

4. SCOPE AND PHILOSOPHY OF CLINICAL SERVICES

4.1 INTRODUCTION

This Chapter of the OBC details the service philosophies and models that will be implemented during the next ten years. These models are based on national and local strategies and priorities. They represent a significant change in the way health services are provided locally and will ensure people living in the Greater Peterborough area have access to services that are based on best practice guidance.

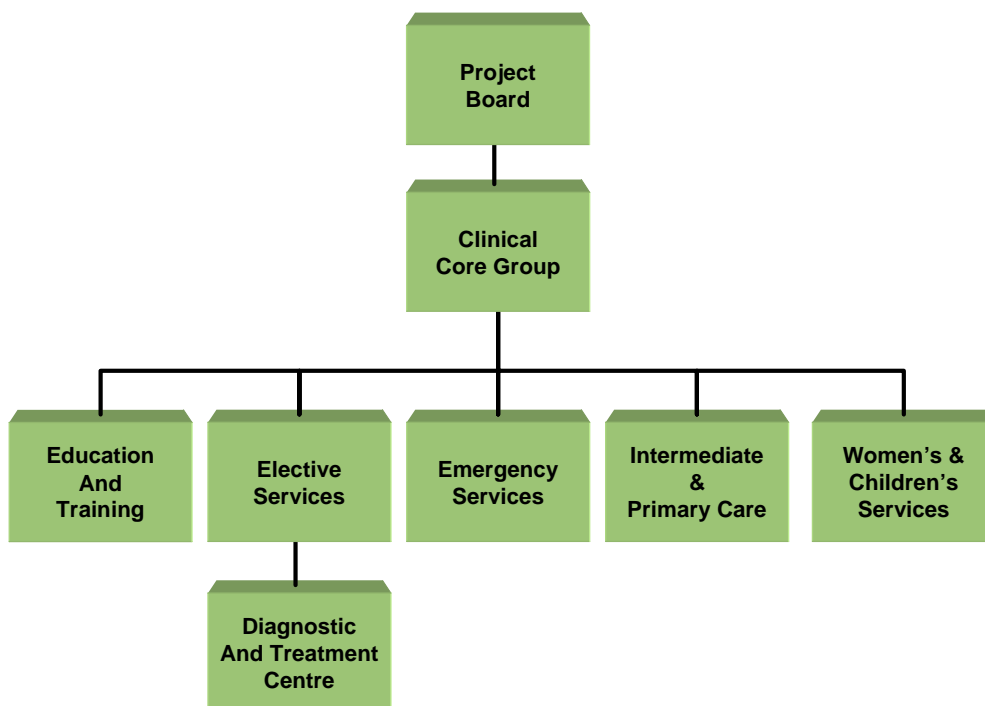
4.2 NEW MODELS OF CARE

4.2.1 SERVICE PLANNING

To ensure the service planning took a whole system approach, a structure was created that covered all the local care partners, see Figure 7. The Project Board brings together the four local PCTs, the hospital and mental health trusts and local social services.

Below the board is the Clinical Core Group (CCG) that provides guidance and leadership, on behalf of the Project Board, in relation to all issues regarding the planning of clinical services. The CCG is chaired by a Medical Director and includes the chairs of all the service planning teams. The membership covers all the principal clinical services and disciplines, together with representatives from Human Resources and the health planning advisor. The CCG also brings in additional members to deal with specialist issues where appropriate.

Figure 7 – Service Planning Structure



4.2.2 SERVICE PLANNING GROUP STRUCTURE

The service planning teams represent the five key operational areas of the GPHIP. They individually form distinct yet dependent sectors of the health system.

- Education and Learning.
- Elective Care (including diagnostic and treatment centre).

- Emergency Care.
- Intermediate and Primary Care.
- Women's and Children's Services.

Philosophies of care were developed for each of these areas based on the service vision developed in the original SOC. Below the elective service planning team, a separate planning team worked on the development of a diagnostic and treatment centre based on the 'one-stop-shop' principle. There was also a separate children's group who worked on the children specific issues, feeding the outcomes into the women's and children's service planning team.

