Reconfiguration of hospital services

A programme to sustain services and improve care

Appendix 2 – Acute model of care - Clinical Pathways

7 November 2017
Emergency Medicine
**Emergency Medicine: summary of proposed changes**

<table>
<thead>
<tr>
<th>How are services currently configured</th>
<th>What will be different in future</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>All three sites currently have 24/7 emergency departments with some specialist services going directly to specialist units e.g. Burns</td>
<td>All sites will continue to have 24/7 consultant led emergency departments taking blue-light ambulances 24/7.</td>
<td>Continued 24/7 emergency departments in local areas to support and stabilise in case of emergency.</td>
</tr>
<tr>
<td>However, a recent review has proposed increasing the number of services that are taken directly to specialist units</td>
<td>There will be enhanced 24/7 specialist medical cover at Basildon Hospital, surgical cover at Broomfield Hospital and cancer care at Southend Hospital using Treat and Transfer models</td>
<td>However, in certain cases patients may be transferred directly to specialist units. Patients needing to be transferred to specialised sites, may experience better outcomes and better quality of care</td>
</tr>
</tbody>
</table>
Emergency medicine (adult): patient flow

Pre-hospital

Local Hospital Care

Local health and care initiatives

Patient calls 999 or attends A&E

Triage

At each site - Enhanced Emergency Hubs

AMU
SATU
FAU
TAU
EPAU
A&E

Treat and Discharge

Inpatient

Local (undiifferentiated frail patients over 75)
- GI
- Soft tissue inflammation
- Diagnosis not classifiable
- Other

Short stay (<72hr)
- Contusion/abradion
- Cardiac conditions
- Head injury
- Nothing abnormal detected
- Sprain/ligament injury
- Muscle/tendon injury
- Bites/stings
- Poisoning (including overdose)
- Electric shock
- Local infection
- Diagnosis not classifiable
- Septicaemia

Specialised or Consolidated services

BTUH
- Stroke
- Vascular Emergency
- Cardiac Surgery
- Cardiology-complex

MEH
- Surgical emergency
- Burns and Plastics
- Nerve injury
- ENT
- Maxillo-facial
- Urology Emergency

SUH
- Complex Gynae

Treat and Transfer

Trust Blue Light Service

Follow up care at local Hospital

Acute/ Non-acute step-down

Home

Treatment & Transfer to Specialised Hubs

Redirected at source
- Burns & scolds (MEHT)
- Amputation (MEHT)
Cardiology
# Cardiology: summary of proposed changes

## How services are currently configured

We are fortunate to have the Essex Regional Cardiothoracic Centre (CTC) based in Basildon. This centre provides acute care for the sickest Cardiology patients – including all patients with ST elevation Myocardial Infarctions.

These patients are either taken directly to the CTC by ambulance, or through a treat and transfer model from other hospitals.

After receiving immediate treatment, patients are discharged back to local hospitals.

All three local sites offer emergency, non-complex elective and outpatient cardiology services. Complex patients requiring diagnostics or interventions are transferred to CTC after local presentation.

## How will services be proposed to be organised in the future

Given the expertise available at the CTC, we are proposing increasing the range of conditions that are seen through this service via a Treat and Transfer model:

- This will include, for example, Non ST elevation Myocardial Infarctions, and Life Threatening Arrhythmias that will likely need a pacemaker.

All sites will continue to offer short stay cardiology, including patients with Cardiac Chest Pain and Arrhythmia or conduction disorders.

It is anticipated that patients admitted to the CTC would stay only a short period, before being repatriated back to local care.

Complex elective procedures, including Coronary Artery Bypass Graft, Percutaneous Coronary Intervention would continue to be delivered in the CTC.

## Implications

There is strong clinical evidence that consolidation of Cardiology services can improve patient outcomes.\(^1\)

This has been evidenced locally through the improvement in outcomes at the CTC.

Most outpatient and short-stay services would continue to be offered locally. However, some patients will have to travel for complex care to BTUH.

