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

How are services currently configured

All three sites currently have 24/7 emergency departments with some specialist services going directly to specialist units e.g. Burns

However, a recent review has proposed increasing the number of services that are taken directly to specialist units

What will be different in future

All sites will continue to have 24/7 consultant led emergency departments taking blue-light ambulances 24/7.

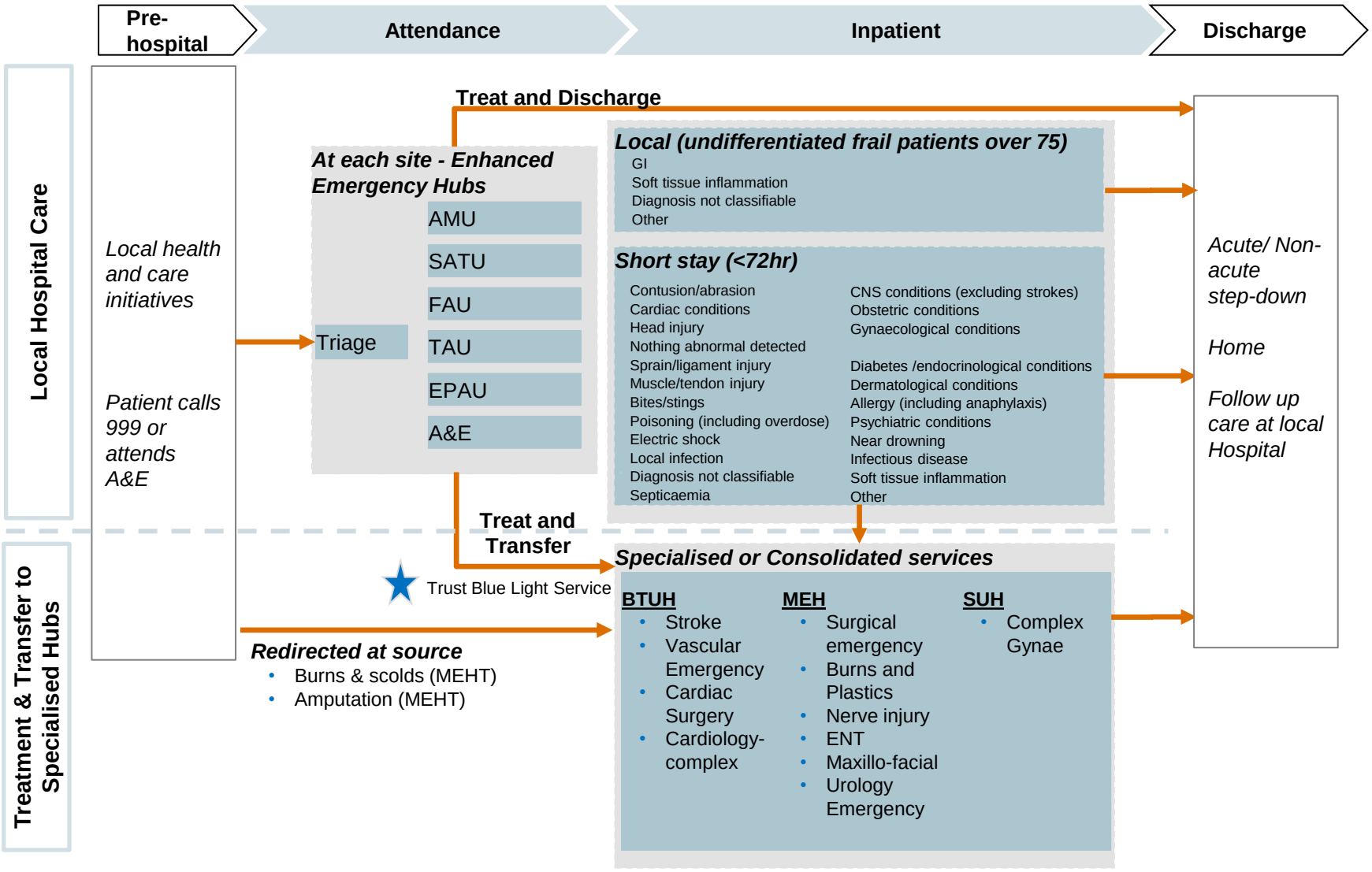
There will be enhanced 24/7 specialist medical cover at Basildon Hospital, surgical cover at Broomfield Hospital and cancer care at Southend Hospital using Treat and Transfer models

Implications

Continued 24/7 emergency departments in local areas to support and stabilise in case of emergency.

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

Emergency medicine (adult): patient flow



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 are 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 re-patriated back to local care

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

Implications

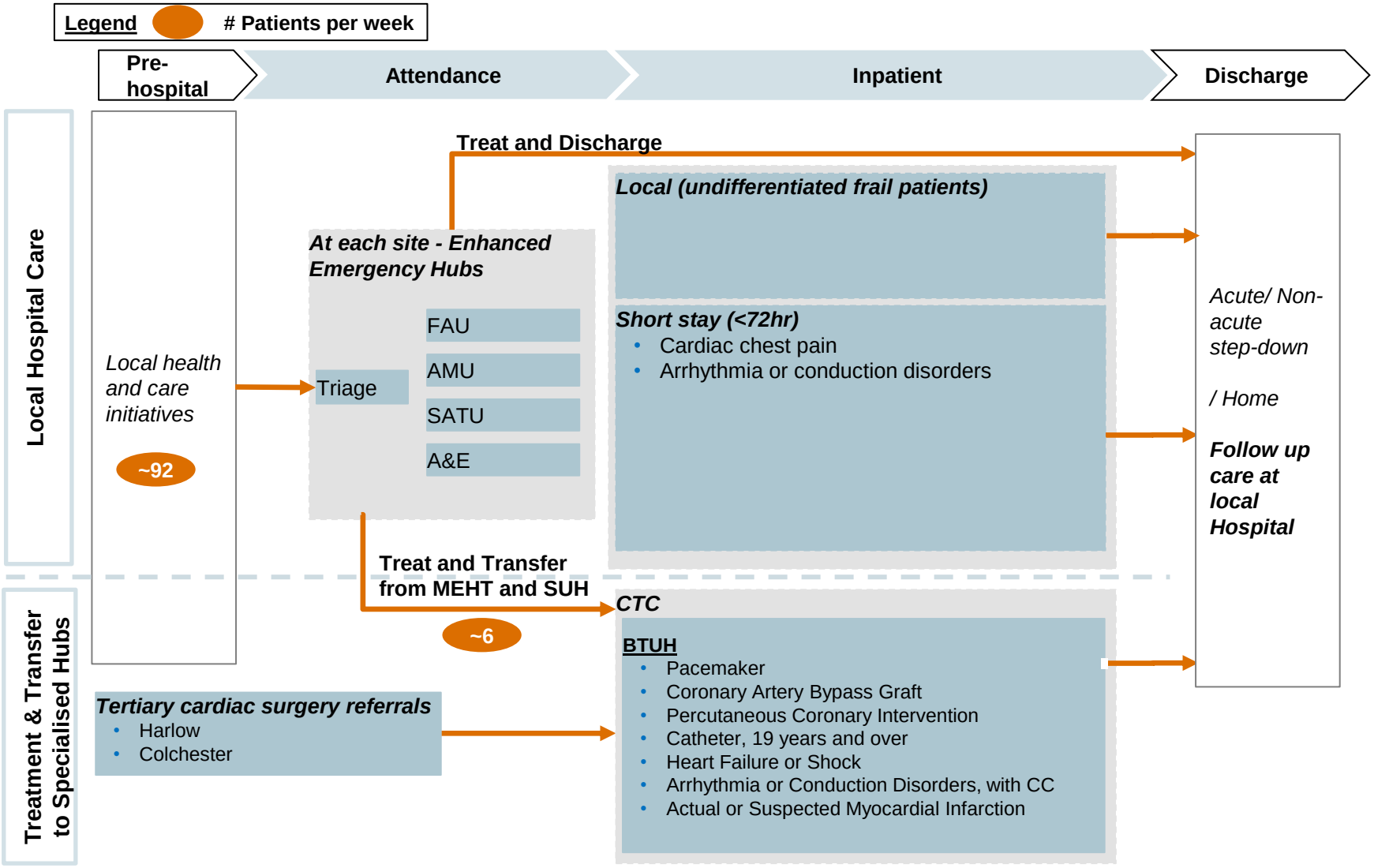
There is strong clinical evidence that consolidation of Cardiology services can improve patient outcomes.[1] This has been evidenced locally through the improvement in outcomes at the CTC