4.2.3 THE SERVICE VISION

Peterborough's health service providers have developed a service vision that covers the 'whole system' and moves many services out of hospital into the community and GP practices. It spans primary and secondary care, providing a solid foundation for the future development and growth. The model embodies the objectives of the NHS Plan and local plans, and will provide patients with a modern, dependable service for the 21st Century. The vision is based on the principle that the service should be centred on the needs of the patient, not the convenience of organisations or professional staff.

The key components of the service vision are:

- An increase in the system's overall bed capacity from 778 to 872 (includes the 80 beds at Stamford Hospital), with flexibility for further growth.
- Improvements in day case rates and a reduction in unnecessarily long lengths of stay to better utilise the beds that are available.
- Reconfiguration of the acute hospital services onto one site comprising:
 - An Emergency Centre with fast tracking of patients from triage to specialties, supported by local diagnostics, coronary care, level 2 and 3 critical care beds and five dedicated theatres.
 - A Women's and Children's Centre providing comprehensive acute paediatric, obstetric and gynaecology services supported by two dedicated theatres and a neonatal intensive care unit.
 - Elective care facilities supported by inpatient beds and 10 dedicated elective care theatres.
 - A Diagnostic and Treatment Centre (DTC) based on the main hospital site providing outpatient clinics, one-stop access to high-tech diagnostics, investigations and day surgery from five dedicated theatres and two additional theatres supporting local anaesthetic work.
- Separation of acute, sub acute and intermediate inpatient care, to ensure an effective intermediate care service can be offered, particularly for rehabilitation, and that more appropriate care can be offered to longer stay elderly patients and short-term emergency patients who do not need to be admitted to hospital but cannot be supported in their own home.
- Separation of elective and emergency resources to provide dedicated services to patients requiring elective treatment, thereby reducing delays and waiting times.
- Investment in community based diagnostics and therapy services, linked to the non-acute / intermediate care facilities and primary care, to provide greater support for the emergency response teams and avoiding the need for minor injuries to be referred to the Acute Hospital Emergency Centre.
- Training for GP, therapists and nurse specialists to undertake some of the work currently performed in hospital, including minor surgical procedures, basic diagnostics, and chronic disease management.
- More consultants' outreach clinics and greater use of technology links, particularly order-communications, results reporting, telemedicine, and computerised booking systems.
- The provision of a multi-professional training and education facility on the main hospital site with high tech links to primary care and other education centres.

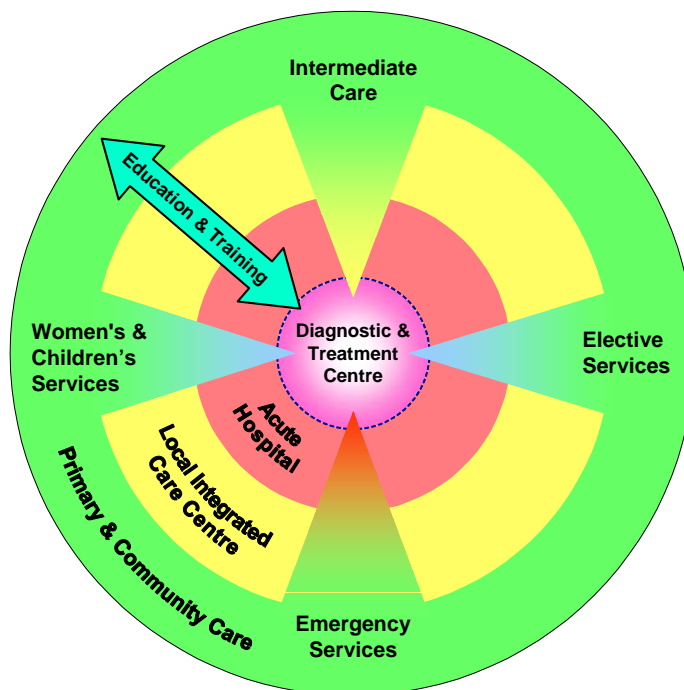
The services that will be developed through this vision will ensure many more patients are treated closer to their home, GPs will have more choice for the care of their patients and hospital care

will involve fewer visits. Streamlining care pathways and eliminating unnecessary hospital stays will create more capacity, reduce waiting time and increase operational efficiency.

