Dorset CCG –
Clinical Services Review

Types of hospitals – what they look like

Case examples

4th March 2015

Contents

YELLOW HOSPITAL

Trafford general is being remodelled as an elective centre with urgent care focus

Trafford General was a sub-scale DGH. It is being remodelled as an elective centre with urgent care 16/24, and a focus on elderly and integrated care, orthopaedics and day surgery. The new service model was approved in July 2013 and implementation began in Nov 2013.

With reference to Trafford's reconfiguration, the Secretary of State said: "Where there is clear evidence that changes will benefit patients ... I will not shy away from taking … tough decisions. I believe these changes are necessary to make sure patients receive safe, high-quality care."

Service delivery - prior to implementation of new service model

- Catchment population of 100,000 people
- 112,000 outpatient attendances per year
- 14,000 elective day cases per year
- 5,000 elective inpatients per year
- 8,000 emergency admissions per year – but as few as 1 emergency surgical operation per day
- 58,000 A&E attendances/year – one of the smallest Type 1 A&E departments in the country
- 93 ICU patient spells/year – below the minimum threshold of 200/year

Key features of new service model:

Urgent care centre available from 8:00-24:00 – transitioning to a nurse-led unit in 3 years
Medical admissions unit
High dependency unit
Out-patient, diagnostic and day surgery services
Specialist orthopaedic centre
Rehabilitation services
Elderly care
Integrated care and rapid discharge

Source: Trust website; Trust annual report

YELLOW HOSPITAL

Solihull hospital forms part of Heart of England FT and provides general, specialist and community care

Heart of England - Solihull Hospital

- Forms part of Heart of England FT, one of the largest Trusts in England - £635.4m turnover in 2013/14
- Employs 11,000 members of staff and sees 1.2m patients a year
- Trust specialises in heart and kidney disease and is a world leader in tackling MRSA
- Solihull provides general, specialist and community care

Service offering

- Provides a range of outpatient, inpatient and emergency care services for its local community.
- Services include supporting local people to stay healthy and well, i.e., ranging from smoking cessation and community dentistry; to pro-active care to support people to stay independent in a community setting ('virtual' wards and community nursing)
- Serves as the regional centre for dermatology services in the area.

Operational Model

- Hospital has ~ 229 beds and provides elective surgery, general medical and minor injuries services
- Includes the Trust's recognised stroke unit (across the three sites), providing out-of-hours stroke treatment service
- There are no children's services on site; unwell children who to A&E are assessed and transferred to Birmingham Heartlands Hospital

SOURCE: HSJ Intelligence 2013/14,; CQC Inspection Report

YELLOW HOSPITAL

Fairfield Hospital in Bury provides hyperacute stroke care and primary PCI whilst referring other emergency services to Oldham

Fairfield hospital is the third largest hospital run by Pennine Trust. The hospital is the only remaining hospital in Bury and is one of three primary stroke units in Greater Manchester. It is also the main site for elective surgery in the North Manchester area.

The trust invested £2m to improve facilities in the hospital's accident and emergency department. The improvements include a new, dedicated state of the art Children's A&E department.

Source: NHS Choices

Key facts and services

- 40,000 square metre hospital
- 270 beds and 7 surgical theatres
- 60,000 A&E attendances per annum
- Serves a population of 185,800
- Hyperacute stroke service (one of three sites)
- 2 cath labs for elective cardiology – not primary PCI
- Critical care Level 2
- No trauma, paediatrics or vascular surgery
- Maternity transferred to North Manchester
- Tertiary referral for most services to Oldham

- The Pennine Trust serves North Manchester, Bury, Rochdale and Oldham, with a population of 820,000
- In 2013/14 the trust invested £16.2 million on capital programmes and in maintaining and improving the physical estate and on smaller projects to develop front line clinical services
- A reconfiguration of clinical services between 2010 and 2013 has resulted in provision of two major emergency receiving hospitals at North Manchester and The Royal Oldham, supported by emergency medical and elective surgery services at Fairfield