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

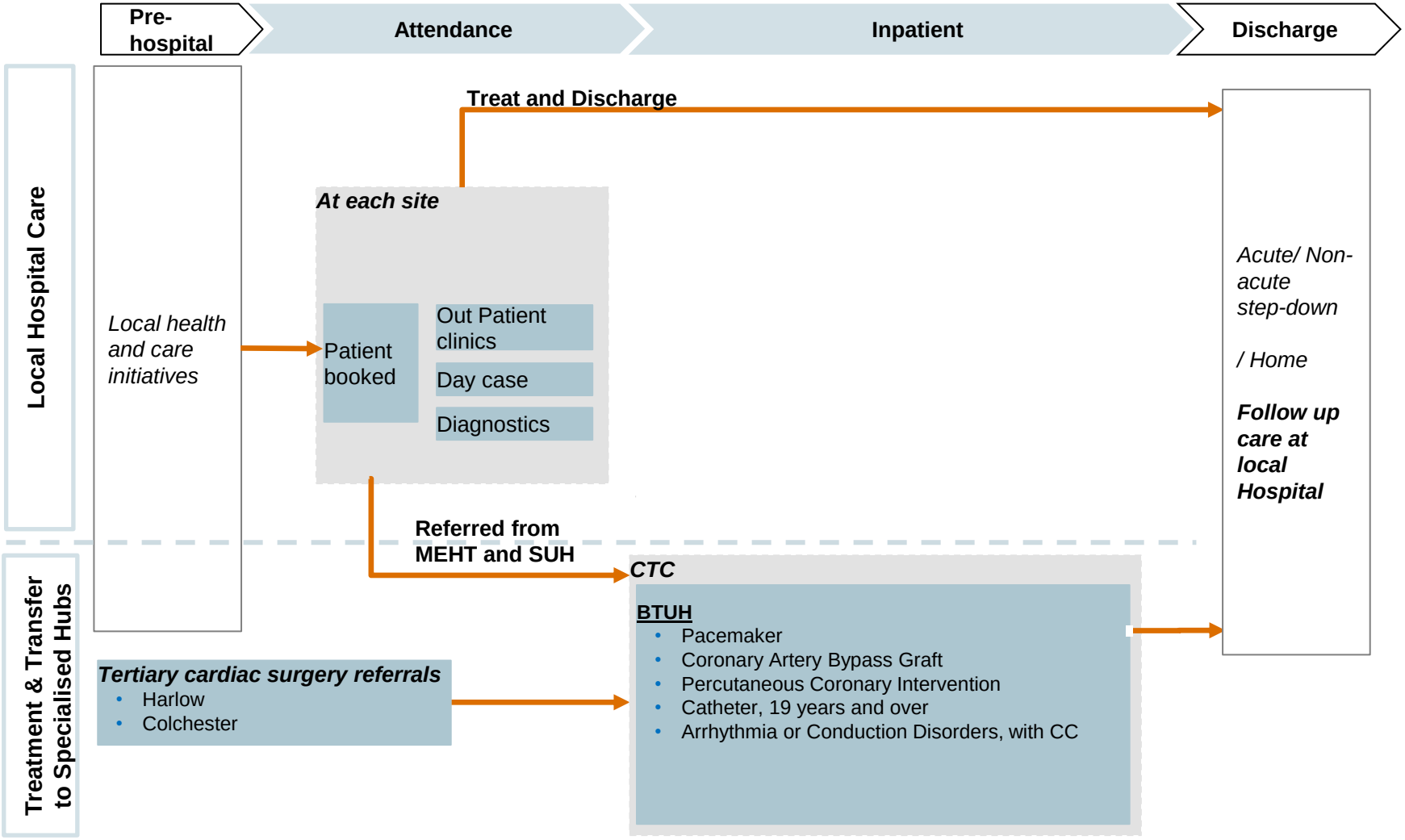
Additional Senior Cardiology cover may be required at each site to ensure compliance with NICE guidance for Cardiologist review within 12 hours

1. Ross et al. NEJM 2010

Cardiology and Cardiac Surgery: Emergency patient flow



Cardiology and Cardiac Surgery: Elective patient flow

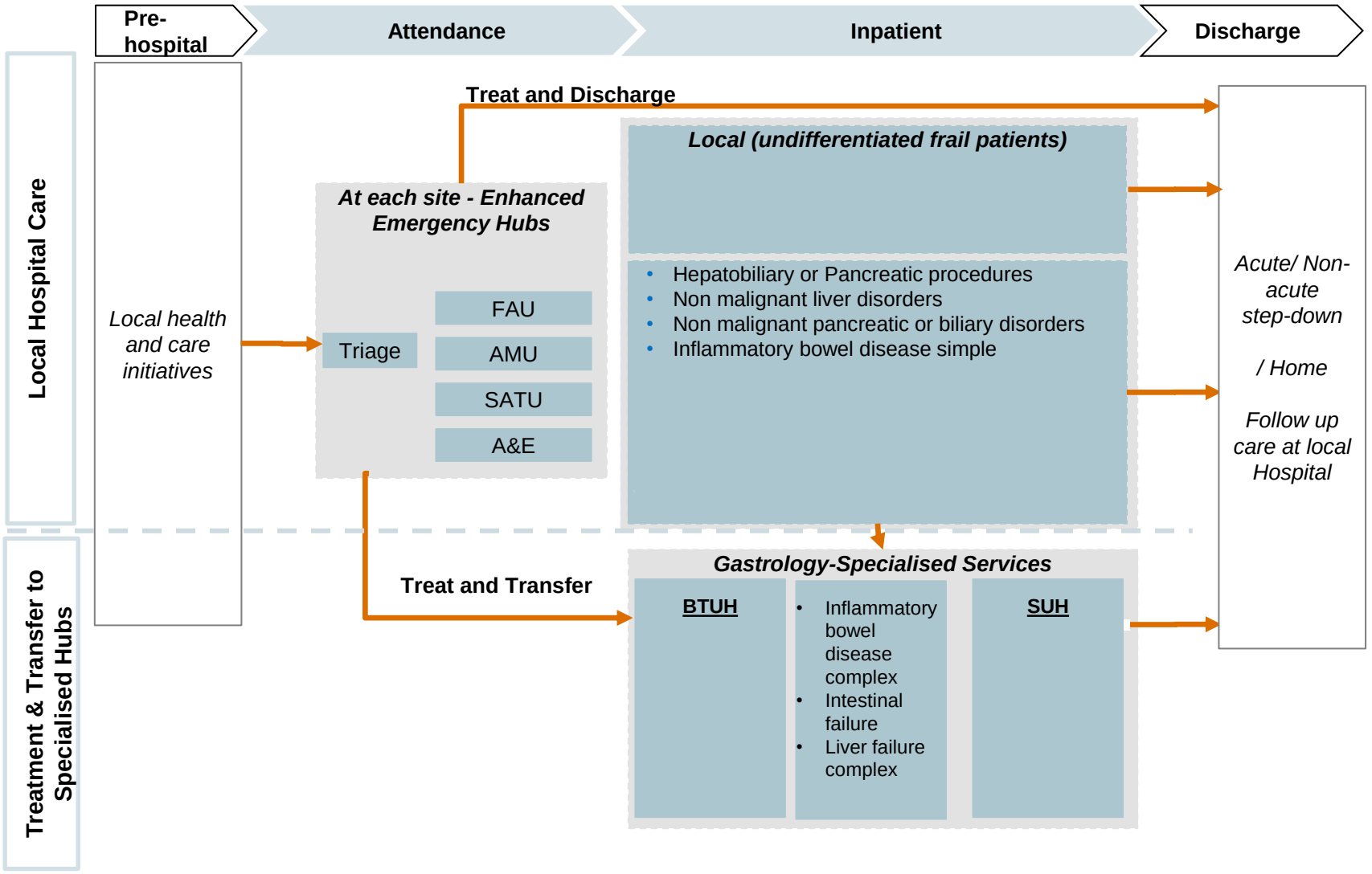


Gastro Intestinal

Gastroenterology: summary of proposed changes

How services are currently configured	How will services are proposed to be organised in the future	Implications
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**	**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, sever 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**	**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**

Gastro: Patient pathways



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

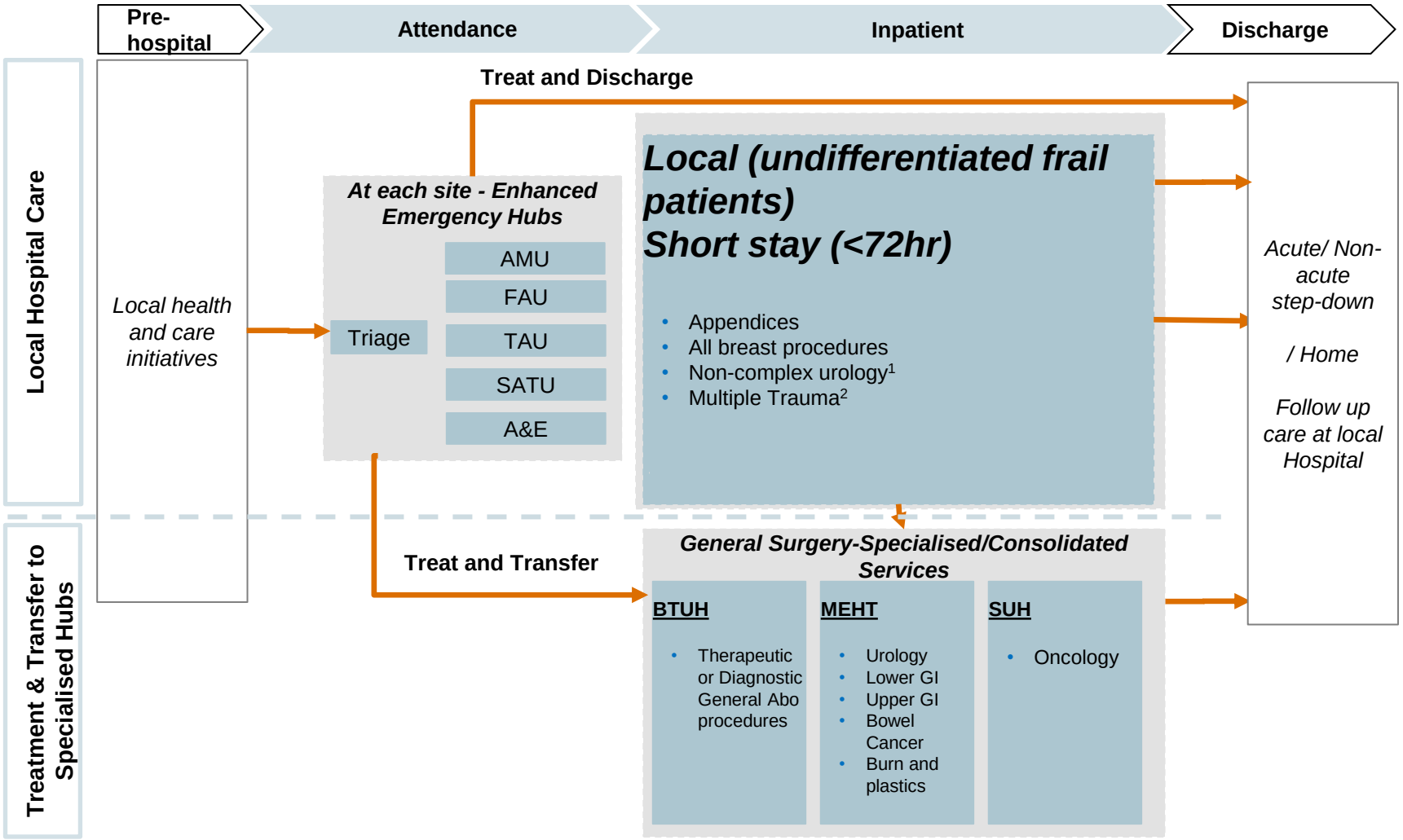
The future model will enable the consolidation of certain specialties which in turn leads to better outcomes. Whilst most outpatient and routine services would continue to be offered locally, some patients will have to travel for complex care to MEHT

