Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
28th April 2011

TITLE	**Future Model of Care**
EXECUTIVE SUMMARY	The health and social care partners in NW Surrey are increasingly working together to respond to the challenges faced in the local health system. In October 2010 work was launched to describe the Future Model of Care for NW Surrey. The aim was for front line clinicians from primary care, community care, acute care and mental health services to be able to work together to develop and agree the future models of care for health services in NW Surrey. The Future Model of Care project provided front line clinical leaders with an opportunity to start with a blank sheet of paper and describe the model they want to see in place in this locality – working together, rather than in silos. The report provides an update on the 5 work streams
BOARD ASSURANCE (Risk) / IMPLICATIONS	Integrated working with partners across the local health economy is essential. Relates to BAF risks 1.1/3.2/3.3/3.5/4.1/4.3/4.8/4.10/4.11
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Collaborative working across North West Surrey
EQUALITY AND DIVERSITY ISSUES	None
The Trust Board is asked to:	Note the report
Submitted by:	Andrew Liles Chief Executive
Date:	19th April 2011
Decision:	For Noting

Future Model of Care for NW Surrey

1 Executive Summary

1.1 The health and social care partners in NW Surrey are increasingly working together to respond to the challenges faced in the local health system. In October 2010 work was launched to describe the **Future Model of Care for NW Surrey**. The aim was for front line clinicians from primary care, community care, acute care and mental health services to be able to work together to develop and agree the future models of care for health services in NW Surrey. The Future Model of Care project provided front line clinical leaders with an opportunity to start with a blank sheet of paper and describe the model they want to see in place in this locality – working together, rather than in silos.

1.2 Five groups, covering Planned Care, Urgent & Emergency Care, Chronic Care, End of Life Care and Women's and Children's Care were facilitated through a process beginning in November 2010 to describe this future model. Each group shared the outputs of their thinking with the local health economy in March 2011.

1.3 Taking together the future models of care developed by these five groups provides us with a picture of the overall model for NW Surrey in future. **The future model of care for NW Surrey involves an integrated and coordinated healthcare system which focuses on the whole care pathway with seamless interventions, where appropriate, from all care providers.**

1.4 Four themes stand out in this integrated system, from the work developed by each of the future model of care groups:

- The system in future needs much greater levels of communication.
- The future system will proactively manage the care of the most vulnerable/those who are repeatedly admitted to hospital - identifying and proactively managing the needs of those who are most at risk.
- In the future system there will be stronger services in place in the community acting as credible, trusted alternatives to being in hospital
- Through Integrated Referral Management Centres we will manage the interface between primary, community and acute care for planned services

1.5 Work is underway to agree the action to be taken in NW Surrey during 2011/12 to begin service changes in line with this Future Model of Care, focussed on three broad areas:

- agreeing and implementing shared criteria and pathways for elective procedures and treatments in order to create a more effective planned care system and control elective demand & costs
- agreeing and implementing a stronger emergency care system with clear and appropriate alternatives to hospital admission
- modernising the communication network between health care sectors in NW Surrey

2 Background

2.1 The health and social care partners in NW Surrey are increasingly working together to respond to the challenges faced in the local health system. At the beginning of 2010, leaders of the primary, community, acute, mental health and social care organisations in NW Surrey agreed the principles of allegiance that would form the basis of the ways in which the organisations would work together, through a 'NW Surrey Transformation Board'. These principles were:

a) The organisations in NW Surrey will work in partnership to drive change - changes to service delivery models will be agreed rather than imposed
b) Where redesign results in moving services out of an existing organisation, clinical staff in that organisation will be involved in designing the new pathways and will have a role to play in providing the new services - in order to avoid having stranded clinical staff
c) We will identify areas of potential conflict of interest and agree strategies for handling them
d) Where agreed changes have a significant impact on the business of an existing provider, time will be allowed to restructure the business, in order to avoid having stranded costs in the system
e) In the redesigned pathways and models of care we create, we will ensure that each organisation has sufficient influence over the delivery of services in that pathway to enable it to meet its responsibilities.

2.2 The NW Surrey Transformation Board led work, through a series of projects, to make improvements to the services currently provided. In October 2010 the Transformation Board also launched work to describe the **Future Model of Care for NW Surrey**. The aim was for front line clinicians from primary care, community care, acute care and mental health services to be able to work together to develop and agree the future models of care for health services in NW Surrey. The Future Model of Care project provided front line clinical leaders with an opportunity to start with a blank sheet of paper and describe the model they want to see in place in this locality – working together, rather than in silos.

2.3 Five groups, covering Planned Care, Urgent & Emergency Care, Chronic Care, End of Life Care and Women's and Children's Care were facilitated through a process beginning in November 2010 to describe this future model. Each group shared the outputs of their thinking with the local health economy in March 2011. This document summarises these outputs.

2.4 NW Surrey has an NHS budget of ~£500m, and a need to reduce costs in the system by 2013/14. Approximately half of the local NHS resources are currently invested in the acute sector, with 76,000 admissions per year (38% for people aged 65+) and almost 400,000 outpatient appointments. Three-quarters of the acute activity in NW Surrey takes place within Ashford & St Peter's NHS Foundation Trust, and at any one time NW Surrey patients occupy about 590 acute inpatient beds.