YELLOW HOSPITAL

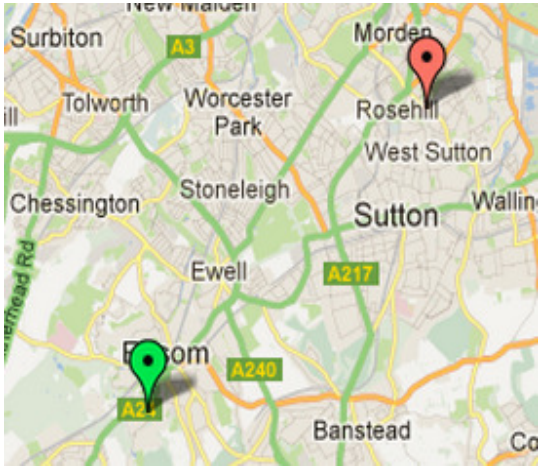
Description of Epsom

What is it?

- Part of **Epsom and St Helier NHS Trust**
- Linked with St Helier 7.2 miles away who provide emergency surgery
- Unselected medical take, but no non-elective surgery
- Obstetrics and Paediatrics on both sites
- Complex elective activity consolidated at Epsom

What are the lessons learnt?

- Distinct emergency and elective teams
- Orthopaedics trauma is co-located with emergency surgery to maximise theatre and anaesthetic efficiency
- Splitting interventional radiology over two sites works well. The GI bleed rota can be on the same site as emergency surgery, but planned endoscopies on the warm site
- Effective partnership with local GPs and ambulance service is key



Warm site

Linked hot site

What are the challenges?

- Surgical emergencies that arrive via A&E need immediate consultant involvement. Therefore there needs to be contingency for dealing with complex emergencies in A&E
- Political constraints stops paediatrics being on the same site as emergency surgery
- The Trust has a surgical consultant on-call team to go to theatre with an acute case and there is an anaesthetic team available 24/7 as obstetrics is on the same site. However, this contingency arrangement hasn't been used in three years
- Establishing a "one trust" culture and effective teamwork amongst surgeons was difficult

Contents

- **Case examples of different hospital types**
  - Yellow hospital
  - **Purple hospital**
  - Elective centres
- Hospital network models for further discussion

Queen Mary's hospital, Roehampton, sees over 130,000 patients a year and offers more than 60 services

Key Facts

- Part of St George's University Hospitals FT, a large teaching hospital
- Amputee rehabilitation unit is an international centre of excellent
- 139 bed capacity
- 61% of staff would recommend this organisation as a place to be treated

The hospital is famous for its specialised seating service which casts and makes wheelchairs for people who cannot use a standard wheelchair and its prosthetic limb-fitting service

Key Services:

Minor Injuries Unit

- Last year saw 16,500 people
- Unit interacts well with the other services at Queen Mary's Hospital
- However the CQC reported evidence of poor interaction with the main A&E service at St George's Hospital due to the location
- Nurse led

Day Surgery Unit

- Offers diagnostic service for endoscopy and urology
- Procedures are carried out under sedation; general anaesthetics are not used in the day surgery unit

Outpatient services

- For children, young people and adults
- Approximately 3,000 patients a week are seen in OP department
- Services include urology, ophthalmology, podiatry, orthopaedic, cardiovascular, prosthetic, orthotic, wheelchair and sexual health, treatment & burn dressing, rapid diagnostic facilities
- CQC reported effective multidisciplinary working at Queen Mary's Hospital in the outpatients departments

Community inpatient services

- Queen Mary's has 20 beds in the rehabilitation centre, 69 mental healthcare beds and 50 elderly and intermediate care beds
- 3 inpatient wards
- Multidisciplinary teams with support from social workers who were based on the hospital site
- Some concern over lack of medical cover during night

SOURCE: Queen Mary's Hospital Quality Report, April 2014 ; https://www.stgeorges.nhs.uk/about/history/qmh/

PURPLE HOSPITAL

Princess Royal Hospital – an A&E without non-elective surgery (1/2)

Case for change

- Brighton and Sussex University Hospital (BSUH) was formed in 2002 from 2 sites
  - Royal Sussex County Hospital (RSCH) in Brighton
  - Princess Royal Hospital (PRH) in Haywards Heath
- Both sites offered unselected medical and surgical takes, with supporting Intensive Care Unit
- Acute surgical take and rota were unsustainable on both sites, due to:
  - Too few consultants
  - Inability to recruit
  - Reliance on non-GI surgeons
- Recognition of the need to change service delivery due to clinical factors