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]

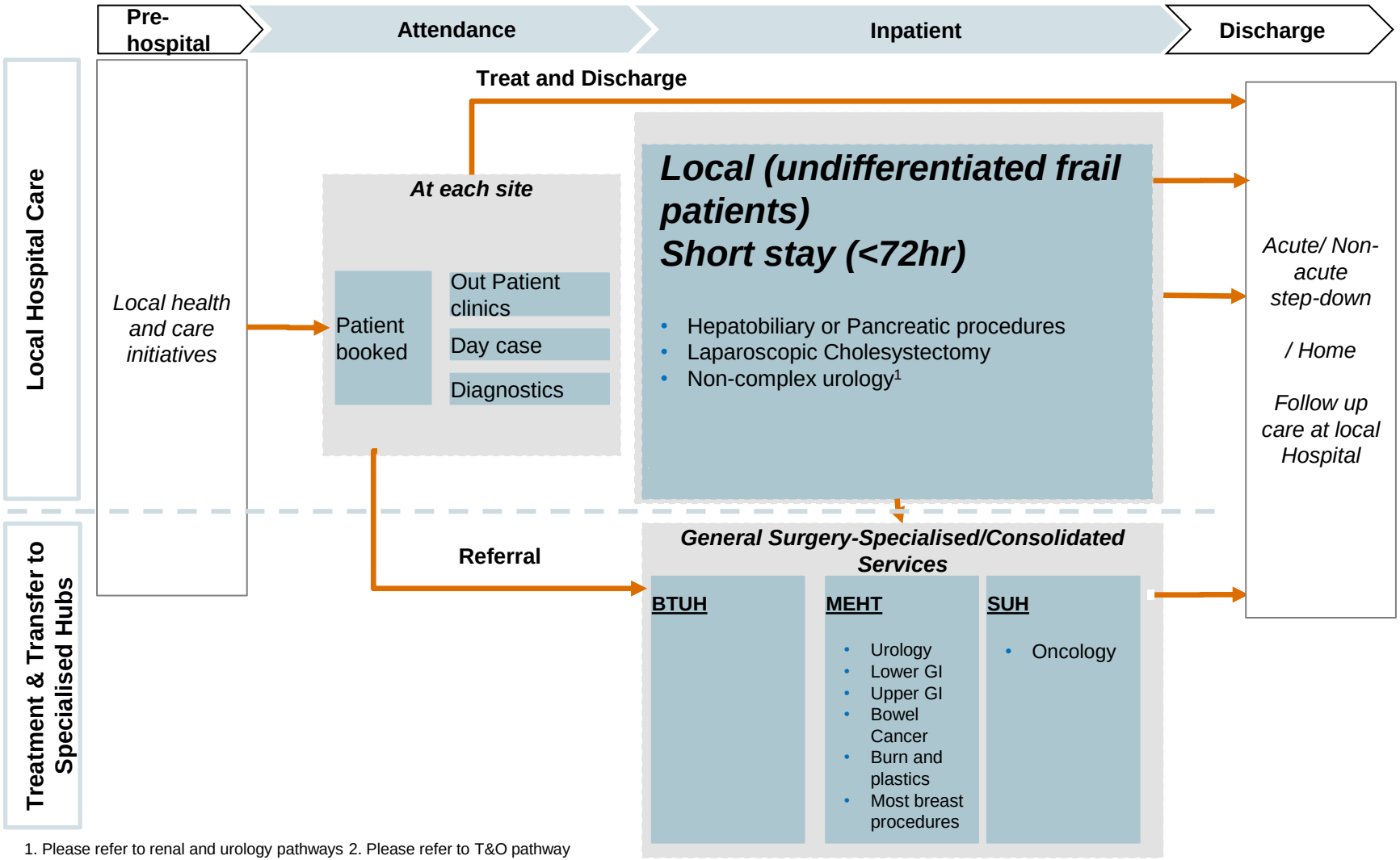
1. Getting it right first time, Aug 2017