3 Vision for NW Surrey

3.1 An overall vision for NW Surrey is emerging where

- Individuals are supported to improve their own health and wellbeing
- System focussed on keeping people as healthy and independent as possible in their own home, with services designed to achieve this
- When people are ill, they receive the best possible healthcare
- As much care as possible is delivered in a community setting, where it makes clinical and economic sense to do so
- NW Surrey is an Integrated Health and Social Care system – thriving organisations working as one, in the common interest
- Proactively managing the health needs of the population we serve, rather than simply responding to the needs as patients present to us
- Stronger primary and community services enabling a smaller high quality acute sector
- Most dying people are able to die where they choose

4 Planned Care

4.1 The Future Model of Care for Planned Care in NW Surrey envisages a system delivering integrated healthcare across the NHS in the locality (summarised in figure 1 below), with

- Access to specialist advice managed through Integrated Referral Management Centres
- Improved communication across all health professionals
- An integrated approach between providers which leads to better discharges from hospital, reduced lengths of acute hospital stay and fewer readmissions

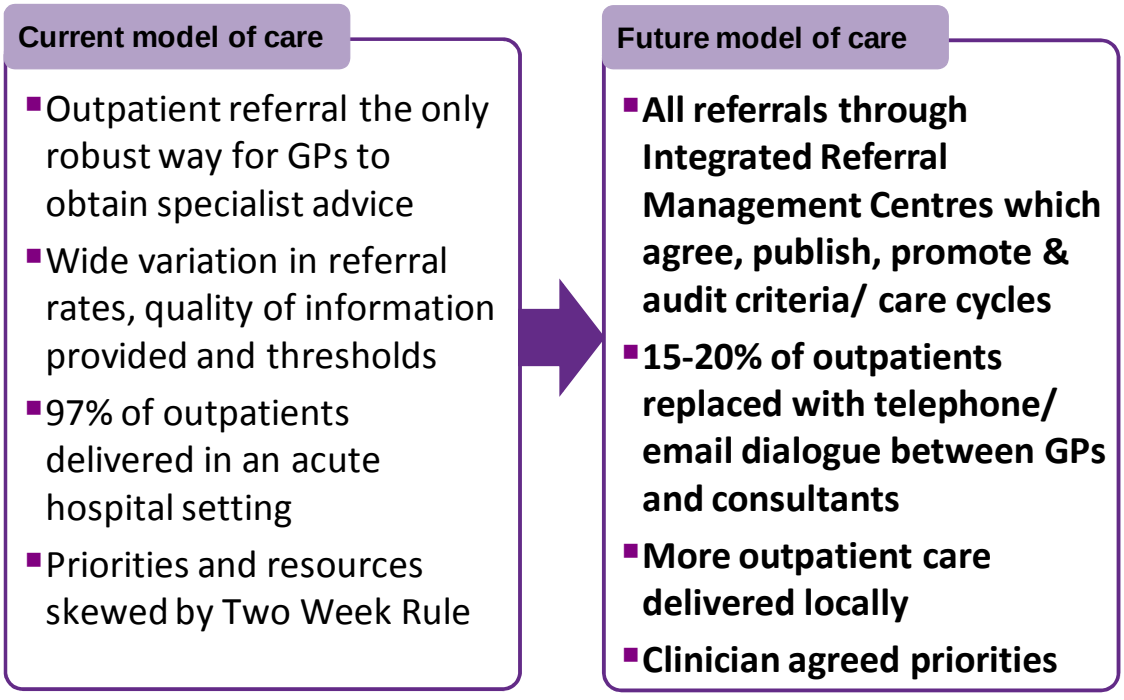
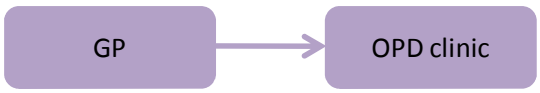


Figure 1: Planned Care Current and Future Model of Care

Access to specialist advice

4.2 With one or two exceptions, referral to an outpatient clinic is the only route through which GPs can obtain specialist advice regarding the management of a patient.

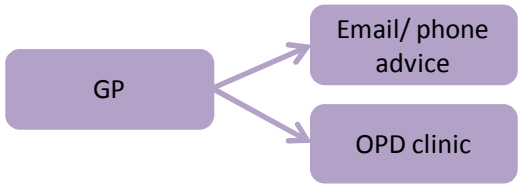


Currently ~400 GP referrals per day to a consultant clinic – approx 300 of them to ASPH

4.3 Some GPs telephone some consultants for advice, but its generally ad-hoc, informal, relies on the consultant or GP being available when needed, and is based on goodwill. The view of primary care clinicians is that the ability to talk through an issue with a consultant would avoid the need for an outpatient appointment in some cases – and that the dialogue would be an important part of the patient's management plan

4.4 **Access to consultants via telephone and email, will form an important part of the future model of care**. Such alternatives may not reduce the time consultants would spend providing advice, but would lead to a significant reduction in the number of outpatient clinics and the associated staffing, prep and facility costs, as well as reducing patient journeys.

4.5 ASPH would develop a robust service offering consultant advice within (say) 48 hours. This would be built into job plans and funded, properly administered, governed and managed. Referrals could be routed through a single email address eg: *gpadvice@asph.nhs.uk*. This system would further strengthen relationships are strengthened between GPs and consultants.



Based on experience elsewhere, up to 15% of GP referrals (approx 60 each day) could be managed through alternative routes

4.6 **Referral management systems form an important part of the Future Model of Care in the area and in future all referrals will be channelled through these centres**. The role of a referral centre is to:

- Agree referral guidance between primary, community and secondary care (this will include the provision to GPs of greater direct access to diagnostics such as MRI)
- Publish, communicate and promote those criteria, guidance and agreed care cycles
- Ensure referrals are consistent with this, reviewing all referrals and ensuring they are channelled to the appropriate location

4.7 The agreement of pathways and their promotion could be done once for NW Surrey, but the process of testing referrals against the agreed process and ensuring they are channelled to the appropriate location may best delivered at a locality level, where relationships between GPs can be most effectively developed and managed.