Programme initiatives

Concentration of all non-elective surgery away from PRH achieved through:

- Reliable ambulance triage protocols, triage away surgical patients and the following:
  - GI bleeds, gynaecology, urology and fractures requiring immediate admission
  - PCI diverted to RSCH
- A&E staffing changes
  - Emergency consultant on site at PRH daily till 1800hrs, except Mondays until 2200hrs
  - Middle grade cover from 1300 till 0900 with remote consultant access from RSCH site
  - Support from 'Hospital at night' team containing both surgical and medical input
  - Independent but collocated GP out-of-hours service
- Surgical input for the limited cases which arise[1]
  - Remote support from RSCH site
  - Heavy daytime presence from all surgical specialties running elective day cases and outpatients on site
  - Hospital at night team, containing a surgical presence for elective surgical inpatients
- Medicine supported by ready access to tertiary opinion in renal, cardiology and neurology
- Supporting infrastructure
  - Access to a maximum of 8 level 2/3 ICU beds
  - Single pool of ICU consultants, divided into two rotas covering both sites (RSCH and PRH)
  - Is the parent site for haematology and biochemistry supporting high volumes of elective activity and outpatients
  - Radiography available out-of-hours, with remote radiology reporting due to the low demand

1 Contingency despite a pre-selected take

SOURCE: BSUH

Princess Royal Hospital – an A&E without non-elective surgery (2/2)

● Service offered at site

Impact

- Ability to run a more sustainable A&E without non-elective surgery, with:
  - 15% reduction in A&E activity
  - 5% of total attendances to A&E require surgical transfer
  - 2 medical cases/month require an off-site surgical opinion, but do not always require transfer
- Able to maintain sustainable rotas
  - Able to recruit for all specialties
  - Ensure sufficient volume of work spanning both sites
  - Ability to ensure training for staff
- PRH site able to offer full range of outpatient clinics and diagnostic service, including all -oscopies and screening for both breast and bowel cancers
- PRH site runs a total of 10 operating theatres for a wide range of elective surgical procedures
  - Strong critical care support
  - Estimated 20 elective cases/yr become complex enough to require stabilisation on HDU and transfer to RSCH

Services currently offered at PRH

Specialty	Haywards Heath main site EL + DC	NEL	OP
A&E		●	
Audiology			●
Breast	●		●
Cancer			●
Cardiac Surgery			
Cardiology		●	●
Digestive Diseases	●[4]		●
Dermatology			●
Diabetes & Endocrine		●	●
Dietetics			●
Elderly[1]		●	●
ENT	●		●
General Medicine	●[4]	●	●[4]
Gynaecology	●	●[5]	●
Haematology	●		●
HIV & GUM			
ITU		●	
Neonatal		●[6]	

Specialty	Haywards Heath main site EL + DC	NEL	OP
Neurology	●	●	●
Neurosurgery[2]	●	●	●
Obstetrics		●	●
Occu. Therapy			●
Ophthalmology	●		●
Oral	●		●
Other			●
Paediatric Medicine			●
Paediatric Surgery			●
Pain Medicine	●		●
Renal			●
Respiratory	●[4]	●	●
Rheumatology	●[4]		●
Speech & Language			●
Surgery	●		●
T&O[3]	●	●	●
Urology	●		●
Vascular	●		

1 All stroke cases treated at Brighton for 48hrs and repatriated to PRH if necessary; 2 Non-elective cover moving to Brighton to achieve major trauma centre status;
3 All #NOF services moving to PRH; 4 Minimal services , predominantly –oscopies and infusions;
5 Limited activity – e.g. hyperemesis or ERPC; 6 Support and resuscitation for neonates >32 weeks only, prior to transfer to another facility

SOURCE: BSUH.