How it could work in practice - General Surgery: Emergency patient pathways



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



1. Please refer to renal and urology pathways 2. Please refer to T&O pathway

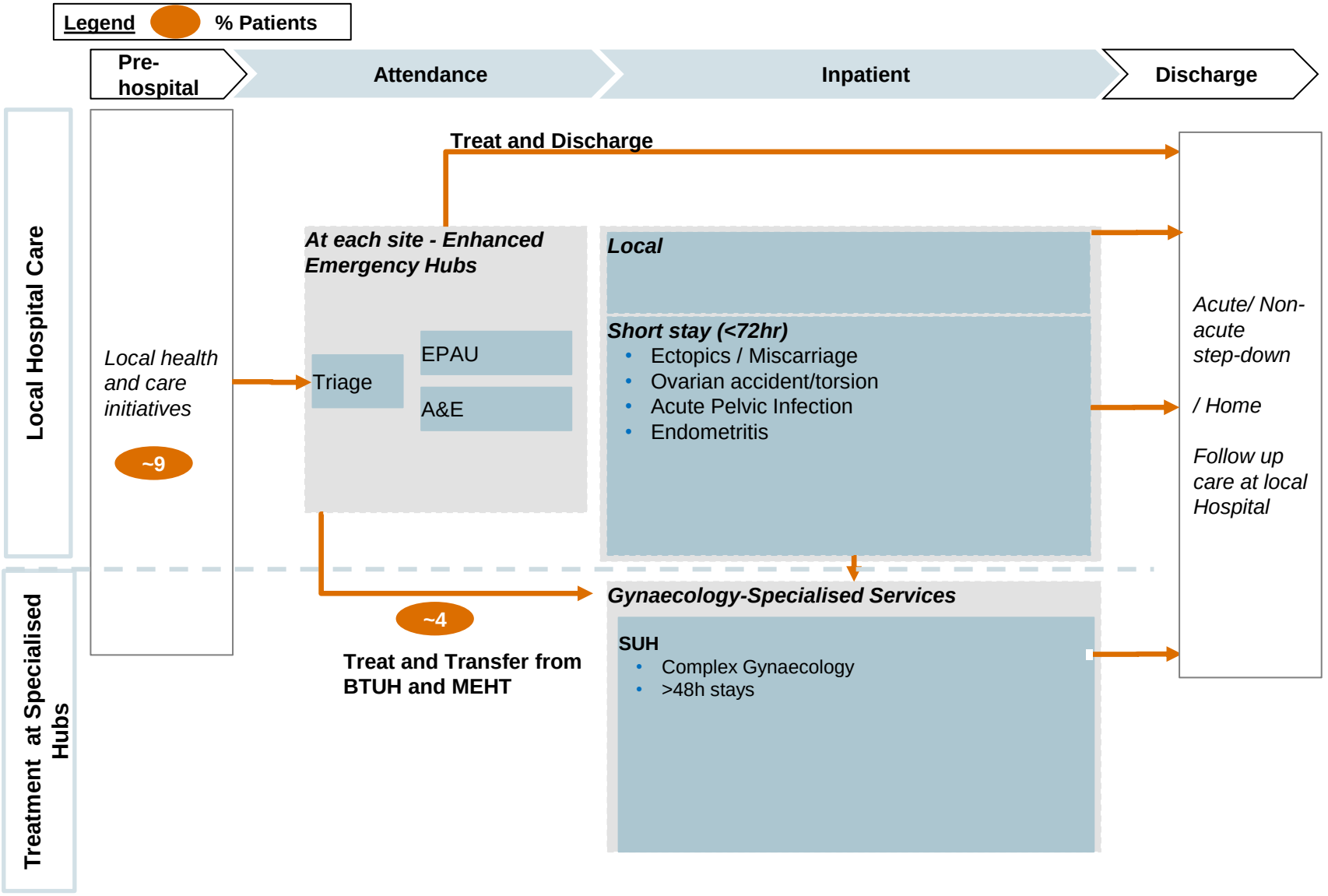
Gynaecology

Gynaecology: summary of proposed changes

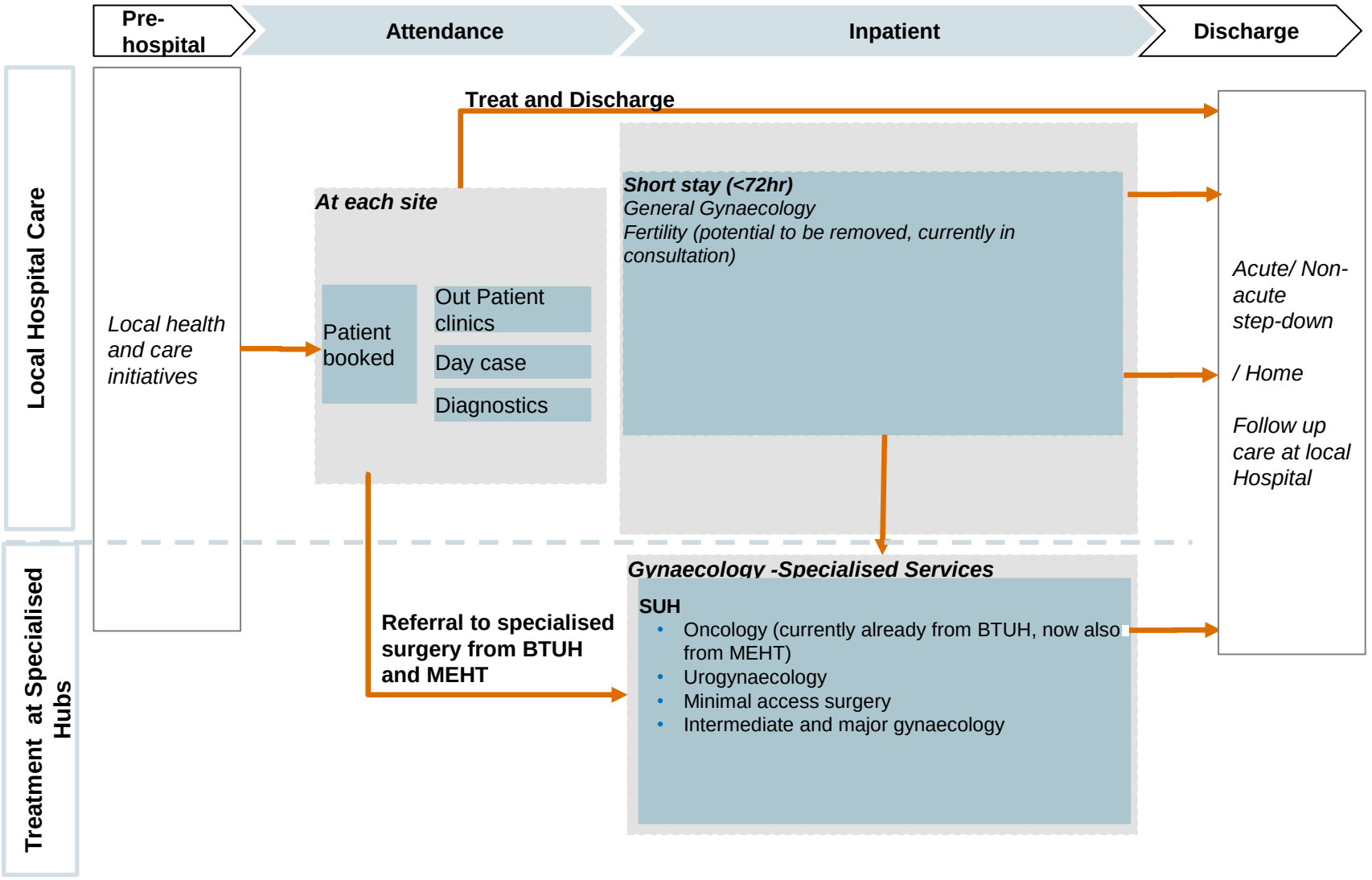
How services are currently configured	How will services are proposed to be organised in the future	Implications
Currently, emergency and routine Gynaecological services are offered on all sites **These include Early Pregnancy Assessment Units, and a range of clinics (e.g. Colposcopy clinics)** **Currently, Oncology patients are transferred from Basildon to Southend, although this arrangement is not in place with patients from Broomfield who are linked to Ipswich.**	**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**	**There is good evidence that consolidating Cancer work improves outcomes for patients.[1] 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**

1. **Pre Options Appraisal information, Feb 2017**

Gynaecology: Emergency patient flow



Gynaecology: Elective patient flow



Hyper-Acute Stroke Care

Stroke: summary of proposed changes

How services are currently configured

Currently, all three hospitals offer Stroke services on site

- Patients suspected of having a stroke are transferred to their local hospital, where they receive care, including Thrombolysis, where indicated and after care.

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

How will services are proposed to be organised in the future

Patients suspected of having a Stroke would still be seen in their local hospital, assessed and thrombolysed if indicated.

Thromolysed 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.

- Usually the first ~72 hrs

After this time, patients will be repatriated back to their local hospital's acute stroke units for ongoing care or discharged for local rehabilitation

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.

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

Implications

There is strong national evidence that consolidating stroke care in HASU's improves patient outcomes.

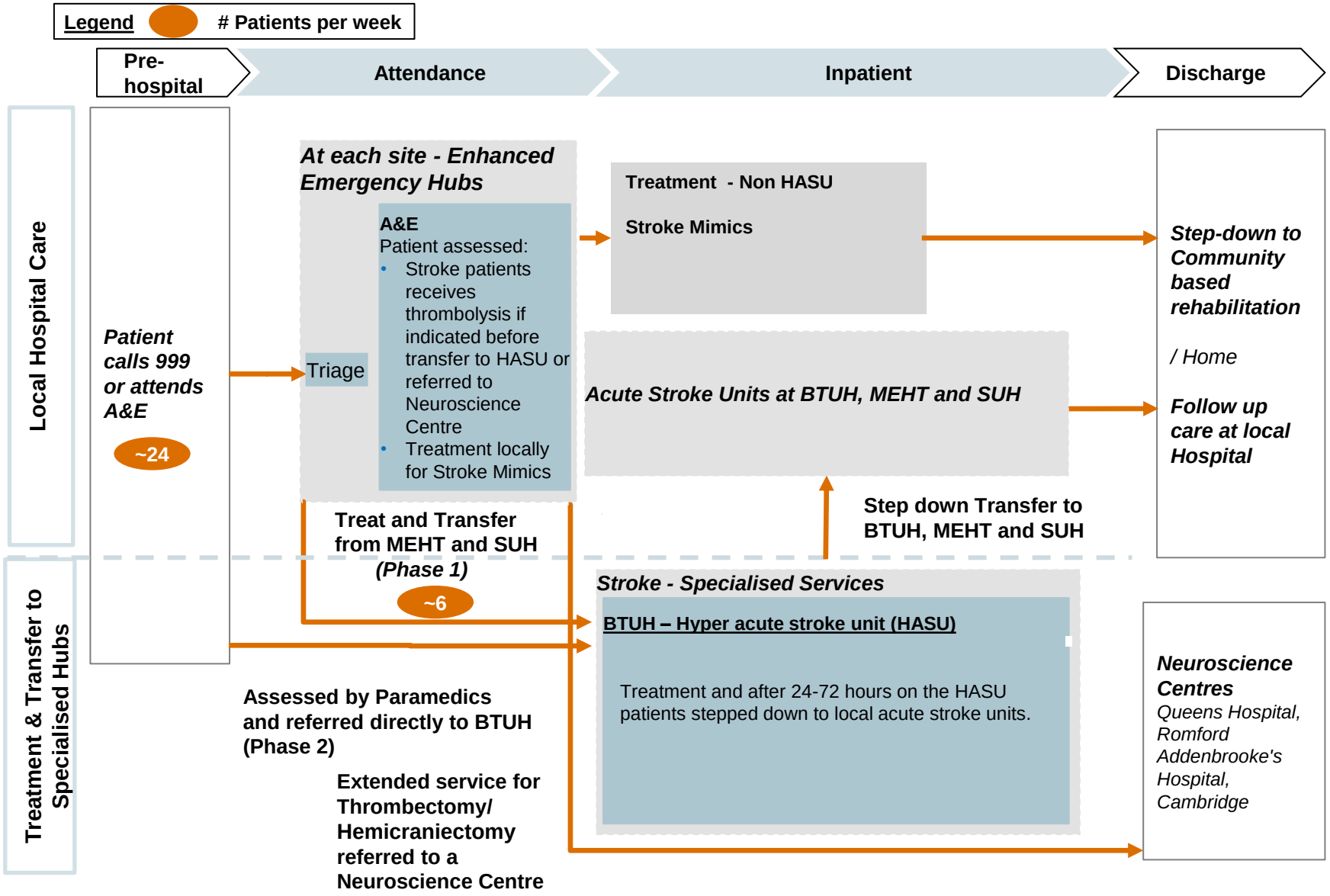
- This type of approach is already in place in Greater Manchester and London and has seen mortality and length of stay decrease by over 15%.[1]

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

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.