4.3 MODELS OF CARE

From the initial development work for the SOC, the service planning teams have developed a model of care that reflects the service vision and delivers the changes required to meet the NHS Plan targets. The Figure 8 illustrates components of the model of care and their relationships.

Figure 8 – Model of Care for Greater Peterborough



The concentric rings represent the various locations within the health community. Services reach inward through spokes and satellite services to provide health care from locations best suited to patient convenience and clinical need.

The triangles represent service the themes and show how service need begins in the community and reaches into the centre of the health system for specialist diagnosis and treatment.

Finally, the double arrow represents the education and training support required by the health community. This will reach out into community and primary care through networked information and technology systems.

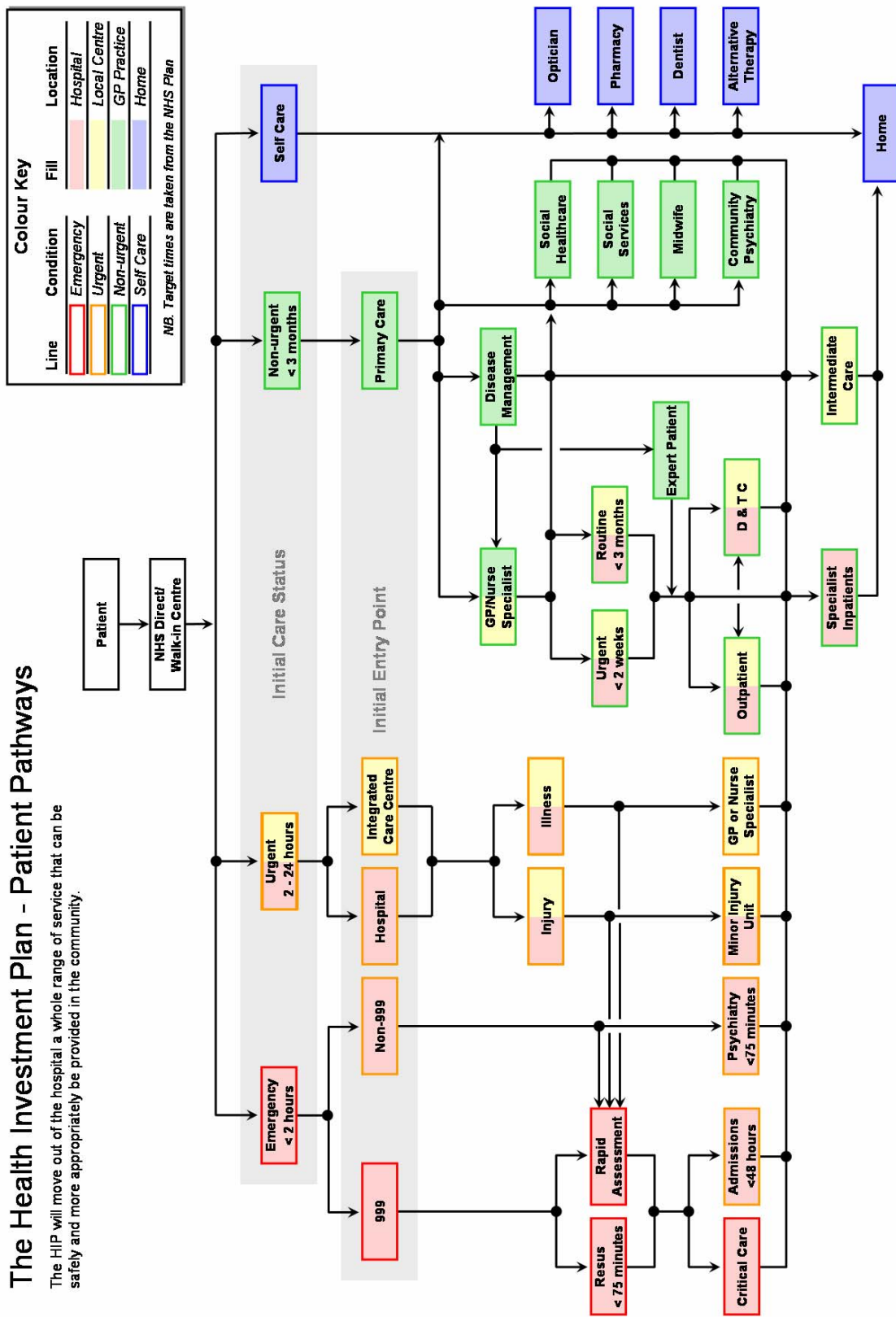
System Flows

Figure 9 shows the patient flows through the new health system. The entry point is through a common gateway protocol that directs the patient to the appropriate location and service. The system has been divided into four streams based on the seriousness of the patient's condition and four zones based on where services are located.

Within the middle ground there are several referral choices, thus eliminating the need to attend the acute hospital for all urgent conditions, unless it is more accessible to the patient than the community options.

The following sections of the OBC describe each of the patient flows in more detail and the philosophy of care that underpins the services. There is also a section on the proposals for the development of education and learning services needed to support the implementation of the GPHIP.

Figure 9 – Flow Diagram of the Proposed Health System



4.4 Emergency Care

Vision:

To streamline the emergency care process by ensuring patients receive the right care from the right people in the fastest possible time.

Emergency care will encompass NHS Direct, minor injury care facilities, Walk-in centres, emergency care, critical care services, ambulance services, rapid access clinics, primary care and out-of-hours services.

Objectives:

- To provide emergency care services that ensure patients get the right treatment in the right place, from suitably skilled personnel as quickly as possible.