Abingdon Community Hospital Emergency Multidisciplinary Unit (1/2)

Context

Case for change

- 40% increase in emergency admissions of patients >65years
- Patients over 65 years have:
  - Longer lengths of stay,
  - Higher cost per case,
  - High risk of hospital-related illness
- Unsustainable model of care with recognition to treat frail elderly closer to and in their own homes, without compromising quality

Initiative

- An Emergency Multidisciplinary Unit setup to provide emergency care for patients seen:
  - in primary care, or
  - by ambulance service
- Services 140,000 population, spanning 11 GP practices, over South West Oxfordshire
- 5 short-term beds (<72hrs) for patients not suitable for remain in own homes
- 8am-8pm Mon-Fri, 10am-4pm Sat and Sun

Key enablers

Multidisciplinary team

- GPs, geriatricians, nurses, physiotherapists, occupational therapists and social care
- Colocation within the same building, hosting other services for quicker rehabilitation

Clear pathway for delivering care

- Acutely unwell individual seen by paramedic
- Dedicated EMU ambulance driver
- If any indication that may need tertiary care, taken directly e.g. HASU, PCI or #NOF
- Clear surgical cases taken to another A&E
- Vast majority of elderly either do not need treatment at mild stages of acute illness, or are not fit for surgery
- Access to large selection of IV therapies

Risk stratification

- Develop clinician skill to manage unwell frail patients
- Identify and appropriately manage patients suitable for ambulatory (non bed-based care)

Rapid Point of Care diagnostics – within 2 mins

- Bloods – tests include U&Es, calcium, blood gases, glucose, Hb, INR and troponin
- Imaging – chest and abdominal XR availability
- Identifies patients too unwell for ambulatory care

SOURCE: Oxford Health NHS Foundation Trust: Community Hospitals in Oxfordshire.

Abingdon Community Hospital Emergency Multidisciplinary Unit (2/2)

Impact

- 20 cases/day seen by the Emergency Multidisciplinary Unit
- Running cost estimated at £1m per year, excluding Fixed Costs
- 30% reduction in over 80s admissions in the area over last 2yrs
- Easier access for patients
  - Closer to home
  - Reduced travel times
  - Median time to assessment, after referral is 1hr
- Flexibility to add modular components to change volume and scope of activity e.g. low-risk maternity services
- Medical staff provided by OUHT as part of a rotation, allowing sufficient volume and training to maintain skillsets

Stakeholder feedback

- Abingdon EMU team were proud winners of prestigious **Guardian Healthcare Innovation Awards** in the category of **Best Service Delivery Innovation**
- "This award underlines that working in partnership can lead to new, improved services for patients closer to where they live," said Pete McGrane, Clinical Director of Community Services Division at Oxford Health NHS FT.
- "When expert teams assess patients promptly and tailor care to individual needs, the results are great quality of care and best value for money. The EMU 'emergency team' approach does exactly that, and is being rolled out county-wide," said Dr James Price, Clinical Director at Oxford University Hospitals NHS Trust said.

NHS Choices feedback:

- "I was referred to Abingdon EMU for a short notice health checkup by my doctor. On arrival I was brought straight through to the ward without waiting. The doctor spoke immediately with me to explain the process, then nurses efficiently and professionally performed the up front tests. Everything was kept calm and unstressed despite being busy and they managed to avoid any long wait on my part."
- "I was seen very promptly by helpful and courteous staff, and was pleasantly surprised to have even had my x-rays reviewed by the time I'd walked the length of the corridor! In total I spent no more than an hour being seen including the time I spent with my GP. I really can't fault this at all."

SOURCE: http://www.phc.ox.ac.uk/news/guardian-healthcare-innovation-award-winners; NHS Choices: Abingdon Community Hospital Director, Out of Hospital Care Network, Oxford AHSN

At Rochdale an advanced EUCC with step-up was developed, covering 80% of previous A&E volumes (1/2)

Care Model: Rochdale 'EUCC' onsite MAU

Reimbursement: A&E Tariff

Patients/conditions treated

- Minor nose bleeds (not on Warfarin)
- Minor cuts, bites and stings
- Burns and scalds
- Infections (including abscesses)
- Foreign bodies in wounds, ears and noses
- Muscular sprains and strains to shoulders, arms and legs
- Fractures to shoulders, arms, legs & ribs
- Dislocations of fingers, thumbs and toes
- Minor eye conditions including conjunctivitis and foreign bodies
- Minor chest, neck and back injuries
- Minor head injuries with no loss of consciousness or alcohol-related
- Minor allergic reactions
- Minor ailments such as coughs, colds, flu symptoms, sore throat, earache, urinary tract infections and sinusitis
- Diarrhoea / Constipation
- Emergency contraception