1. Saposnik et al, Neurology 2007, Hosp. A and B internal data, BCG Analysis

Stroke: patient flow

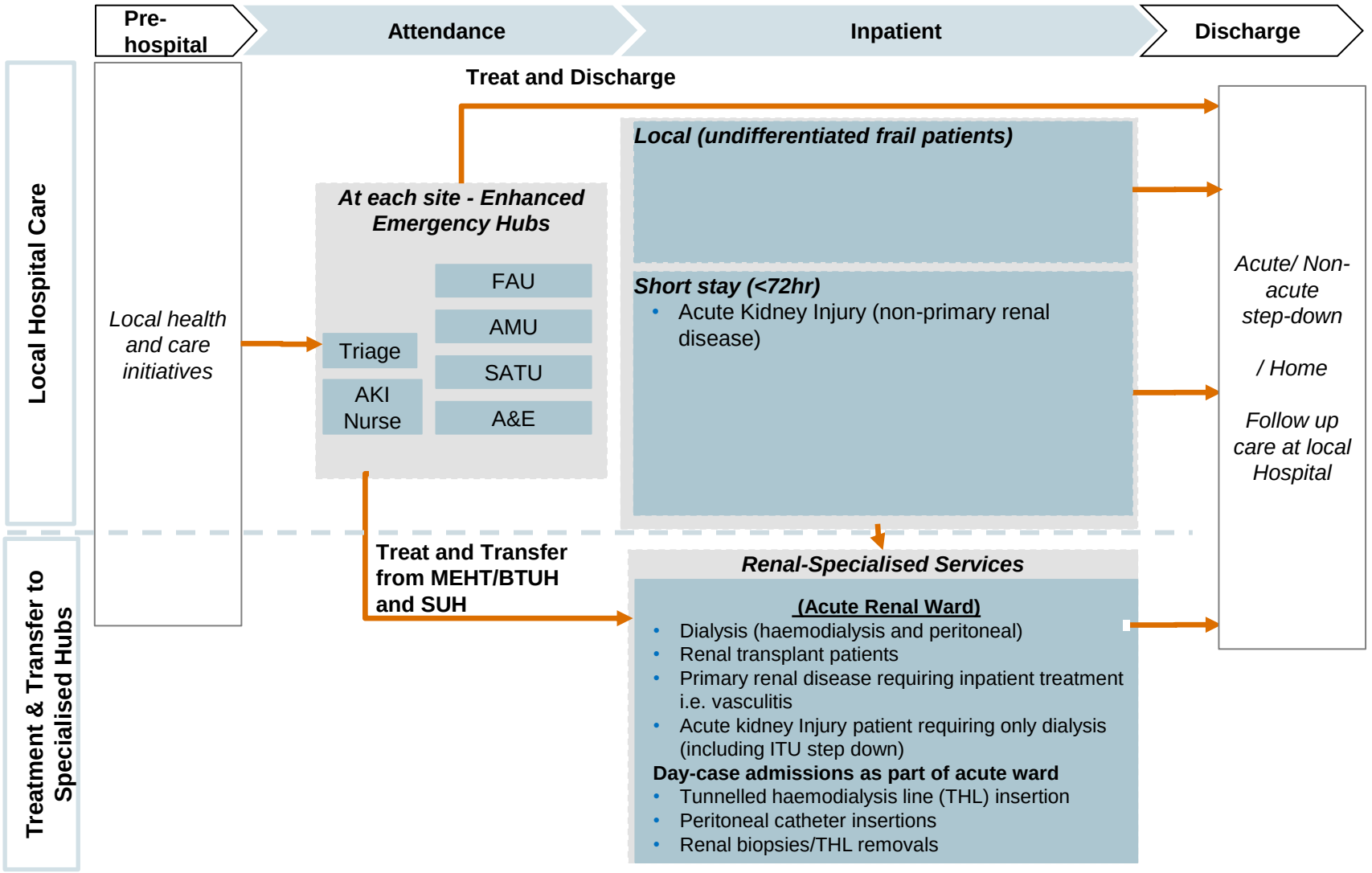


Renal

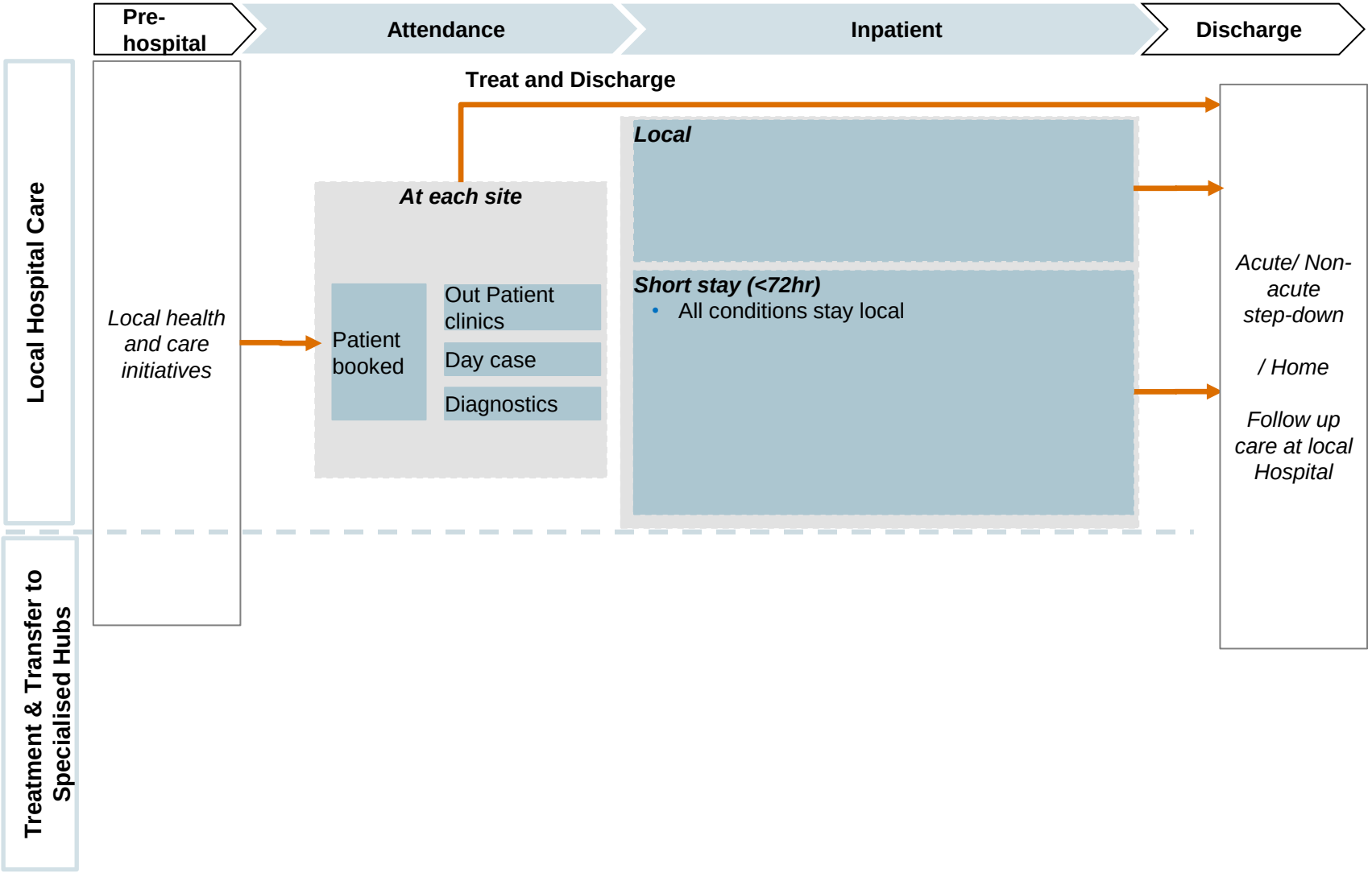
Renal: summary of proposed changes

How services are currently configured	How will services are proposed to be organised in the future	Implications
Emergency and elective services are currently offered at all three sites **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**	**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.** **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.** **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.** **Very complex work will continue to be delivered in London. Outpatient and less complex cases would continue to be delivered locally**	**The provision of the Acute Renal Ward will allow local patients to access the highest quality of care possible** **Most outpatient and dialysis services would continue to be offered locally. However, some patients will have to travel for complex care to BTUH**

Renal: Emergency patient pathways



Renal: Elective patient pathways



Respiratory

Respiratory: summary of proposed changes

How are services currently configured

Emergency services, elective services and outpatient clinics are offered at all three sites