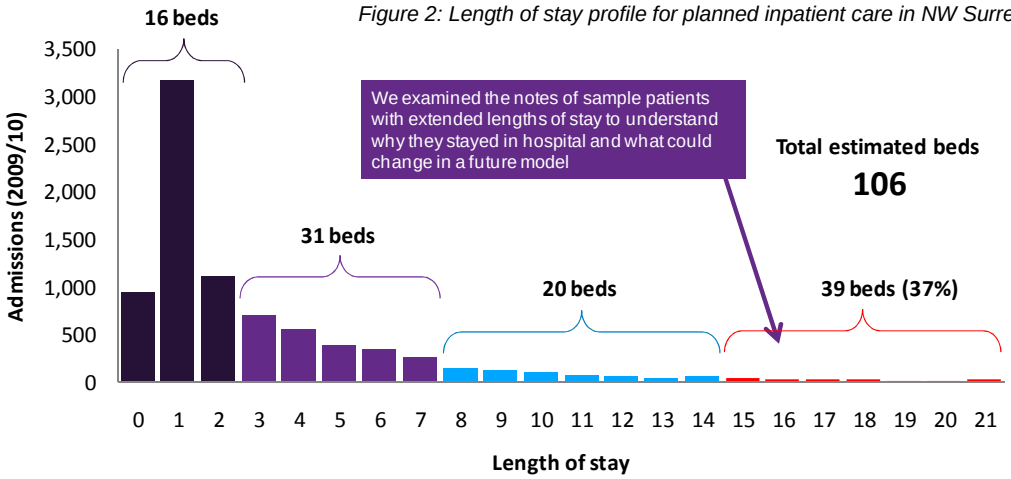
4.8 The 'hubs' where this process takes place will become centres of expertise on handling referrals. A referral centre will become a centre of expertise on handling referrals, a route to standardise the quality and nature of referrals, and an important channel through which ASPH can communicate with primary care & commissioners, and through which primary care communicates with ASPH. A similar process of 'sorting' referrals is increasingly taking place within ASPH it would be possible to bring together

the 'sorting' in primary care and in ASPH into a single process – a fully integrated referral centre with clinicians from primary & secondary care.

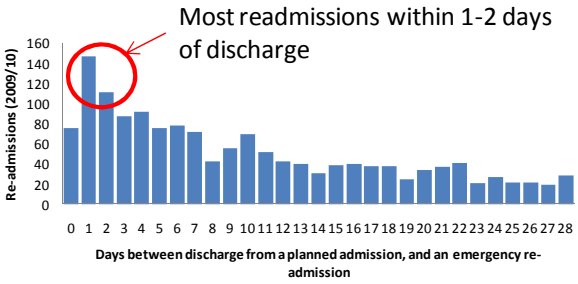
Better Acute Elective Care

4.9 There are currently approximately 9500 planned inpatient admissions each year in NW Surrey, and although most patients have a small length of stay, approximately one-third of the 100 beds utilised by elective inpatients at any one time are occupied by patients who have, or who will, stay in hospital for more than two weeks.

Figure 2: Length of stay profile for planned inpatient care in NW Surrey 2009/10



4.10 1 in 25 elective admissions leads to an unplanned readmission within 28 days - most occur within the first week, with a peak in the first two days. Review of the records of sample patients with extended lengths of stay and readmissions, found that for ~40% of long stay patients, the issues which led to an extended hospital stay or complicated discharge were predictable. Much earlier (pre-admission) assessment of the patients' post acute needs and planning the discharge would have led to significantly better quality and shorter length of stay.



4.11 **In the future model of care, much earlier, more holistic assessments of patients prior to admission for elective care would identify (and allow better preparation/planning for) many of the issues which typically lead to extended lengths of stay, delayed discharges, and in some cases, readmission**. Information sharing is crucial to improving the care pathway – all clinicians involved in the care pathway need access to all the relevant information (eg discharge summaries)

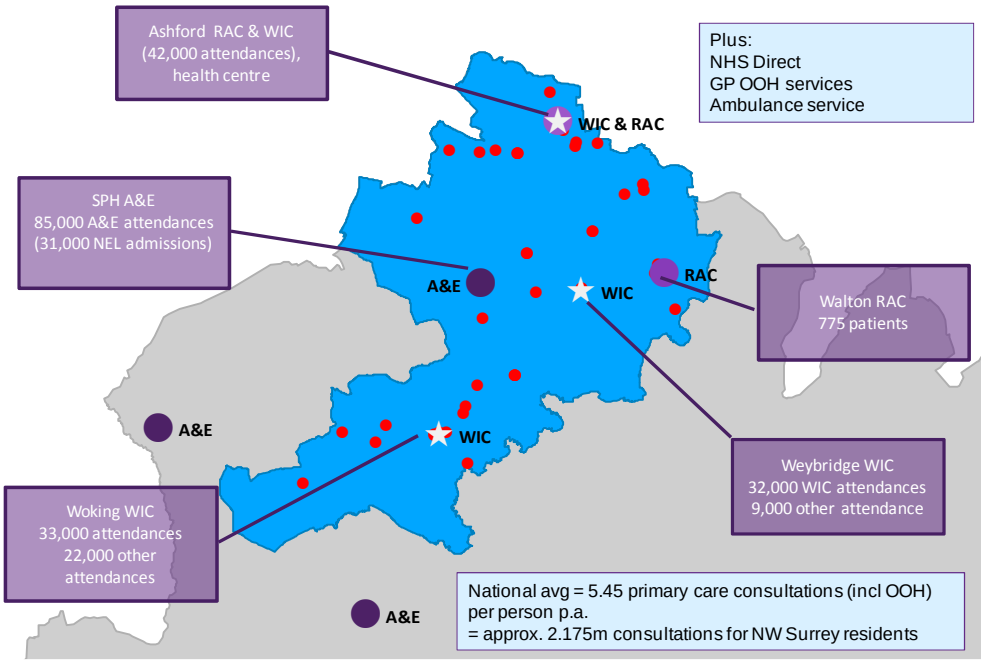
4.12 It is proposed that 'admission assessment checklists' be created - the checklists would consist of a generic assessment which would apply to all patients and would ensure that the patient's wider needs are identified, and a specialty/procedure specific component which would vary depending on the reason for admission.