Additional Senior Cardiology cover may be required at each site to ensure compliance with NICE guidance for Cardiologist review within 12 hours.

---

1. Ross et al. NEJM 2010
Cardiology and Cardiac Surgery: Emergency patient flow

**Local Hospital Care**
- Local health and care initiatives
  - Triage: ~92 patients per week

**Pre-hospital**
- Attendence
- Triage
  - At each site - Enhanced Emergency Hubs
    - FAU
    - AMU
    - SATU
    - A&E

**Inpatient**
- Local (undiifferentiated frail patients)
- Short stay (<72hr)
  - Cardiac chest pain
  - Arrhythmia or conduction disorders

**Discharge**
- Acute/ Non-acute step-down
  - / Home
- Follow up care at local Hospital

**Tertiary cardiac surgery referrals**
- Harlow
- Colchester

**Legend**
- # Patients per week

**Treat and Discharge**
- Treat and Transfer from MEHT and SUH
  - CTC
  - ~6 patients per week
- BTUH
  - Pacemaker
  - Coronary Artery Bypass Graft
  - Percutaneous Coronary Intervention
  - Catheter, 19 years and over
  - Heart Failure or Shock
  - Arrhythmia or Conduction Disorders, with CC
  - Actual or Suspected Myocardial Infarction

**Treatment & Transfer to Specialised Hubs**
- Local Hospital Care
- Emergency patient flow
Cardiology and Cardiac Surgery: Elective patient flow

**Pre-hospital**

- Local health and care initiatives

**Attendance**

- Patient booked
- Out Patient clinics
- Day case
- Diagnostics

**Inpatient**

- At each site
- CTC

**Discharge**

- Acute/ Non-acute step-down
- / Home
- Follow up care at local Hospital

**Treatment & Transfer to Specialised Hubs**

- Tertiary cardiac surgery referrals
  - Harlow
  - Colchester

**CTC**

- Pacemaker
- Coronary Artery Bypass Graft
- Percutaneous Coronary Intervention
- Catheter, 19 years and over
- Arrhythmia or Conduction Disorders, with CC
Gastro Intestinal
# Gastroenterology: summary of proposed changes

<table>
<thead>
<tr>
<th>How services are currently configured</th>
<th>How will services are proposed to be organised in the future</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and elective services are currently offered at all three sites with significant outpatient endoscopy services. Very complex work, such as intestinal failure are managed with tertiary centres such as the Royal London Hospital and Addenbrookes, with patients repatriated locally for follow up.</td>
<td>It is anticipated that the majority of gastroenterology activity would remain at the local sites in the future model. This would include, for example, outpatient and short stay activity, and endoscopy. Complex procedures would be pooled at one site. However, it is proposed that the establishment of an Acute Gastroenterology Ward at MEHT will enable more complex patients to receive specialist care, through a Treat and Transfer model. Patients who may attend this centre include acute liver failure, severe pancreatitis, intestinal failure. Very complex work will continue to be delivered in London/Cambridge. Outpatient and less complex cases would continue to be delivered locally.</td>
<td>The provision of the Acute Gastro Ward will allow local patients to access the highest quality of care possible 7/7. Most outpatient and endoscopy services would continue to be offered locally. However, some patients will have to travel for complex care to MEHT.</td>
</tr>
</tbody>
</table>
Patient pathways

**Pre-hospital**

- Local health and care initiatives

**Attendance**

- Triage
  - FAU
  - AMU
  - SATU
  - A&E

**Inpatient**

- Local (undifferentiated frail patients)
  - Hepatobiliary or Pancreatic procedures
  - Non malignant liver disorders
  - Non malignant pancreatic or biliary disorders
  - Inflammatory bowel disease simple

**Discharge**

- Acute/ Non-acute step-down
- / Home
- Follow up care at local Hospital

**Gastrology-Specialised Services**

- BTUH
  - Inflammatory bowel disease complex
  - Intestinal failure
  - Liver failure complex

- SUH

**Local Hospital Care**

- Local Hospital Care

**Treatment & Transfer to Specialised Hubs**

- Local (undifferentiated frail patients)

**Enhanced Emergency Hubs**

- FAU
- AMU
- SATU
- A&E
General Surgery
# General Surgery: summary of proposed changes

## How are services currently configured

- Emergency and elective services are currently offered at all three sites.
- Patients are referred to a specialist centre for burns and plastics to MEHT and for complex oncology to SUH.

