Programme

Find out more about two of the CCG’s proposed commissioning intentions for 2017/18

**Stroke Care**

Dr David Eyre-Brook

Chair

**Questions**

**Community Hospitals**

Dr. Jonathan Inglesfield

Medical Director

**Questions**
Stroke care: What we know

A whole pathway approach for the provision of stroke care improves outcomes (hyper-acute through to community rehabilitation)

The first 72 hours of care are vitally important (Hyper-acute stage)

Stroke specialist doctors, nurses and therapists are essential but are also in limited supply

Many patients benefit from undertaking rehabilitation in their own home (Early Supported Discharge or ESD)
Stroke care: Potential Improvements

- Standardised, higher quality care across the whole stroke care pathway regardless of where you live in Surrey (improved equity)
- Fewer days spent in hospital (length of stay)
- Patients could be discharged straight home with intense support (early supported discharge) - 50%
- Each stroke team will have clinical staff with the right specialist skills to deliver high quality stroke care
- Improved outcomes
- A single point of contact for families and carers throughout rehabilitation, reducing duplication
Stroke Care: What has happened so far?

2014 to 2015

January 2016

July 2016

September 2016

Surrey Stroke Review

- Consider how to deliver an improved and more effective whole pathway of care to ensure better clinical outcomes
- Engagement via stakeholder meetings, questionnaires and website to find out what’s important to patients and the public
- Expert panel convened April 2015
Stroke Care: What has happened so far?

Committees in Common (CiC) request for proposals

- CiC comprises representatives of 6 CCG governing bodies
- Providers across Surrey asked to work together in ‘systems’ to develop proposals to deliver the whole pathway of care
- How could they meet the quality standards required by the South East Coast Stroke Service Specification?
Expert panel provided feedback to providers

Providers continued to develop the new models and pathways of care
Stroke Care: Current position

Proposals submitted

- Final plans have been submitted to CiC
- CiC meet on 6th October 2016 to assess feasibility of proposals and compliance with quality standards
- Public consultation plan being prepared by CCGs
What would the proposals mean for our population?

**Current Position**
- Stroke suspected
  - Royal Surrey
    - Farnham or Milford or ESD

**Proposals at this stage**
- Stroke suspected including ‘See & Transfer at RSCH’
  - Frimley Park Hospital
    - Farnham or ESD
  - St. Peter’s Hospital
    - Woking or ESD
Stroke Care: What next?

Public Consultation

- Health & Wellbeing Scrutiny Committee will advise on overall consultation plans and appropriate timing for and of the consultation
- Nature of public consultation to be agreed by CiC
- Surrey-wide or clusters of CCGs
- Wide variety of channels will be used to ensure the consultation is open and accessible to all population groups
- Details will be widely publicised online and via print and broadcast media
- Contact our Partnership & Engagement Team for more information and to invite the CCG to your own group/forum
Questions
Community Hospitals

- Implement new Integrated Proactive Care services
- Provide ‘out of hospital’ services in the community closer to the patient
- Work with communities to scope local estates solution for the future
Future Proofing Services

What community services will be needed in the future to enable our older population to live and thrive in their own home for as long as possible?

Demographics

Life expectancy in Guildford and Waverley is amongst the highest in the country

- 82 years in men
- 85 years in women

At age 65 in G&W:

- Men can expect to live 8 years of their remaining 20 in poor health.
- Women can expect to live 10 years out of remaining 23 in poor health

10% expected increase in over 65s by 2037
Current Community Hospitals

60 beds across 3 sites

- Community hospital beds - 3 sites in Farnham, Haslemere & Milford
- No single standard for admission pathway or models of care
- Most patients are admitted after an acute hospital stay
- Very few patients admitted directly from the community to avoid admission
- Small number of beds being provided across multiple sites results in challenges in:
  - Managing staffing capacity over small wards
  - Variance in pathways of care
  - Less flexibility in male/female bed allocation
  - Reduces opportunity for multidisciplinary working
Working together

Community Provision fit for the future

Proactive Care Hubs providing integrated, same day care and community beds

Single point of access into community beds with clearly defined pathways

Community Services Estates that meets the needs of patients in the community

Community Hospitals are key for caring for patients in the community

Need to develop a new community hospital model with patients and the public

This is just the beginning. You can help scope the future models.
Co-design options with stakeholders

- Autumn 2016: Stakeholder Engagement
- Winter 2016/17: Draft options appraisal
- Spring/Summer 2017: Public consultation
Contact us and Get Involved

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