4.13 Currently 77% of elective activity undertaken in NW Surrey is on a day case basis. **We expect the range of procedures that are undertaken on a day case basis to have increased further in 3 years time, for example day case hip replacements will be**

the norm in NW Surrey in 3 years time – with the associated shift in resources from hospital into community to enable the necessary physiotherapy and intermediate care to be provided at home.

5 Urgent and Emergency Care

5.1 NW Surrey currently has a wide range of emergency and urgent care services – an A&E at St Peter's, three Walk-In Centres, two rapid access centres, primary care, community rapid response services and the ambulance service.



5.2 Approximately 60% of patients attending A&E are discharged without further treatment, and not all of these patients necessarily needed to be seen in an A&E department. More than half of patients attending Walk-In Centres do so with minor injuries and minor illnesses. Only a small proportion (approx 15%) say that they would have attended A&E had the walk-in centre not been available, most would have gone to see their GP.

5.3 **The future model of urgent care in NW Surrey has six core components**:

St Peter's A&E with 'meet & greet'	SPH A&E supplemented by a primary care and nurse-led **'meet and greet service'.** This service would register and assess patients, signpost appropriate patients to primary care where their conditions could be treated by their GP (including booking same day appointments). GP practices make available urgent care appointment slots each day.
Community hubs at Ashford & Woking	Enhanced **community hospital hubs** incorporating walk-in centre; diagnostics; and rapid access centre with assessment beds. **Ambulance service convey patients on the 49 ambulatory care pathways to the hub**. Ashford regarded as a community hub.
Walk-In Centres (fewer than today?)	WICs - as current model plus standardised: opening hours; diagnostic and primary care support; links to A&E (e.g. expert advice) **One WIC model for NW Surrey. Typically co-located with community hub, but not A&E.**
Ambulance service	As current model plus introduction of **NHS Pathways** and **Paramedic Practitioners**
GP 'clustering' for OOH urgent care	GP practices work together on a locality basis to provide evening and weekend cover for urgent care. **One centre within each locality would be staffed by local GPs on a rota, until (say) 10pm & 9-5 at weekends**. Service would be funded from OOH contract monies perhaps through ThamesDoc or the extended hours LES. Link with A&E 'meet and greet'.
Community services	As per chronic care group – community health and social care services **focusing on patients at risk of acute attendance** (and admission) would be enhanced, especially out of hours. Increased case management and in-reach/liaison services to proactively manage patients at home.

5.4 Each of these components is described in more detail below:

a) **Introduction of a meet and greet service at St Peter's Hospital**
People attending A&E would receive an initial triage and if considered likely to be appropriate would be diverted to the nurse-led meet and greet service. The purpose of this service would be to:

- Provide advice on the appropriate service to use for the presenting condition.
- Offer advice of alternative services available on a walk-in (e.g. WICs, high street pharmacist) or short-notice booking basis (e.g. patient's GP).

- Make an appointment for the patient with their GP if necessary (NW Surrey GP practices would need to agree to make available emergency clinic appointment slots each day)

It is not the aim of the meet and greet service to treat patients, the service isn't a primary care front-end to A&E.

b) **Developing Community Hubs and implementing the ambulatory care pathways**

Ashford and Woking hospitals provide an important mix of services interfacing with St Peter's Hospital and community services. Both would be developed as community hubs, providing ambulatory care for the 49 care pathways - 49 conditions where there is a robust evidence base that patients can be treated on a day case basis thus avoiding inpatient admission. The list on the right sets out the top-25 reasons for treatment ranked by potential for ambulatory care.

Rank	Clinical scenario
1	Chest pain
2	Appendicular fractures not requiring immediate internal fixation
3	Deliberate self-harm
4	Acute abdominal pain not requiring operative intervention
5	Cellulitis
6	Falls including syncope or collapse
7	Seizure in known epileptic
8	First seizure
9	Lower respiratory tract infections without COPD
10	Head injury
11	Supraventricular tachycardias
12	Gastroenteritis
13	Congestive cardiac failure
14	Deep vein thrombosis
15	Renal/ureteric stones
16	Acute admissions from care homes
17	Acute painful bladder outflow obstruction
18	Acute headache
19	Transient ischaemic attack
20	COPD
21	Community acquired pneumonia
22	Pulmonary embolism
23	Abscesses requiring surgical drainage – perianal, breast, wound etc.
24	Pleural effusions
25	Low risk pubic rami fractures

In the future model, community services would operate on a hub and spoke model from both sites. Services would include rehabilitation beds, rapid access centres, walk-in urgent care for minor illness and injury, an out of hours primary care base, diagnostics (to a standard model of provision), team bases for community staff, and clinics delivered by acute staff.

c) **A single model of walk-in centres for NW Surrey**

There are currently three walk-in centres (WICs) in NW Surrey – Ashford, Weybridge and Woking, each operating different models. National research indicates that patients are confused about alternatives to A&E – WICs, urgent care centres, primary care A&E front ends, so will 'take the path of least resistance' i.e. A&E attendance. In future a standardised model of walk-in centres would be in place across NW Surrey - standard opening times, standard staff skill mix and standard diagnostic support, and the number of walk-in centres may need to reviewed.

d) **NHS Pathways and Paramedic Practitioners**

NHS Pathways is an integrated, web-based directory that can be populated with the skills and services within any given area. It will be used by the ambulance service to make telephone-based clinical assessments. As the assessment progresses, certain answers determine that a particular clinical skill will be required by this caller. At the end of the assessment, a unique combination of codes identifies the clinical skills required, and the time frame within which they must be provided to the patient.

