 working day response to a Healthwatch formal referral and the involvement of full Council in referring matters to the Secretary of State for Health. The Scrutiny Officer responded that the Committee would not have to consult the full Council before responding to Healthwatch and that a 'holding letter' would suffice as a response, prior to further investigations about the matter referred. Full Council will not have to endorse referrals to the Secretary of State but it may be useful for the Committee to ensure it is aware of what the Committee intends to do.

20/13 RECOMMENDATION TRACKER AND FORWARD WORK PROGRAMME [Item 11]

Declarations of Interest:

None.

Witnesses:

Leah O'Donovan, Scrutiny Officer, Democratic Services

Key Points Raised During the Discussion:

1. The Scrutiny Officer indicated that the draft work programme was suggestions for the next year and was available for members to review at their leisure and comment on outside of the meeting.

2. Member thanked the Chairman for all of his hard work and showing excellent leadership for the group. Members also thanked the Scrutiny Officer for her support for the Committee.

21/13 DATE OF NEXT MEETING [Item 12]

Noted that the next meeting of the Committee would be held on 4 July 2013.

Meeting ended at: 12.55 pm

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Chairman

Health Scrutiny Committee
Members Questions
14 March 2013

Q. I understand that about 16% of over 75s need emergency readmission to hospital within 28 days of being discharged. This number has doubled in the last 10 years.

Is the Health Scrutiny Committee aware of this? What discussion has it had with the local NHS on this issue?

Please could the Chairman tell this Council about work that is planned to lower the numbers of patients, especially elderly patients, being readmitted in Surrey?

Will Forster, County Councillor

A. The Health Scrutiny Committee is keenly aware of the issue of hospital readmissions for the frail/elderly. The issue of readmissions stems from a national issue of frail/elderly hospital admissions that are often unnecessary. Care for frail/elderly is often much better delivered in the community, rather than in an acute hospital setting.

In the last year, the Committee has had several formal committee items related to the prevention of unnecessary hospital admissions, particularly in the frail/elderly. The most relevant of these was on the development of what is known as Virtual Wards. A Virtual Ward involves the identification of patients at each GP surgery that are most at risk of a hospital admission. These individuals are placed in a 'virtual ward' and have their care managed by a Community Matron while they remain at home. This care can involve visits from community nurses, social care and GPs. It is very much a multi-disciplinary care management pathway, to enable the person to remain in his/her home while being cared for in a way that would have required hospital admission in the past.

Across Surrey there are Local Transformation Boards aligned to the acute hospitals and the local health economy which have multi-stakeholder membership. The Boards consist of Chief Officers and Directors responsible for the delivery of care, working alongside commissioners to ensure that the right services are developed for the patients in each area.

The Member may be aware of the restructure of the NHS and the plans for new Clinical Commissioning Groups to take over commissioning responsibilities from 1 April. Each CCG is developing its own plans for the next year and many include priorities to reduce the number of hospital admissions, and therefore readmissions, in the frail/elderly population. Each CCG has been contacted regarding their plans in this area and the following responses have so far been received. Northeast Hampshire & Farnham CCG has indicated they will be sending information through but were unable to meet the deadline for the 14 March meeting. This information, along with that from any other CCGs not able to respond at this point in time will be passed on to the Member upon receipt. The Committee will continue to work with all CCGs on their plans to address this issue.

East Surrey CCG

East Surrey has provided investment in their community provider to ensure it has the resources in place to support the care of patients. In October 2011 First Community Health and Care (FCH&C) received further investment of £900k. This was to provide increased staffing for a rapid assessment clinic at Caterham Dene Community Hospital, ward staffing and community nurses. The services have been set up to respond to patients with complex needs, caring for them effectively in the community rather than resulting in a secondary care admission. The pathways were designed in conjunction with the acute provider to ensure they were supportive of the pathways.

The CCG uses Docobo, which is a Risk Stratification Tool. The CCG have invested in a software tool that compares both primary and secondary care data to highlight those patients requiring a higher level of care. The tool has been installed at all the GP practices.

Finally, the CCG has a Proactive Care Team (Virtual Ward). Following further investment in FCH&C in October 2012, it is working with the GP Practices and community provider to implement proactive case management of patients. This will allow the health and social care system to provide care to patients before a crisis occurs, working with a multi-disciplinary approach to deliver to the patients needs. This work will also include improved support to nursing/care homes.

North West Surrey

The CCG has a unplanned care programme designed to reduce emergency admissions in the over 75's. The CCG is working with partner organisations to develop a frail elderly pathway to improve the care of the older person. The aim of the pathway is to proactively support people in their own homes and when a hospital admission is required to rapidly assess and treat the older person and discharge them back to their own home with the required health and social care support. We know that the longer an older person stays in hospital the more likely they are to decompensate hence rapid assessment, treatment and supported discharge.

The CCG is also focusing on providing support to care homes (Nursing and residential homes) to ensure the older person is cared for as long as possible in their usual place of residence.

The virtual ward has successfully reduced admissions for the older person particularly those living with one or more long term conditions the virtual wards will continue and will be developed further over the next year with the introduction of tele-health to support more people at home.

The CCG is also working with primary and community services to improve identifying those patients who are approaching the end of their life to ensure that a care plan is put in place to support the older person die in their preferred place of death with a supportive package to meet their needs and that of their carers. We know that a person approaching the end of their life have on average 3.5 hospital admissions in their last year of life if those who are approaching their end of life not identified and care plans and packages of support are not put in place.

Clinical commissioners and secondary care clinicians are developing other clinical pathways to avoid a hospital admission where this is clinically safe and appropriate.