What will be different in future

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

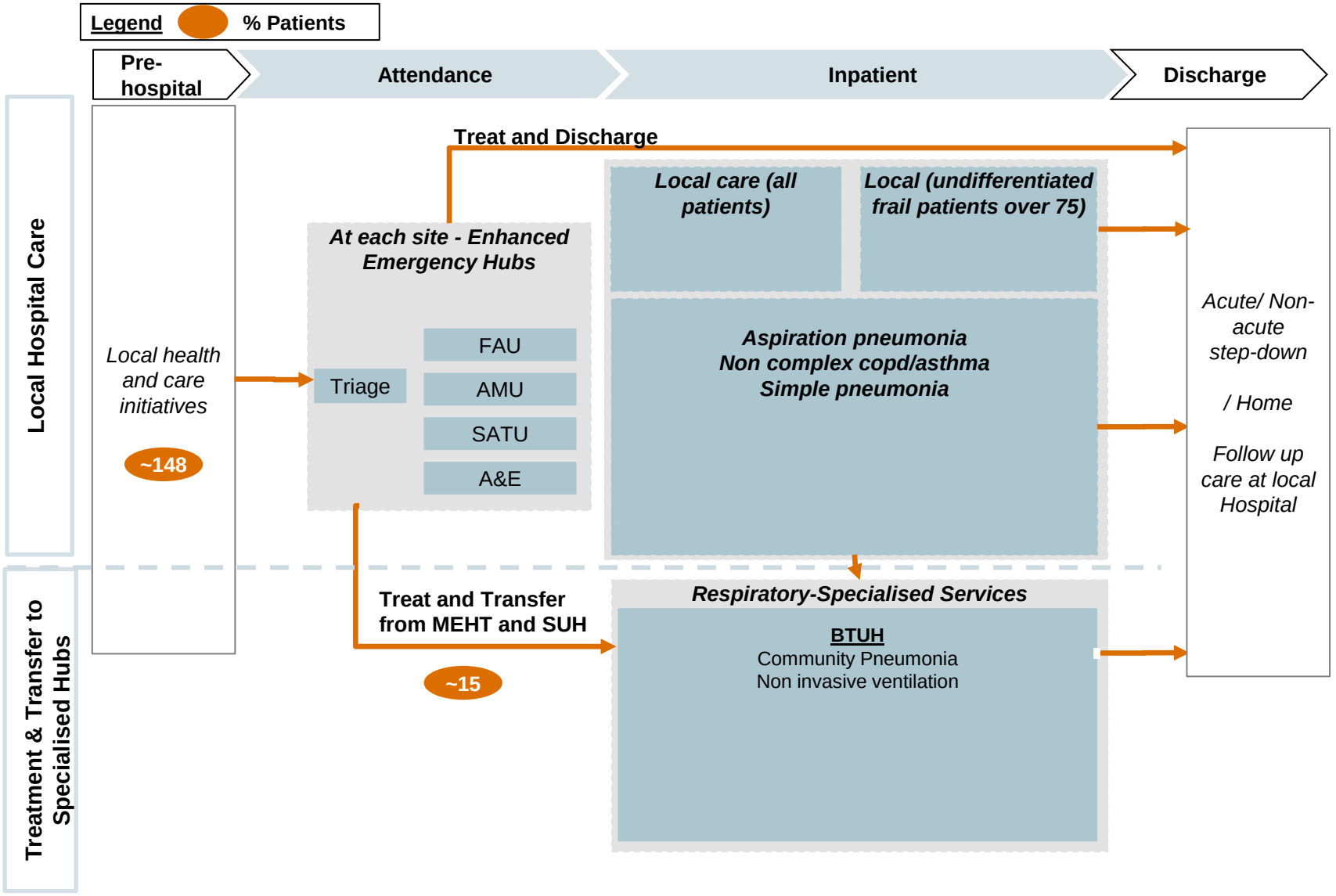
Patients who may attend this centre include patients who required non-invasive ventilation and with severe pneumonia