Conditions not treated

- Extensive trauma
- Extensive burns
- Patients requiring resuscitation
- Suspected acute heart attack
- Suspected acute stroke
- High risk gastrointestinal haemorrhage
- Sick children (cardiac arrest/peri-arrest, head injuries)

Support services provided

- Basic Laboratory services
- X-ray diagnostics 08:00 – 24:00, 7 days a week
- Ante-Natal Ultrasound 08:00 – 17:00, Monday – Friday
- CT when coverage is available, 09-17, Monday – Friday
- MRI 08:00 – 20:00 Monday - Friday
- Step-up/ Resuscitation room
- Pharmacy support 7 days a week

Key goals and achievements

- Patients discharged within 4 hrs
- Retains 80% of old A&E activity and growing
- Patients assessed within 20 minutes of arriving
- Patients will be seen by a Clinical Decision Maker within an hour of presenting
- Children and the elderly will be cared for along the above guidelines

SOURCE: Rochdale EUCC Operational Policy 2012

PURPLE HOSPITAL

The Rochdale EUCC is consultant led but with flexibility to ensure appropriate clinical input at all times (2/2)

Clinician type	Number /shift	Coverage	Rationale
Specialist Consultant	0	As needed	There is an understanding that when necessary the OP Consultants will provide support
A&E Consultant	0.5	1 session Mon-Fri, 1 on weekend days[1]	Additional support provided from Fairfield DGH during OOH; Staffing takes place when possible
Staff-grade Physician	0.5	8am-10pm 7 days a week	Available to cover for an A&E consultant and to support other Clinical Decision Makers (CDM)
General Practitioner	1.0	1-3CDM on early shift, 2-3CDM on late shift, 2CDM on night shift[2]	CDMs provide the majority of the care with Consultant and Staff Grade input when necessary (CDM = consultant, GP staff-grade physician or ENP)
Emergency Nurse Practitioner	1.0		
Practice Nurse	1.0	1 on early and late shifts	Provide support to the Clinical Decision Makers
Triage Nurse	1.0	24/7	Generally a Senior ER practice nurse/Triage nurse to swiftly identify needed escalation
Healthcare Assistant	1.0	24/7	Provide support to the Clinical Decision Makers

1 A&E consultant 6 days a week is the goal but is not always feasible due to availability, covered by Staff Physicians
2 Includes 1 GP 24/7

SOURCE: Rochdale UCC Operational Policy 2012

PURPLE HOSPITAL

Louth County Hospital has been GP-led since 2006

History and Foundations:

Louth County Hospital was part of United Lincolnshire Hospitals Trust. Under constant threat of diminishing services, the hospital was valued by local people and GPs, and perceived to be neglected. Local GPs had experience of working together through their established PBC cluster.

GP Leadership

- In 2006 with a new PCT, the GP leaders once more put forward the idea of developing a new model of care for the hospital which would be GP-led
- The process was led locally by the East Lindsey PBC Cluster Executive Group comprising 5 GPs
- Key to success was strong upfront engagement of local GPs, clinicians and other key stakeholders in the PCT, ULHT and the local community

Outcomes

- Safe transition to new model
- A&E attendances increased (currently block contract)
- Admissions increased with reduced length of stay – anticipated acuity maintained
- Financial envelope clearer with PBC (moving to Consortia Based Commissioning)
- 'Ownership' of Louth model of care by GP commissioners
- The process has now been adopted by 3 other clusters to tackle issues – all are being led by GPs

Contents

- **Case examples of different hospital types**
  - Yellow hospital
  - Purple hospital
  - **Elective centres**
- Hospital network models for further discussion

There are five types of elective centre in the UK

Type	Examples
1 Independent, stand-alone regional elective hospital	▪ Robert Jones and Agnes Hunt Orthopaedic Hospital ▪ Royal National Orthopaedic
2 Partnership elective centre	▪ South West London Elective Orthopaedic Centre ▪ Nottingham
3 Cold site of a multi-site Trust	▪ Ashford and St Peter's Hospitals ▪ Calderdale and Huddersfield
4 Elective centre co-located with a major acute	▪ Lister hospital in Stevenage ▪ Nuffield Orthopaedic and John Radcliffe
5 Independent Sector Treatment Centre	▪ Shepton Mallet

There are some “must haves” for successful elective centres

The centre must be able to guarantee *a critical mass of the right type of work* to achieve economies of scale. This can only be done if there is cluster-wide agreement to centralise these types of surgery.