Paramedic practitioners are being piloted by SECamb. These practitioners represent a higher level of skill available on an ambulance, enabling more patients to be treated at the scene, thus reducing the hospital conveyance rate. Initial results from pilot show hospital conveyance rates reduced from 65% to 46% and the future model anticipates wider use of these practitioners across NW Surrey.

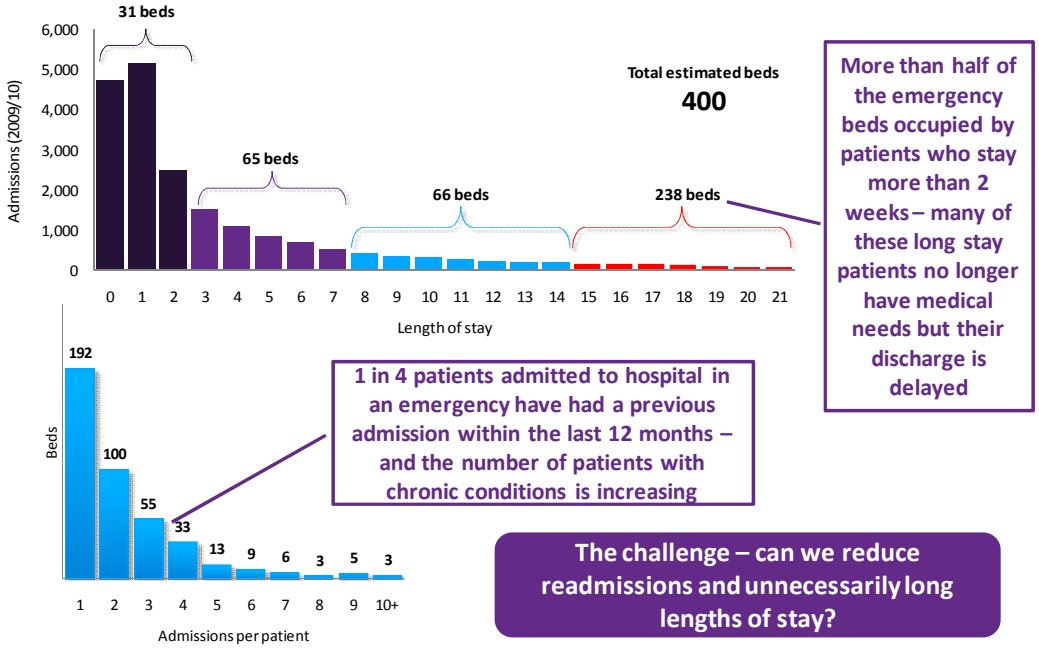
e) **GP clustering for out of hours care**

Primary care 'out of normal working hours' is currently provided by a combination of extended hours services provided by some practices under an extended hours local enhanced service (LES) arrangement, ThamesDoc and Walk-In Centres. There are currently an estimated 34,000 ThamesDoc contacts and 13,000 WIC evening attendances. The future model would use funding from these three sources to provide standardised extended primary care opening hours on a cluster (locality) basis in the evening (say to 10pm), and at weekends (say 9am-5pm). A single centre within each cluster would open for the extended hours, staffed by local GPs on a rota basis. These centres could be, for example, Weybridge Primary Care Centre in Thames Medical, Woking Community Hospital in Woking and Staines Health Centre or Ashford Hospital in SASSE.

6 Chronic Care

6.1 There are approximately 22,000 adults and older people in NW Surrey admitted to hospital in an emergency each year. 1 in 4 patients admitted to hospital in an emergency have had at least one previous admission within the last 12 months, most with chronic or enduring health issues.

6.2 Patients with complex conditions and those with chronic conditions who are frequently readmitted consume disproportionate resources in the acute care system. Of the 400 beds used by emergency patients in NW Surrey, more than half are occupied by patients who have or will stay in hospital more than 2 weeks. For many of these long stay patients they no longer have medical needs but their discharge is delayed.



Length of stay and readmissions profile for unplanned inpatient care for adults/older people in NW Surrey 2009/10

6.3 **We have described the future model of care in three areas**:

1. **Effective acute episode for those patients with Chronic Conditions who do require acute hospital based inpatient care**

   Communication between GP and consultant on admission, greater continuity of care within hospital, better more timely discharge, reduced readmissions and a post discharge management plan in place

2. **Robust alternatives to hospital based care for patients who have an acute deterioration in their health & social circumstances**

   Holistic assessment of patients functional needs and immediate access to the equipment, advice, diagnostics and health & social care services needed to maintain patients safely in the community

3. **Integrated services that are effective at supporting patients with chronic conditions to remain healthy & independent in the community**

   Minimised risk of deterioration of a patients' health and social circumstances that would in the past have led to acute admission

6.4 The following paragraphs describe more fully the envisaged model in using these three sets of headings.

a) Effective acute episode for those patients with Chronic Conditions who do require acute hospital based inpatient care

In the future system there will be:

- Communication taking place between GP & consultant on admission, during admission and on discharge to discuss, plan and agree the most appropriate package of care the patient needs. The acute admission and the input of the acute team is an integrated part of the care delivered by the NHS for that patient.
- A functional assessment of each patients' needs – rather than just managing their medical diagnosis, eg using CARDS approach (assessment of Continence, Ambulation, Rationality - including medicines management, Daily living, Skin - including nutrition)
- Discharge letters proposing a management plan for the patient rather than simply documenting what happened in hospital – this letter is seen as a key output of the acute intervention in the patient's care, is signed off by the consultant, & shared with GP/community team at discharge
- Patients at highest risk of readmission are identified & supported post discharge to minimise risk of readmission
- Community staff able to access patient information in the ASPH IT system remotely and hospital able to access GP system.
- Community staff working with acute wards to pull their patients out of hospital – identifying needs much earlier and with immediate access when they need to it to the equipment and social care packages they need
- Staff rotating between acute hospital and community service roles to gain an understanding and experience of both.
- A system which values and supports the development of relationships and trust between GPs, Consultants and community teams, rather than being transactional
- Fewer internal ward movements which add delay & duplication to the inpatient episode
- Better management of the ~100 patients who no longer require the level of support available in an acute hospital bed

b) Robust alternatives to hospital based care for patients who have an acute deterioration in their health & social circumstances