- To empower patients to access emergency services.
- To utilise common triage protocols for all emergency episodes.

Facilities:

There will be a number of locations at which a patient might first make contact with the emergency care services. However, it is anticipated that for many the first contact will be through NHS Direct, who will direct them to the appropriate service. On the acute site, emergency care facilities will be accommodated in an Emergency Centre that includes:

- Patient Triage for those who have not been previously assessed.
- Resuscitation area.
- Rapid assessment areas for medical, surgical/orthopaedic and paediatrics staffed by appropriate specialist.
- Separate minor injuries units for adults and children.
- An observation Unit.
- Inpatient wards, including coronary care.
- Critical care beds that can be used flexibly, providing varying levels of level 2 and 3 beds.
- Five emergency and trauma theatres and supporting accommodation.
- Dedicated imaging, diagnostics and minor surgical treatments.

Emergency care will also be provided from a community based minor injuries unit supported by diagnostic radiology facilities.

A diagram of the patient flow through the emergency centre is presented in Figure 10 and a diagram for the pathway of a patient with complex medical needs is presented in Figure 11. More detailed information can be found in the draft emergency service philosophy and the output specifications. See Appendix 5.

New ways of working:

The new facilities will facilitate and improve patient centred care through:

- The development of an emergency centre facilitating the early streaming of patients will improve the service provided to patients by reducing the delay in a patient being examined by a specialist and hasten the initiation of appropriate treatment.
- The implementation of a shared assessment tool for triage to ensure that patients follow a standard care pathway.
- The implementation of direct access protocols reducing the number of steps in the patient pathway to allow, for example patients diagnosed as suffering a stroke by an ambulance crew can gain direct access to the CT scanner on arrival at the hospital.
- Increased access to diagnostic tests for GPs
- Increased range of diagnostic radiology services with more direct access from primary and community care.