## What will be different in future

- Routine outpatient, day case and inpatient general surgeries would remain local for both emergency and elective services.
- MEHT will remain the centre for burns and plastics, upper GI surgery, Ear, Nose and Throat; and Oral and Maxillofacial surgery.
- Complex general surgery admissions, possibly requiring laparotomy will be treated and transferred to MEHT to be operated on by a team of consultants. Lower GI elective work will be co-located at MEHT with a dedicated 24/7 rota supporting the three hospitals. Clinical pathways are to be developed to further consolidate specific procedures at each site.

## Implications

The future model will enable the consolidation of certain specialties which in turn leads to better outcomes. Whilst most outpatient and routine services would continue to be offered locally, some patients will have to travel for complex care to MEHT.

The provision of the specialised centres will allow local patients to access the highest quality of care possible.

It will also enable the consolidation of certain specialties which in turn leads to better outcomes, supported by clinical evidence.¹

---

¹. Getting it right first time, Aug 2017
How it could work in practice - General Surgery: Emergency patient pathways

Local (undifferentiated frail patients)
Short stay (<72hr)

- Appendices
- All breast procedures
- Non-complex urology\(^1\)
- Multiple Trauma\(^2\)

Local Hospital Care

Local health and care initiatives

Pre-hospital

Attendance

Triage

At each site - Enhanced Emergency Hubs

- AMU
- FAU
- TAU
- SATU
- A&E

Treat and Discharge

Inpatient

General Surgery-Specialised/Consolidated Services

- BTUH
  - Therapeutic or Diagnostic General Abo procedures
- MEHT
  - Urology
  - Lower GI
  - Upper GI
  - Bowel Cancer
  - Burn and plastics
- SUH
  - Oncology

Discharge

Acute/ Non-acute step-down

Follow up care at local Hospital

1. Please refer to renal and urology pathways
2. Please refer to T&O pathway
How it could work in practice - General Surgery: Elective patient pathways

Local (undifferentiated frail patients)
Short stay (<72hr)

- Hepatobiliary or Pancreatic procedures
- Laparoscopic Cholesystectomy
- Non-complex urology

1. Please refer to renal and urology pathways
2. Please refer to T&O pathway
Gynaecology
## Gynaecology: summary of proposed changes

<table>
<thead>
<tr>
<th>How services are currently configured</th>
<th>How will services are proposed to be organised in the future</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently, emergency and routine Gynaecological services are offered on all sites. These include Early Pregnancy Assessment Units, and a range of clinics (e.g. Colposcopy clinics)</td>
<td>Routine outpatient, day case and inpatient gynaecological services would remain local for both emergency and elective services. However, some complex work would be consolidated into a specialist service at SUHFT. This would include any treat and transfer for emergency procedures where it is expected that patients would need to stay in hospital for more than 48 hours. In addition, this would include specialist elective cases, including all Oncology (extended to include Broomfield as well as Basildon patients), Urogynaecology, Minimal Access surgery, Intermediate and Major Gynaecology</td>
<td>There is good evidence that consolidating Cancer work improves outcomes for patients. This is already partially done in Mid and South Essex, and would be extended under this model. This means that some patients will have to travel further, particularly for cancer and other specialist elective work.</td>
</tr>
</tbody>
</table>

1. Pre Options Appraisal information, Feb 2017
Gynaecology: Emergency patient flow

Legend

% Patients

Pre-hospital

Attendance

Inpatient

Discharge

Local Hospital Care

Local health and care initiatives

~9

Triage

EPAU

A&E

At each site - Enhanced Emergency Hubs

Treat and Discharge

Local

Short stay (<72hr)