Implications

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

Respiratory: Patient pathways



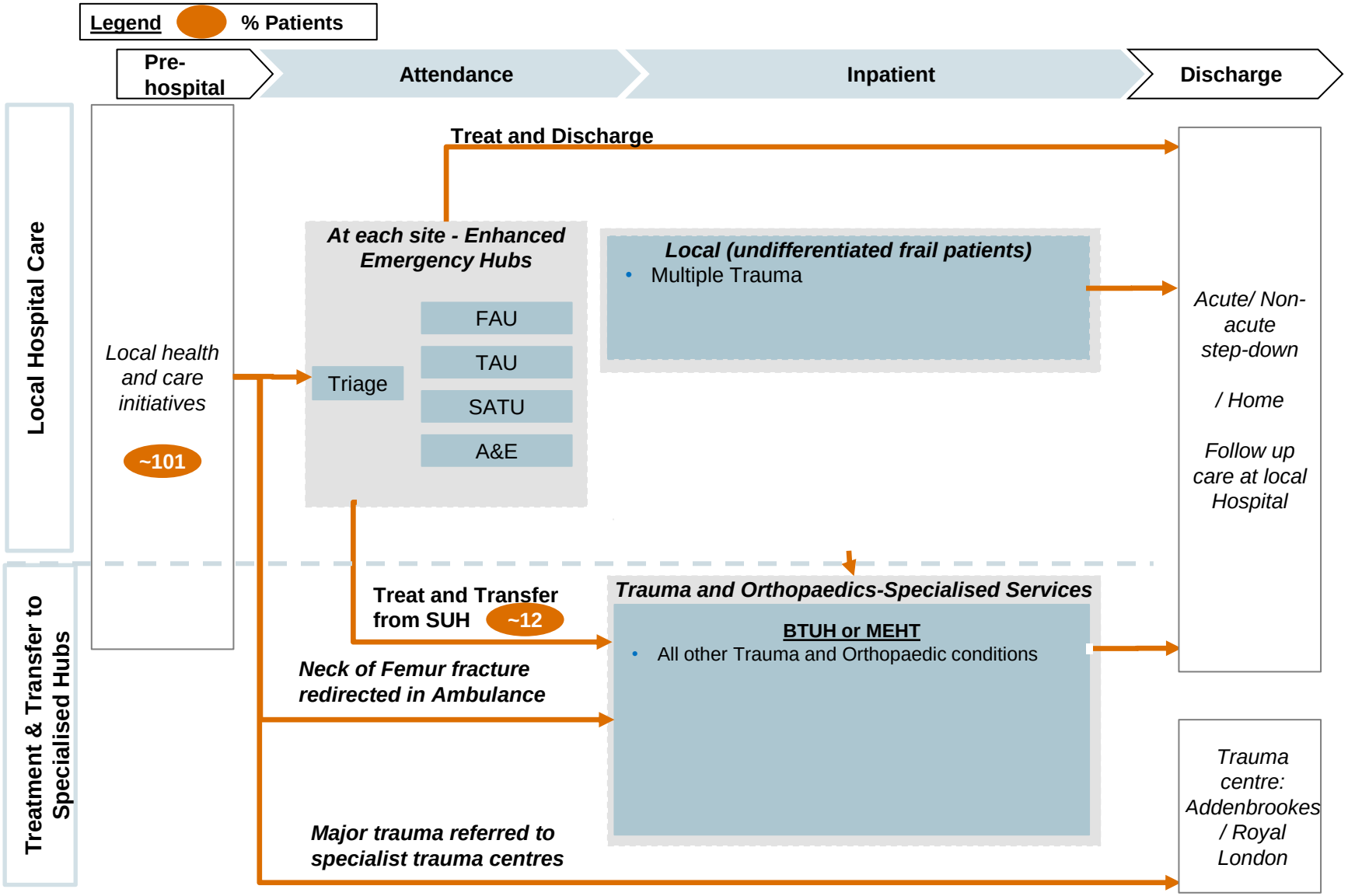
Trauma and Orthopaedics

Trauma and Orthopaedics: summary of proposed changes

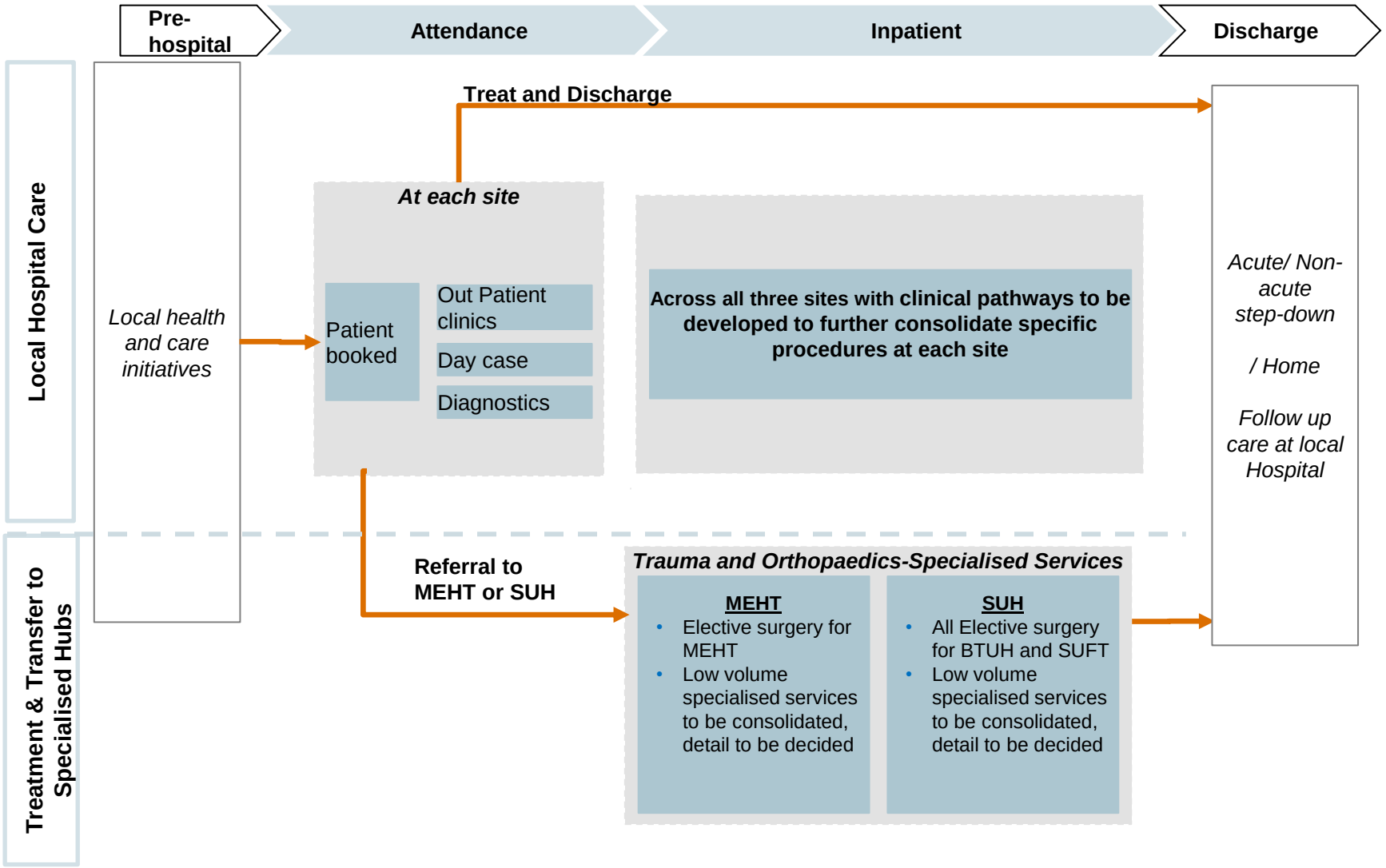
How services are currently configured	How will services are proposed to be organised in the future	Implications
All three sites currently offer a wider range of inpatient, outpatient and daycase Trauma and Orthopaedic services There are currently two major Trauma Networks in operation for the sites – 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	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 Major trauma would continue to be delivered outside of Essex 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. Elective surgery would be consolidated on two sites: MEHT and Southend. Clinical pathways will be developed to further consolidate specific procedures at each site	There is good evidence that consolidating surgical procedures can improve outcomes for patients[1-2] – for example, reducing complications and length of stay for patients receiving hip operations 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

1. **NCBI Report, Nov 2010 2. Getting it right first time, March 2015**

Trauma and Orthopaedics: Emergency patient pathways



Trauma and Orthopaedics: Elective patient pathways



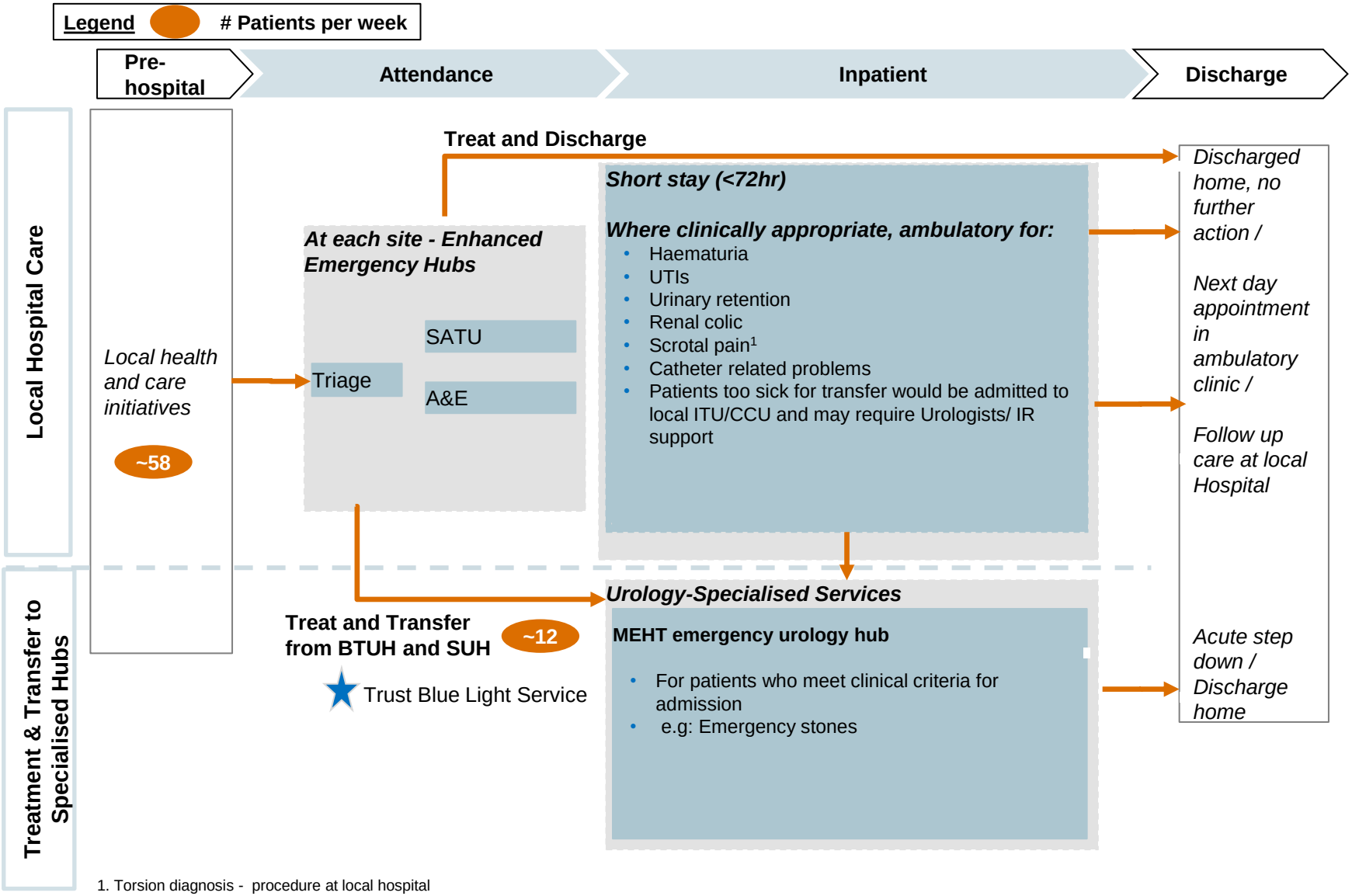
Urology

Urology: summary of proposed changes

How services are currently configured	How will services are proposed to be organised in the future	Implications
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**	**Emergency patients will be assessed at an n 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)	**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**

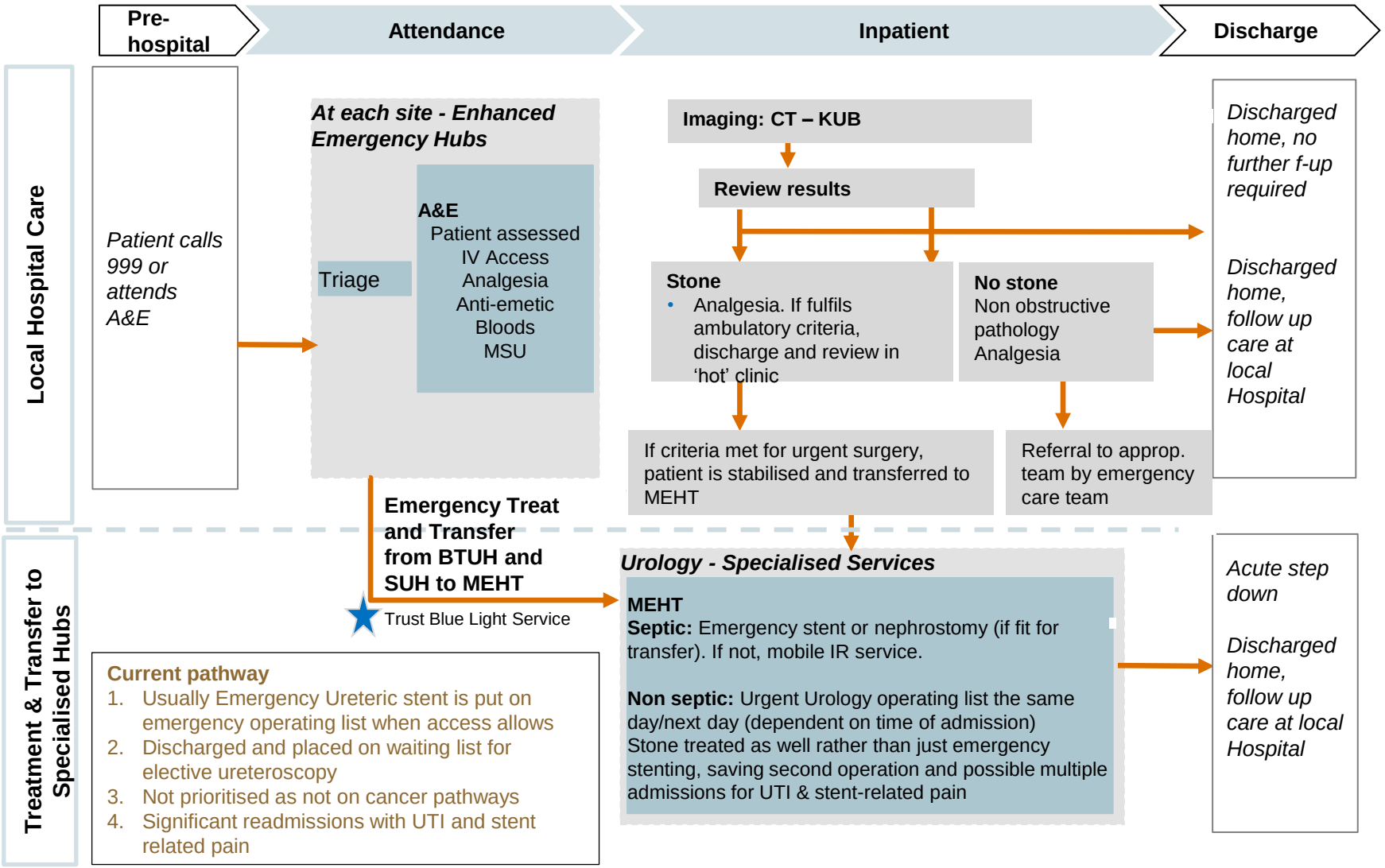
1. NHS Futures Martini – Kilnic, Nov 2013