Surrey Downs

Surrey Downs CCG has provided a comprehensive briefing on its plans, which is attached to this as an annexe.

Surrey Heath

Surrey Heath has the following projects aimed at reducing hospital admissions

- Virtual wards
- Carer support
- Nursing home projects
- Risk stratification and proactive care
- Dementia diagnosis and early intervention
- 111 Directory of Service
- End of life registers

The Committee thanks the member for raising this issue. It will remain a priority scrutiny area for the Committee's work programme going forward.

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Briefing for: Surrey Health Scrutiny Committee

Subject: Preventing avoidable emergency readmissions for over-75s

Date: 13 March 2013

Request

The Committee has requested information on Surrey Downs CCG's plans to reduce the number of emergency readmissions for people over the age of 75 years living in the local area. This follows a question the Committee has received from one of its members who has enquiried about the plans in place to address this across all Surrey CCGs.

Background

From 1 April 2013 Surrey Downs Clinical Commissioning Group will become the statutory organisation responsible for commissioning healthcare for the patients living in the Surrey Downs area. This includes the boroughs of Epsom and Ewell, Mole Valley, the eastern part of Elmbridge, as well as Banstead and surrounding areas.

Over the past few months local clinicians have engaged with key stakeholders and local people to lead the development of the CCG's commissioning intentions for 2013/14.

Improving care for the frail and elderly, which includes reducing unnecessary hospital admissions, is one of seven key priorities for Surrey Downs.

Work is already underway on a range of initiatives to reduce unplanned admission and readmission rates among older people. These include the introduction of a new community contract and the expansion of virtual wards, collaborative working to support frail and elderly patients in the local area, an initiative to enhance dementia care and plans to deliver improved end of life care.

These initiatives, and the work already underway to reduce unnecessary hospital admissions in the Surrey Downs area is summarised below.

New community contract and the introduction of virtual wards

As an emerging CCG, one of our first areas of work was the re-procurement of the community services contract for the area as the current contract had run its course. Clinicians in Surrey Downs CCG led this process and welcomed the opportunity to develop a new service specification that would improve care and ensure local health needs are being met, including those of older people.

The new community contract, which commenced on 1 February 2013 with Central Surrey Health included the introduction of a new integrated model of care which will help ensure frail and older people get the care they need, when they need it. The contract includes the expansion of virtual wards in the Surrey Downs area. It also places a greater emphasis on identifying those who need help earlier and supporting older patients to manage their health conditions in the community, with the right help.

Virtual wards are managed by GP practices and supported by Central Surrey Health who provide case management support to patients with long-term conditions or other co-morbidities. Many of the patients referred into this service are 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 in the community by making sure they have the right level of support to help manage their conditions at home and in the community.

As a result of virtual wards we are already seeing a reduction in preventable unplanned admissions. In view of this, plans are already in place to extend this service and increase its capacity so that from 2013/14 1,000 local patients can benefit. This will enable us to further reduce unplanned admission and readmission rates for these patients.

Supporting older people and the frail and elderly

With an ageing population, and more people living with long-term health conditions, ensuring the right care is available in the community is a key priority for Surrey Downs CCG.

Working with Kingston Hospital Trust, social care colleagues from both Surrey and London, and other local commissioners, local clinicians have already put plans in place that will improve care for patients in the East Elmbridge area.

Working together, clinicians have developed a shared vision that focuses on delivering the right care in the right place at the right time through a fully integrated and patient-centred care pathway. The organisations are also working differently to reduce duplication of services and ensure closer working between all agencies, including better sharing of information.

Following a successful grant from the King’s Fund, and with the support of Surrey Council Council, clinicians have mapped the range of services available for frail and older patients that are referred into Kingston Hospital and have already starting working on a number of joint initiatives. This includes opportunities for jointly commissioning older patient psychiatric liaison services and agreeing joint processes and standards of care across health, social care, the voluntary sector and in

residential homes.

Clinicians have also established a Whole Systems Transformation Group involving providers and commssioners in the Kingston and East Elmbridge area that will focus on the frail elderly and access to urgent care. As a result of this group, a joint commissioning quality target has been established with community services, Kingston Hospital and social services to incentivise providers to work together to deliver a reduction in re-admissions in the frail elderly group over the next year.

Furthermore, following on from this work a co-operative working arrangement is now in place between A&E consultants/therapy staff and community nursing staff that enables patients in the Elmbridge area to be discharged directly into the virtual ward or community hospitals if there is a risk of readmission.

Following the success of this initiative, these principles are being applied across other areas of the CCG, where similar improvements are being made for the benefit of local patients.

Improving care for people living with dementia

In Surrey Downs 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, Surrey Downs Clinical Commissioning Group 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 have the support they need at home or in the community.

Based on similar initiatives that have delivered improved dementia care in other parts of the country, we are introducing a team of new community-based specialist nurses. 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 will be 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 so that together we can improve dementia care for local patients.

Enhancing end of life care

Working with local care homes, we want to ensure patients receive the best possible care at the end of their life. We also want to make sure their wishes are respected. To achieve this we will be recruiting an End of Life Care Facilitator who will be a single point of contact for care homes, offering education, support and advice to homes to help them reach the highest standards of care (known as the Gold

Standards Framework).

Recognising the crucial role of carers at this sad time, we will also be supporting carers to make sure they are looking after their own health and well-being and receiving the advice and support they need.

Through more co-ordinated care and better support in the community, this area of work will enable us to further reduce the number of older patients who are admitted or readmitted to hospital as part of an unplanned attendance for people who are in the last stages of their life.