- Ectopics / Miscarriage
- Ovarian accident/torsion
- Acute Pelvic Infection
- Endometritis

Gynaecology-Specialised Services

SUH

- Complex Gynaecology
- >48h stays

Treat and Transfer from BTUH and MEHT

~4

Acute/ Non-acute step-down / Home

Follow up care at local Hospital

Treat and Discharge

Inpatient Attendance

Pre-hospital
Gynaecology: Elective patient flow

- Oncology (currently already from BTUH, now also from MEHT)
- Urogynaecology
- Minimal access surgery
- Intermediate and major gynaecology

Local Hospital Care

- Local health and care initiatives

Treatment at Specialised Hubs

- Referral to specialised surgery from BTUH and MEHT

At each site

- Patient booked
- Out Patient clinics
- Day case
- Diagnostics

Treat and Discharge

- Short stay (<72hr)
  - General Gynaecology
  - Fertility (potential to be removed, currently in consultation)

Inpatient

- Acute/ Non-acute step-down
- / Home
- Follow up care at local Hospital

Discharge

Pre-hospital

Local Hospital Care

Out Patient clinics

Diagnostics

Gynaecology - Specialised Services

SUH

- Oncology (currently already from BTUH, now also from MEHT)
- Urogynaecology
- Minimal access surgery
- Intermediate and major gynaecology
Hyper-Acute Stroke Care
**Stroke: summary of proposed changes**

<table>
<thead>
<tr>
<th>How services are currently configured</th>
<th>How will services are proposed to be organised in the future</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently, all three hospitals offer Stroke services on site</td>
<td>Patients suspected of having a Stroke would still be seen in their local hospital, assessed and thrombolysed if indicated.</td>
<td>There is strong national evidence that consolidating stroke care in HASU's improves patient outcomes.</td>
</tr>
<tr>
<td>• Patients suspected of having a stroke are transferred to their local hospital, where they receive care, including Thrombolysis, where indicated and after care.</td>
<td>Thrombolysed cases and stroke patients where thrombolysis is not indicated will be transferred to the hyper-acute stroke unit at BTUH, for a period of intense support.</td>
<td>• This type of approach is already in place in Greater Manchester and London and has seen mortality and length of stay decrease by over 15%.</td>
</tr>
<tr>
<td>There are links to off-patch Neuroscience centres, for example at Addenbrooke's or Queen's Hospital, where some of the most complex patients may be referred</td>
<td>• Usually the first ~72 hrs</td>
<td>Patients will not have to travel further than today to access immediate care including Thrombolysis. However, some patient's families may need to travel further during the period of stay in the HASU</td>
</tr>
<tr>
<td></td>
<td>After this time, patients will be repatriated back to their local hospital's acute stroke units for ongoing care or discharged for local rehabilitation</td>
<td>There may need to be an increase in workforce trained to deliver Thrombolysis in order to meet national Stroke guidelines. There may also need to be investment in additional nursing and therapy staff at the HASU</td>
</tr>
<tr>
<td></td>
<td>Links to extended services will remain, for example, the delivery of Thrombectomy's at SUHFT. Links to the Neuroscience centres off-patch will remain as today for services e.g. Management of Haemorrhagic or Hemicraniectomy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In the longer term, if patients with the most severe Strokes are identified by Ambulance crews, these patients could be diverted straight to the HASU</td>
<td></td>
</tr>
</tbody>
</table>
**Stroke: patient flow**

**Pre-hospital**

- **Patient calls 999 or attends A&E**
  - ~24

**At each site - Enhanced Emergency Hubs**

- **A&E**
  - Patient assessed:
    - Stroke patients receive thrombolysis if indicated before transfer to HASU or referred to Neuroscience Centre
    - Treatment locally for Stroke Mimics

  - **Triage**

**Local Hospital Care**

- **Patient assessed**
  - Stroke patients receive thrombolysis before transfer to HASU or referred to Neuroscience Centre
  - Treatment locally for Stroke Mimics