In the future system there will be:

- Community based rapid access to multidisciplinary (acute, community and primary care skills) team to assess and deliver services which provide care where this is more appropriate than admission
    i. Includes a holistic assessment (identifying functional needs not just diagnosis)
    ii. Able to respond very quickly and access services which are immediately available (including community beds, virtual wards, social care, equipment, other community services)
    iii. Serving a population of approx. 100,000 and linked to a community hub

- Care Plans in place for all patients with chronic conditions which include agreed approaches when crisis occurs. Its existence is known to, and it can be accessed by all services, including ambulance service
- 'Virtual wards' which enable sick patients to be supported out of hospital through high intensity community based care
- System which values and strengthens relationships and trust between GPs, community staff and consultants. GPs can access urgent specialist hospital advice by talking to consultants rather than just by referral or admission
- Acute physicians able to 'discharge for assessment'

c) Integrated services that are effective at supporting patients with chronic conditions to remain as healthy & independent as possible in the community

In the future system there will be:

- Integrated primary and community teams based around general practice, working together to pro-actively plan and meet the needs of the practice population with chronic care needs
- Levels of continuity and relationship building that lead to trust between professionals and therefore higher quality seamless care
- Teams systematically and earlier identifying patient's needs and every patient with chronic conditions having a care plan to manage those needs. Patients to sign up to care plans 'nothing about us, without us'
- Continuity of health and social care professionals involved in caring for patients - to better understand what is 'normal' for any given patient and when things are changing, and building of effective relationships between professionals
- GPs able to access to specialist consultant advice to help them manage the patient – perhaps not always through outpatients – Acute specialists as part of the integrated team that GPs know and trust to help them manage patients.
- Nursing homes develop the skills and access to specialist advice as part of an integrated system

7 End of Life Care

7.1 Although every individual may have a different idea about what would, for them, constitute a 'good death', for many this would involve:

- Being treated as an individual, with dignity and respect;
- Being without pain and other symptoms;
- Being in familiar surroundings; and
- Being in the company of close family and/or friends.

7.2 Some people in NW Surrey do indeed die as they would have wished. Some people experience excellent care in hospitals, hospices, care homes and in their own homes, but the reality is that many do not. Some people experience unnecessary pain and other symptoms, some are not treated with dignity and respect and many people do not die where they would choose to.

7.3 Our aim is that all people approaching the end of life have access to high quality care, wherever the person may be: at home, in a care home, in hospital, in a hospice or elsewhere, and irrespective of age, gender, ethnicity, religious belief, disability, sexual orientation, diagnosis or socioeconomic deprivation.

7.4 Approximately 1100 people die each year in hospital in NW Surrey. 60% of these patients have had more than 1 admission in the last year of life, and many have a very long length of stay in hospital. The table opposite shows the causes and conditions of the 1100 people who died in hospital in NW Surrey during 2009/10.

Causes and conditions	Admis.	(%)
Acute resp. infections & disorders	251	23%
Cancer	127	12%
Older people - physical problems	101	9%
Lower GI emergencies	83	8%
Stroke	94	9%
Acute coronary syndrome	38	3%
Heart failure	37	3%
COPD/Asthma	30	3%
Renal disease	32	3%
Acute upper GI	29	3%
Elderly fragility fractures	31	3%
Vascular	17	2%
Other causes	226	21%
Total	**1,096**	

7.5 Nationally 60% of deaths occur in hospital – we would like to reduce this to 40%. In NW Surrey this means reducing from 1,096 to fewer than 700 the number of deaths in hospital.

7.6 Our view is that the model described in the national end of life strategy should be the future model of care for NW Surrey. Using this as a structure, **the future model of care for NW Surrey has been described around 6 themes**:

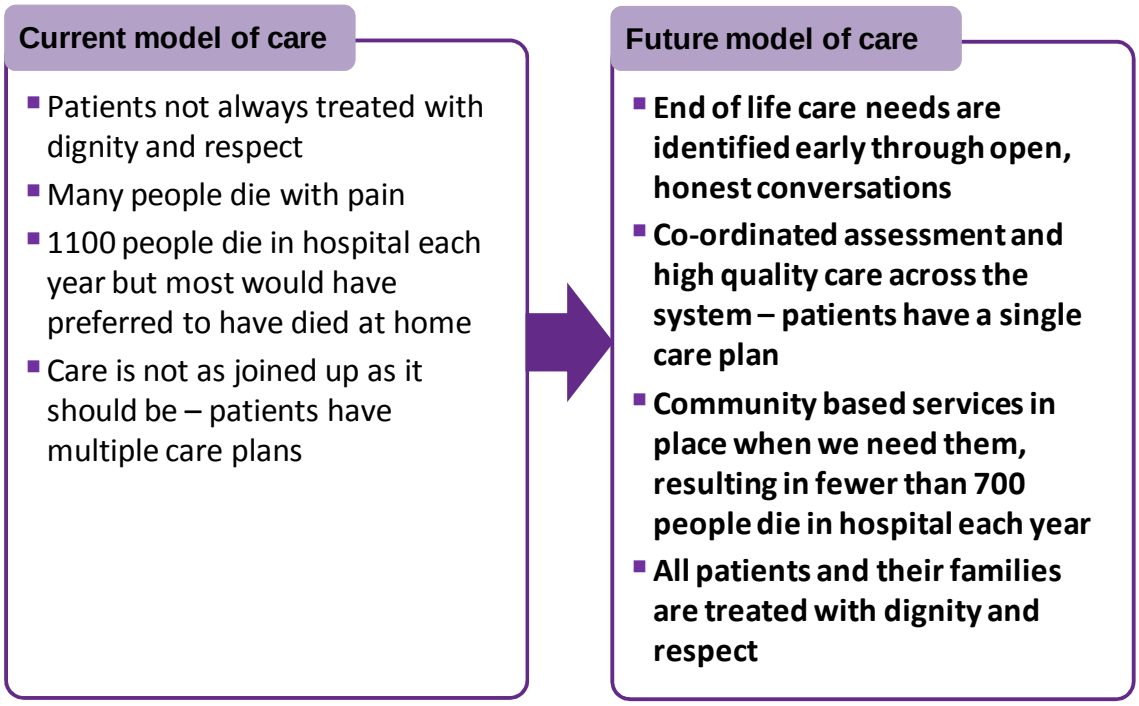
Discussions as end of life approaches	People approaching the end of their life are identified and identified earlier than currently. Open, honest conversations initiated with patients and their carers. Patients are placed on an EoL care pathway.
Assessment, care planning & review	Shared holistic assessments acceptable to providers across health and social care services, covering physical, psychological, social and spiritual needs of the patient and carers. Agreed care plans result from assessments.
Co-ordination of care	A locality based centralised register of EoL patients accessible by all care providers. Patient and carer given single point of contact number accessible 24/7. Preferences (eg 'do not resuscitate') clearly stated.
Delivery of high quality services	Patients and their carers received uniformly high quality end of life care at all times/in all care settings, and multi-disciplinary specialist palliative care input; quality measures used to leverage change.
Care in the last days of life	Final review of needs and preferences for place of death once the last phase of life is identified. The last days of life are as far as possible free from pain, discomfort and fear. Fewer than 700 per year die in hospital.
Care after death	Families are supported by high quality bereavement care – e.g. access to bereavement counselling. Recognition that end of life care does not stop at the point of death – support continues as long as needed.

7.7 For our future workforce this means that all relevant professionals receive end of life care training as part of their core curriculum. Patients and carers are confident that those caring for them are well trained, competent, confident and sensitive to their needs and wishes.

7.8 An integrated approach to service delivery requires improved communication. IT solutions will enable timely access to information about patient's care plans; centrally held registers of care plans will be accessible, remotely, by all providers. There will be shared protocols and assessments, and link/key workers to co-ordinate care.

7.9 All providers will monitor, audit & review end of life service delivery and use this information to continuously improve services. Patient and carer feedback will be sought and actively reviewed. Service delivery will be underpinned by clear contracts between commissioners and all providers which lever change and facilitate delivery of strategy.

7.10 The figure below summarises the current and future model of end of life care in NW Surrey:



8 Women's and Children's Services

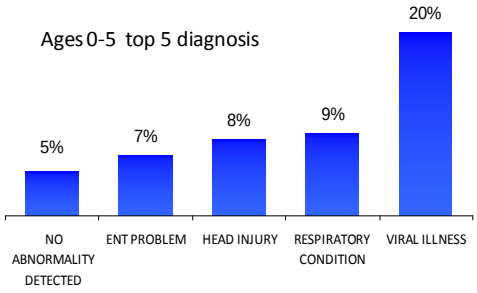
8.1 In describing the future model of care for women's and children's services in NW Surrey consideration has been given to the key service issues where change could lead to improvements, based on the issues raised by patients and the perspective of the clinicians working in the system. These areas are:

- Paediatrics – paediatric urgent care, allergy pathway, ADHD pathway and integrated paediatric services
- Maternity – reducing unnecessary C-sections, improving information flow between secondary and primary care, development of a midwifery led unit
- Gynaecology – urogynaecology service and pathway

Paediatric Urgent Care

8.2 There are currently approximately 34,000 paediatric attendances each year at ASPH Paediatric A&E and the Ashford Walk In Centre. Of these attendances, the largest group is children aged <5, and for these young children, viral illness represents 1 in 5 diagnoses – with attendance rates for this group 50% higher at weekends.

8.3 In the future, our principle is that primary care problems should be dealt with in primary care – a key issue for the system in order to enable this is to commission an out-of hours primary care service that is sufficiently responsive, and incentivised to provide appropriate patient management. In the future model we also envisage better triage of patients attending A&E – including to telephone advice from their GP and self care.



Allergy and ADHD referrals

8.4 Allergy and ADHD referrals represent the two groups where demand most significantly outstrips available capacity. Simple referral protocols have been developed and agreed which describe what should be managed in future in primary care, what to refer, what information to provide, and the long term follow up arrangements. These protocols take the documentation used in hospital clinics and enable GPs use it in the referral process – improving the quality of information received in hospital and helping prepare families (and manage expectations).

8.5 ADHD medication is managed through a shared care protocol – but a significant minority of GPs choose not to work with the protocol. As a result parents currently attend clinics to receive prescriptions. In the preferred future model all GPs would participate in the shared care protocol, and in the mean time better systems will be developed for prescribing which eliminate the need for as frequent hospital visits for this group.

Integrated Paediatric Services

8.6 There are currently separate consultant led paediatric services in ASPH and Surrey Community Health, with different funding streams & contracts. GPs (and others) are unclear about what to refer where, or about the roles of the two services. Many services across the country are fully integrated, with no distinction between hospital and community.

8.7 In an ideal model there would be an integrated community and acute paediatric service, which would plan the use of all the resources to best meet need, and ensure that patients see the most appropriate clinician in most appropriate location.