The centre must be able to *streamline pathways and processes* to fully benefit from a high-throughput, uncomplicated environment. This includes designing just-in-time patient flows as well as leveraging the purchasing power of a large centre.

Consultants and the *trainee medical workforce must be able to rotate seamlessly* through both acute sites and the elective centre. This ensures good exposure to intensive elective experience while also giving good exposure to emergency surgery. This arrangement would ensure that clinical staff receive support to maintain the full range of clinical skills required in line with Royal College guidance.

The centre must have *appropriate risk assessment* to ensure the facilities are appropriate for the patient and procedure. The acceptable level of co-morbidity would depend on the type of unit, location and the level of back-up available . This requires appropriate networking and governance of elective centres across the cluster, with clearly defined accreditation and protocols.

ELECTIVE CENTRE

South West London Elective Orthopaedic Centre (1/2)

History

- Opened in March 2004 as a trailblazer for the NHS Diagnostic and Treatment Centre programme
- Initially teamed up with a US mentor organisation who made a similar journey

Business model

- **What do they do?**
  - Purpose-built orthopaedic hospital offering service of predominantly hip and knees replacement
- **Facilities**
  - Stand-alone unit on Epsom Hospital site with 'ring-fenced' theatres, beds and staff for planned orthopaedic surgery
  - 65 beds (two 25-bed post-operative wards and 15-bed recovery suite with high dependency and critical care facilities)
  - Four state-of-the-art orthopaedic operating theatres
  - 28 consultant orthopaedic surgeons
- **Population base**
  - 1.5 million in South West London
- **Governance**
  - Managed through partnership model across four local acute Trusts: Epsom and St Helier University Hospitals NHS Trust, Kingston Hospital NHS Trust, Croydon Health Services NHS Trust and St George's Healthcare NHS Trust
- **Finances**
  - Surplus of £0.5m on a £27m turnover (1.8%)

SOURCE: EOC webstie; EOC Annual Report 2010; Better Services Better Values (2011)

ELECTIVE CENTRE

South West London Elective Orthopaedic Centre (2/2)

Clinical model

Procedures include

- Hip replacements: Bilateral primary hip replacement, primary hip replacement, resurfacing of hip, revisional procedures of hips
- Knee procedures: Bilateral primary knee replacement, primary knee replacement, knee resurfacing, revisional procedures to knees
- Arthroscopies: Simple arthroscopic procedure, complex procedure or including metalwork
- Shoulder procedures: Subacromial decompression, ACJ excision, anterior stabilisation, rotator cuff repair
- Elbow procedures: Elbow arthroscopy

Further clinical detail

- Surgery routinely performed with regional anaesthesia accompanied by either sedation or general anaesthesia, reducing the incidence of post-operative pain and nausea
- Post-operative care provided by dedicated team of intensive care physicians resident on call 24 hours a day 365 days a year, thereby offering safe surgery to patients with multiple co-morbidity
- One of first centres in the UK to routinely carry out detailed follow-up on patients for up to two years after surgery, enabling staff to understand both the short and long term successes and complications following orthopaedic surgery which can be tracked for every surgical team
- Streamlined care pathway has continued to evolve into a robust enhanced recovery programme

Activity

- One of largest hip and knee replacement centres in Europe
- Performs ~3,000 joint operations a year
- 2009/10: For fourth consecutive year, carried out largest recorded volume of joint replacements in the UK
- 2004-2009/10: Treated over 14,000 patients

SOURCE: EOC webstie; EOC Annual Report 2010; Better Services Better Values (2011)

Gateway Elective Centre, North East London (1/2)

Business model

What do they do?