**Treatment & Transfer to Specialised Hubs**

- **Assessed by Paramedics and referred directly to BTUH (Phase 2)**
  - ~6

**Treat and Transfer from MEHT and SUH (Phase 1)**

**Acute Stroke Units at BTUH, MEHT and SUH**

- **Step down Transfer to BTUH, MEHT and SUH**

**Inpatient**

- **Treatment - Non HASU**
  - Stroke Mimics

**Discharge**

- Step-down to Community based rehabilitation
  - / Home

- Follow up care at local Hospital

**Legend**

- # Patients per week

**Neuroscience Centres**

- Queens Hospital, Romford
- Addenbrooke's Hospital, Cambridge

- **BTUH – Hyper acute stroke unit (HASU)**
  - Treatment and after 24-72 hours on the HASU patients stepped down to local acute stroke units.

- **Extended service for Thrombectomy/Hemicraniectomy referred to a Neuroscience Centre**

- **Legend**
  - # Patients per week
Renal
### Renal: summary of proposed changes

<table>
<thead>
<tr>
<th>How services are currently configured</th>
<th>How will services are proposed to be organised in the future</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and elective services are currently offered at all three sites</td>
<td>It is anticipated that the majority of Renal activity would remain at the local sites in the future model. This would include, for example, outpatient and short stay activity, including standard Dialysis.</td>
<td>The provision of the Acute Renal Ward will allow local patients to access the highest quality of care possible</td>
</tr>
<tr>
<td>Very complex work, such as renal transplantation is referred to specialist centres, such as the Royal London Hospital and Guy's hospital, with patients repatriated locally for follow up</td>
<td>However, it is proposed that the establishment of an Acute Renal Ward at BTUH will enable more complex patients to receive specialist care, through a Treat and Transfer model.</td>
<td>Most outpatient and dialysis services would continue to be offered locally. However, some patients will have to travel for complex care to BTUH</td>
</tr>
<tr>
<td></td>
<td>Patients who may attend this centre include unwell Renal Transplant patients; Acute Kidney injury patients requiring dialysis (including patients who had previously been in ITU) and Renal biopsies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Very complex work will continue to be delivered in London. Outpatient and less complex cases would continue to be delivered locally</td>
<td></td>
</tr>
</tbody>
</table>
**Renal: Emergency patient pathways**

**Pre-hospital**

**Attendance**

**Inpatient**

**Discharge**

*At each site - Enhanced Emergency Hubs*

- FAU
- AMU
- SATU
- A&E

**Triage**

**AKI Nurse**

**Local (undifferentiated frail patients)**

**Short stay (<72hr)**

- Acute Kidney Injury (non-primary renal disease)

**Renal-Specialised Services**

*(Acute Renal Ward)*

- Dialysis (haemodialysis and peritoneal)
- Renal transplant patients
- Primary renal disease requiring inpatient treatment i.e. vasculitis
- Acute kidney injury patient requiring only dialysis (including ITU step down)

**Day-case admissions as part of acute ward**

- Tunnelled haemodialysis line (THL) insertion
- Peritoneal catheter insertions
- Renal biopsies/THL removals