Maternity Services

8.8 There are currently just over 4000 births for NW Surrey women each year – and approximately 85% of these births take place at ASPH.

8.9 The Caesarean Section rate at ASPH has fallen by 2.7% to 25.2% since Apr 10 – the future model of care includes continuation of this trend, but a shift towards ensuring an *appropriate* rate rather than simply a lower rate. The future model includes a greater role for GPs in reducing the number of repeat sections – with hospital discharge

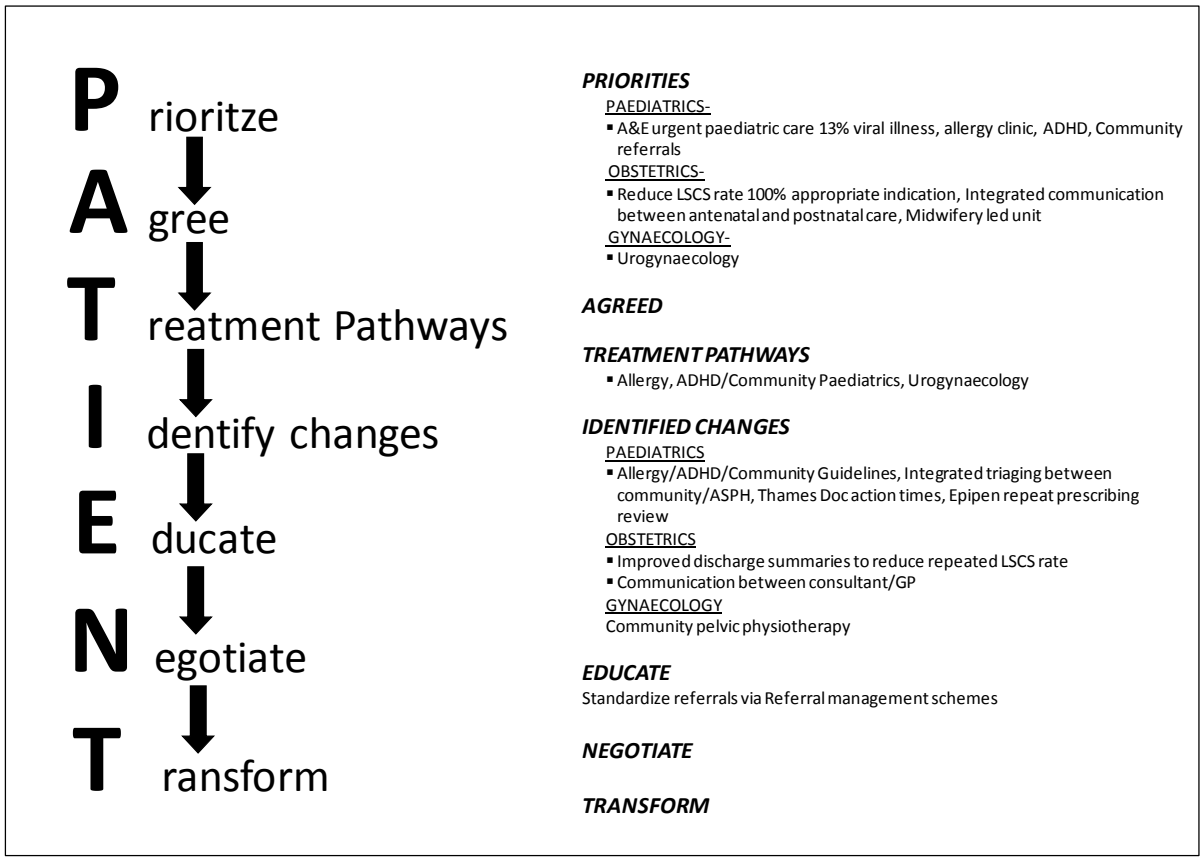
summaries providing GPs with statement “this woman is suitable for vaginal birth after LS (VBAC)”.

8.10 There is broad support across NW Surrey for the concept of developing a Midwifery Led Unit at St Peter's Hospital - in a discrete unit within Abbey Wing but with direct access if required to Labour Ward. This model would provide a low risk birth alternative, which research indicates results in lower epidural rates, increased breast feeding rates and earlier discharge. With birth rates at St Peter's rising, the existing facilities at St Peter's are reaching capacity and an MLU provides an attractive option to expand capacity.

Uro-gynaecology

8.11 Approximately 17,000 women are seen in gynaecology outpatient clinics each year, with an annual total of 2600 day case or inpatient admissions. The highest priority area for redesign is uro-gynaecology. Clinicians from primary care have engaged with ASPH during March to begin work to undertake joint service redesign, which it is anticipated will identify the need for increased availability of community based pelvic physiotherapy and direct access to uro-dynamics, as well as highlighting an opportunity for more activity to be undertaken in a community setting.

8.12 The overall thinking of the group developing the future model of care for Women’s and Children’s services is summarised in the figure below:



9 Summary and next steps

9.1 Taking together the future models of care developed for planned care, urgent care, chronic care, end of life care and women's and children's care provides us with a picture of the overall model for NW Surrey in future. **The future model of care for NW Surrey involves an integrated and coordinated healthcare system which focuses on the whole care pathway with seamless interventions, where appropriate, from all care providers.**

9.2 Four themes stand out in this integrated system, from the work developed by each of the future model of care groups:

- The system in future needs **much greater levels of communication**.
- The future system will **proactively manage the care of the most vulnerable**/those who are repeatedly admitted to hospital - identifying and proactively managing the needs of those who are most at risk.
- In the future system there will be **stronger services in place in the community** acting as credible, trusted alternatives to being in hospital
- Through **Integrated Referral Management Centres we will manage the interface** between primary, community and acute care for planned services

9.3 Work is underway to agree the action to be taken in NW Surrey during 2011/12 to begin service change in line with this Future Model of Care.

March 2011