- Provides day care, elective surgery and diagnostic procedures
- Specialties include orthopaedics, urology, gynaecology, and general surgery
- Also houses the Trust's sports injuries clinic and the fracture clinic

Facilities

- Integrated with main hospital staff and high-dependency facilities
- Centre is located 5 minutes from
- Opened in 2005 with 3 theatres, 4 treatment rooms, and 65 beds

Governance

- On 1 April 2012, Newham University Hospital NHS trust merged with Barts and The London and Whipps Cross University Hospital NHS Trust to form Barts Health NHS Trust

Financial data

- Spending in Newham University Hospital was reported to exceed plan by £25,000 in March 2012

SOURCE: Barts Health NHS Trust, press search

ELECTIVE CENTRE

Gateway Elective Centre, North East London (2/2)

Clinical model

Working model with Newham University Hospital

- Case-selective only by patient complexity (up to ASA3)
- Surgeons doing elective lists are not on-call
- Performs the majority of elective surgery at Newham, increasing capacity for emergency surgery
  - Separating elective and emergency rotas enhances expertise and improves quality of patient care
  - Centre meets clinician recommendation of larger teams of 8-12 specialists working together across all Trust hospitals
- Accepts acute post-operation patients from Newham General Hospita

Successes

- Lean and timely management of services
  - Diagnosis, pre-assessment and booking on the same day
  - Patients arrive 'just in time' for their scheduled surgery

Problems faced

- Distance (5-minute walk) from hospital makes clinical movement difficult and inefficient
  - Difficult to get priority on-call treatment
  - Surgical team often has to start list at Elective Centre and move to main theatres for last case if complex

Activity

- Performs 99% of Newham's elective surgery
- Majority of patients in single rooms: 12 day-case beds, 23 short-stay (1-2 day) beds, 30 long-stay (>2 day) beds
- Newham's elective surgery cancellation rate is just 0.35% (<0.8% national target)

SOURCE: Health NHS Trust, press search.

Contents

- Case examples of different hospital types

- **Hospital network models for further discussion**

Any emerging models are all based on strong networks

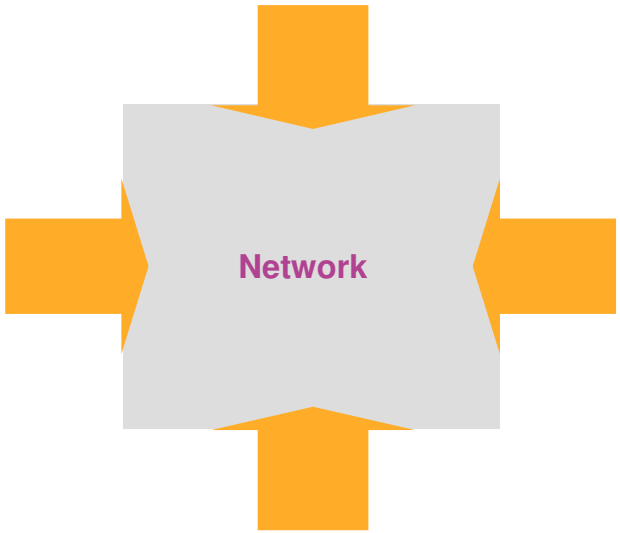
Four features of successful hospital networks

Successful routing of patients across and within sites

- Clearly defined, effective triaging at A&E
- Clear criteria for ambulance service for where to take each case at a specific time of day/night
- Senior decision making needed upfront

Ability to accept patients

- Commissioning is critical to make emergency centre model work
- Patients of lower acuity at a major acute site should be moved to accommodate more urgent cases to be transferred from another site if required
- This needs to be reflected in commissioning contracts



Cover across sites

- Staff must provide on-call cover across sites (i.e., within the network)
- Contracts to be tied to network rather than a single hospital/site
- Rotas needed for exposure to Major Acute in order to make Emergency Centre attractive to employees
- Reasonable travelling distance required between sites in network to facilitate safe transfers

Transfer protocols

- Clearly defined protocols
- Accepted by ambulance service and enforced
- Commissioning of services needed to ensure patients in hospital are not de-prioritised against those that are not

SOURCE: Clinical working group, 8th July; Expert interviews