**Local health and care initiatives**

**At each site**

**Enhanced Emergency Hubs**

**FAU**

**AMU**

**SATU**

**A&E**

**Triage**

**AKI Nurse**

**Treat and Discharge**

**Acute/ Non-acute step-down / Home**

**Follow up care at local Hospital**

**Treat and Transfer from MEHT/BTUH and SUH**

**Treat and Discharge from local Hospital**

**Treatment & Transfer to Specialised Hubs**

**Local Hospital Care**
Renal: Elective patient pathways

At each site

- Patient booked
- Out Patient clinics
- Day case
- Diagnostics

Local health and care initiatives

Pre-hospital

Attendance

Inpatient

Discharge

Treatment & Transfer to Specialised Hubs

Local Hospital Care

Treat and Discharge

Local

Short stay (<72hr)
- All conditions stay local

Acute/ Non-acute step-down / Home

Follow up care at local Hospital

Inpatient Attendance

Pre-hospital
Respiratory: summary of proposed changes

<table>
<thead>
<tr>
<th>How are services currently configured</th>
<th>What will be different in future</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services, elective services and outpatient clinics are offered at all three sites</td>
<td>Majority of Respiratory activity will remain at the local sites in the future model. This would include, for example, outpatient and short stay activity. However, it is believed that the establishment of an Acute Respiratory Ward at BTUH will enable more complex patients to receive specialist care, through a treat and transfer model. Patients who may attend this centre include patients who required non-invasive ventilation and with severe pneumonia.</td>
<td>The provision of the Acute Respiratory Ward will allow local patients to access the highest quality of care possible. Most outpatient services would continue to be offered locally. However, some patients would travel to BTUH for complex care.</td>
</tr>
</tbody>
</table>
**Respiratory: Patient pathways**

**Legend**
- **% Patients**

**Pre-hospital**
- Local Hospital Care
- Local health and care initiatives
  - ~148

**Attendance**
- Triage
- At each site - Enhanced Emergency Hubs
- FAU
- AMU
- SATU
- A&E

**Inpatient**
- Local care (all patients)
- Local (undifferentiated frail patients over 75)

**Respiratory-Specialised Services**
- BTUH
  - Community Pneumonia
  - Non invasive ventilation

**Discharge**
- Acute/ Non-acute step-down
- / Home
- Follow up care at local Hospital

**Pre-hospital**
- Treatment & Transfer to Specialised Hubs
- ~15
Trauma and Orthopaedics
# Trauma and Orthopaedics: summary of proposed changes

<table>
<thead>
<tr>
<th>How services are currently configured</th>
<th>How will services are proposed to be organised in the future</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>All three sites currently offer a wider range of inpatient, outpatient and daycase Trauma and Orthopaedic services</td>
<td>Under the proposed model, all three sites would continue to offer routine trauma care – including outpatient and daycase, as well as have the expertise to manage non-complex trauma emergency cases not requiring admission</td>
<td>There is good evidence that consolidating surgical procedures can improve outcomes for patients&lt;sup&gt;1-2&lt;/sup&gt; – for example, reducing complications and length of stay for patients receiving hip operations</td>
</tr>
<tr>
<td>There are currently two major Trauma Networks in operation for the sites – Addenbrookes is the Major Trauma Centre for Mid Essex, whilst Basildon and Southend are part of a Trauma network with The Royal London as the Major Trauma Centre</td>
<td>Major trauma would continue to be delivered outside of Essex</td>
<td>This approach seeks to gain benefits of consolidation, whilst ensuring that there is appropriate access and volumes across all three sites to make staffing Rotas work effectively</td>
</tr>
<tr>
<td></td>
<td>It is proposed that Basildon and MEHT would treat all complex emergency Trauma cases through a treat and transfer model. These patients would be repatriated to their local hospital once stabilised.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elective surgery would be consolidated on two sites: MEHT and Southend. Clinical pathways will be developed to further consolidate specific procedures at each site</td>
<td></td>
</tr>
</tbody>
</table>

1. NCBI Report, Nov 2010 2. Getting it right first time, March 2015
**Trauma and Orthopaedics:** Emergency patient pathways

**Legend**
- % Patients

**Pre-hospital**

**Local Hospital Care**
- Local health and care initiatives
- ~101

**Triage**

**At each site - Enhanced Emergency Hubs**
- FAU
- TAU
- SATU
- A&E

**Treat and Discharge**

**Local (undifferentiated frail patients)**
- Multiple Trauma

**Trauma and Orthopaedics-Specialised Services**
- BTUH or MEHT
  - All other Trauma and Orthopaedic conditions

**Treatment & Transfer to Specialised Hubs**
- Major trauma referred to specialist trauma centres

**Neck of Femur fracture redirected in Ambulance**
- ~12

**Trauma centre:**
- Addenbrookes / Royal London

**Acute/ Non-acute step-down / Home**

**Follow up care at local Hospital**
**Trauma and Orthopaedics: Elective patient pathways**

- **Pre-hospital**
- **Attendance**
  - Treat and Discharge
  - At each site:
    - Patient booked
    - Out Patient clinics
    - Day case
    - Diagnostics
- **Inpatient**
  - Across all three sites with clinical pathways to be developed to further consolidate specific procedures at each site
- **Discharge**
  - Acute/ Non-acute step-down
  - / Home
  - Follow up care at local Hospital

**Local Hospital Care**

- Local health and care initiatives

**Treatment & Transfer to Specialised Hubs**

- Referral to MEHT or SUH

**Trauma and Orthopaedics-Specialised Services**

- **MEHT**
  - Elective surgery for MEHT
  - Low volume specialised services to be consolidated, detail to be decided

- **SUH**
  - All Elective surgery for BTUH and SUFT
  - Low volume specialised services to be consolidated, detail to be decided
# Urology: summary of proposed changes

## How services are currently configured

Currently, urology inpatient and outpatient clinics are offered on all three hospital sites.

Emergency patients are reviewed via A&E, and are admitted locally if indicated.

Elective surgery is offered on all sites, although complex cancer is now located at SUFT.

## How will services are proposed to be organised in the future

Emergency patients will be assessed at an enhanced emergency hub at each site. Patients with less complex conditions treated at the local hospital, usually within 72 hours for conditions such as UTIs, Renal Colic and Haematuria.

For some specific complex surgical procedures, patients would be assessed, treated and then transferred to the Emergency Urology Hub in MEHT e.g. patients with Emergency Stones.

Post surgery, patients at the Emergency Urology Hub would be discharged, with follow up care at their local hospital.

Patients too sick for transfer would be admitted to local ITU/CCU and may require Urologists/IR support.

The majority of routine elective work would continue to be delivered at the local site via day case.

- However, some low volume, complex work would be consolidated onto a single site, including Nephrectomy and Pyeloplasty at MEHT, and Complex Cancer work at SUHFT (e.g. Radical Prostatectomy).

## Implications

This approach should support enhanced patient outcomes: for example, there is clear clinical evidence that consolidation of complex Urology surgery (including Cancer surgery) can improve patient outcomes.

Most services would continue to be offered locally. However, some patients will have to travel for complex elective care to another site.

---

1. NHS Futures Martini – Kilnic, Nov 2013
**Urology: Emergency patient flow**

**Legend**  
- Orange circle: # Patients per week

1. **Pre-hospital**
   - Local Hospital Care
   - Local health and care initiatives
   - SATU
   - A&E
   - Triage
   - Torsion diagnosis - procedure at local hospital

2. **Attendance**
   - Enhanced Emergency Hubs
   - Short stay (<72hr)
   - Where clinically appropriate, ambulatory for:
     - Haematuria
     - UTIs
     - Urinary retention
     - Renal colic
     - Scrotal pain
     - Catheter related problems
     - Patients too sick for transfer would be admitted to local ITU/CCU and may require Urologists/IR support

3. **Inpatient**
   - Urology-Specialised Services
   - MEHT emergency urology hub
     - For patients who meet clinical criteria for admission
     - e.g.: Emergency stones

4. **Discharge**
   - Discharged home, no further action /
   - Next day appointment in ambulatory clinic /
   - Follow up care at local Hospital
   - Acute step down / Discharge home

**Legend**
- Orange circle: # Patients per week

- ~58
- ~12
**Urology: Emergency stone patient flow**

**Pre-hospital**
- **Local Hospital Care**
  - Patient calls 999 or attends A&E

**Attendance**
- **At each site - Enhanced Emergency Hubs**
  - A&E
    - Patient assessed
    - IV Access
    - Analgesia
    - Anti-emetic
    - Bloods
    - MSU
  - Triage

**Inpatient**
- **Imaging:** CT – KUB
- **Review results**
- **Stone**
  - Analgesia. If fulfils ambulatory criteria, discharge and review in ‘hot’ clinic
- **No stone**
  - Non obstructive pathology
  - Analgesia

- **If criteria met for urgent surgery, patient is stabilised and transferred to MEHT**
- **Referral to approp. team by emergency care team**

**Discharge**
- **Discharged home, no further f-up required**
- **Discharged home, follow up care at local Hospital**

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**Current pathway**
1. Usually Emergency Ureteric stent is put on emergency operating list when access allows
2. Discharged and placed on waiting list for elective ureteroscopy
3. Not prioritised as not on cancer pathways
4. Significant readmissions with UTI and stent related pain

**Urology - Specialised Services**
- **MEHT**
  - **Septic:** Emergency stent or nephrostomy (if fit for transfer). If not, mobile IR service.
  - **Non septic:** Urgent Urology operating list the same day/next day (dependent on time of admission)
  - Stone treated as well rather than just emergency stenting, saving second operation and possible multiple admissions for UTI & stent-related pain

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**Treatment & Transfer to Specialised Hubs**
- **Emergency Treat and Transfer from BTUH and SUH to MEHT**
  - Trust Blue Light Service

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**Discharge**
- **Acute step down**
- **Discharged home, follow up care at local Hospital**
1. At SUHT paediatric services provided by general surgery. 2. Specialised cancer services commissioned at SUHT.
Vascular
### Vascular: summary of proposed changes

<table>
<thead>
<tr>
<th>How services are currently configured</th>
<th>How will services be proposed to be organised in the future</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular outpatient, elective and emergency services are currently delivered across all three sites. However, a recent review has proposed consolidating emergency and specialist work into a single hub.</td>
<td>Under the proposed model, all patients would be reviewed at their A&amp;E through the enhanced emergency hub. All patients that require emergency surgery would be transferred to the 24/7 Emergency Vascular Hub at BTUH. Patients treated at the Emergency Hub would be repatriated to local hospitals for their ongoing care once stable. Complex elective surgery would also be delivered at this hub site, including Aorta-thoracic / abdominal surgery. However, day and short stay surgery would be delivered locally, including lower limb, carotid and venous surgery.</td>
<td>This approach is supported by Local Vascular Review, published in August 2016. This recommended the creation of a networked approach, with a single 24/7 emergency Vascular hub hospital with co-located Interventional Radiology services. Consolidation will also enable the service to more effectively meet workforce requirements: National guidance recommends that the high volume arterial hospital (hub hospital) for the network should have a 24/7 consultant on-call rota for vascular emergencies of 1:6 or greater, covered by a combination of vascular surgeons and interventional radiologists to ensure adequate care.</td>
</tr>
</tbody>
</table>
**Vascular: Emergency patient flow**

- **Pre-hospital**: Local health and care initiatives
  - ~13

- **Presence**
  - Triage
  - Treat and Discharge
  - Treat and Transfer from MEHT and SUH

- **Vascular-Specialised Services**
  - BTUH:
    - All emergency surgery for patients that require surgery before 8am the next day.

- **Legend**: # Patients per week

- **At each site - Enhanced Emergency Hubs**
  - FAU
  - AMU
  - SATU
  - A&E

- **Inpatient**
  - Discharge
  - Acute/ Non-acute step-down / Home
  - Follow up care at local Hospital

- **Local Hospital Care**
  - Treatment & Transfer to Specialised Hubs
  - ~2
Vascular: Elective patient flow

Pre-hospital

Local Hospital Care

Local health and care initiatives

Treat and Discharge

At each site

Patient booked

Out Patient clinics

Day case

Diagnostics

Inpatient

Local

Short stay (<72hr)

- Lower limb
- Renal
- Carotid
- Venous

Vascular-Specialised Services

BTUH:

- Aorta- thoracic / abdominal

Discharge

Acute/ Non-acute step-down

/ Home

Follow up care at local Hospital

Treatment & Transfer to Specialised Hubs

Local Hospital Care

Local health and care initiatives