Urology: Emergency patient flow

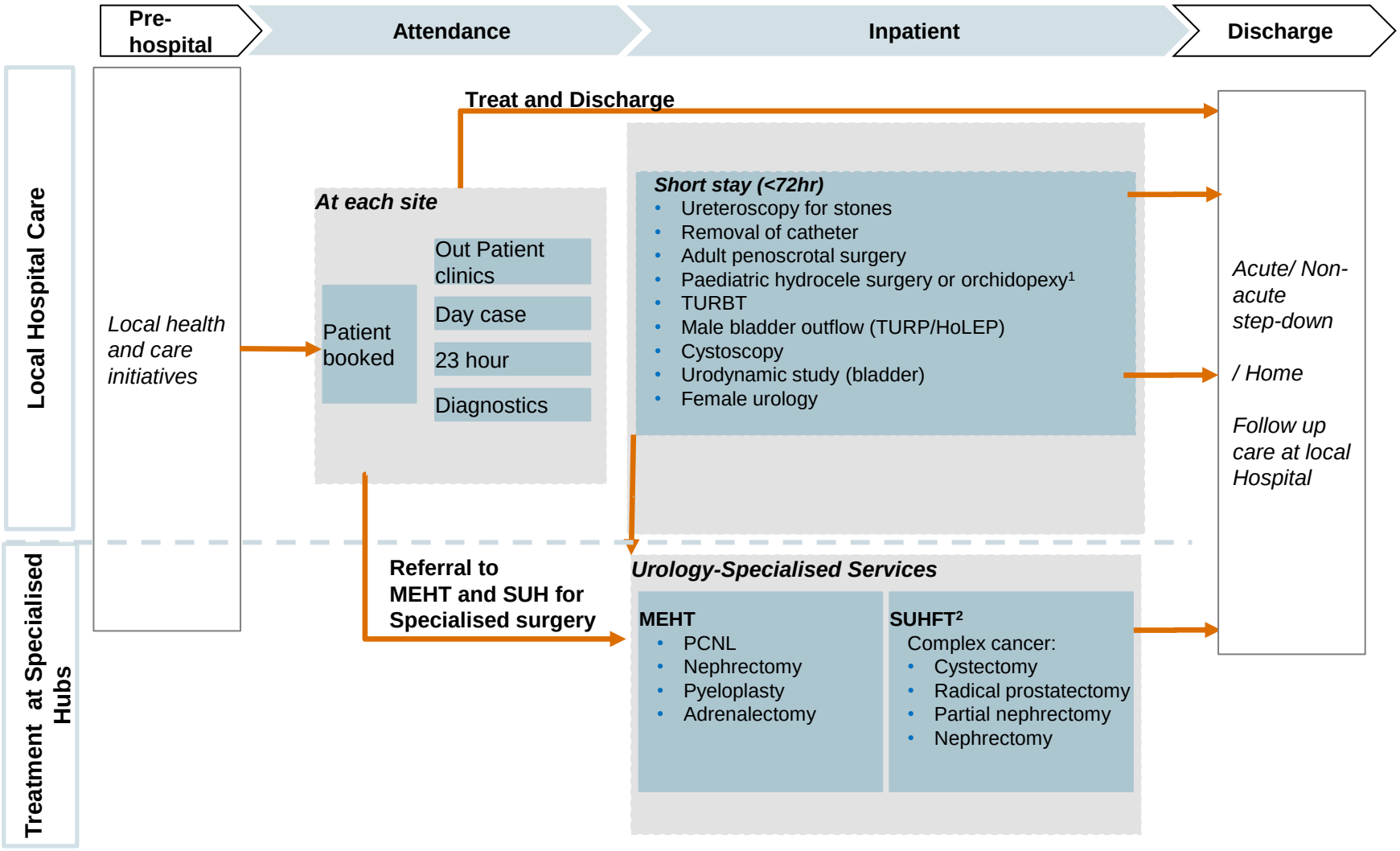


1. Torsion diagnosis - procedure at local hospital

Urology: Emergency stone patient flow



Urology: Elective patient flow



1. At SUHT paediatric services provided by general surgery 2. Specialised cancer services commissioned at SUHT.

Vascular

Vascular: summary of proposed changes

How services are currently configured

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.

How will services are proposed to be organised in the future

Under the proposed model, all patients would be reviewed at their A&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

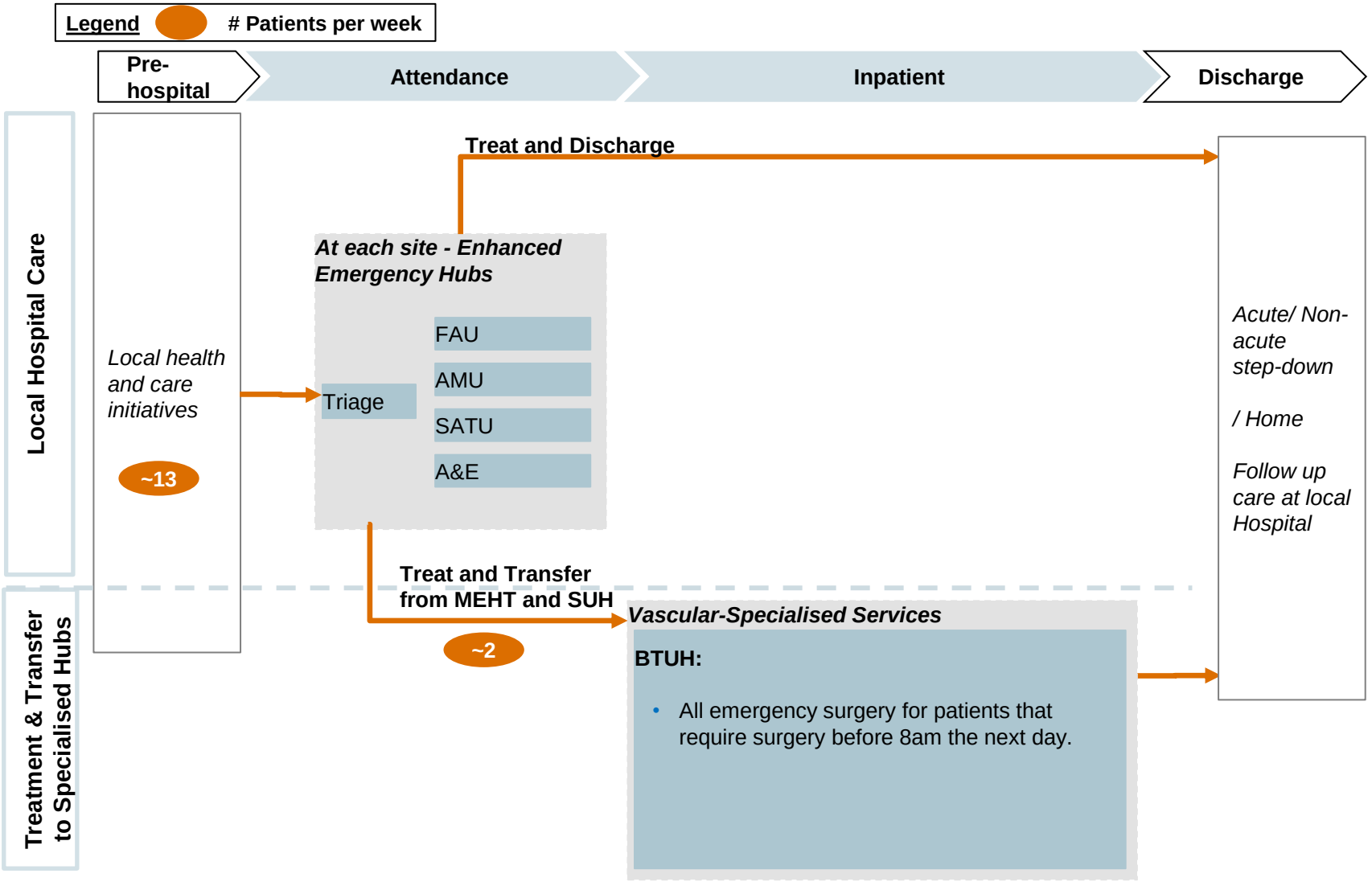
However, day and short stay surgery would be delivered locally, including lower limb, carotid and venous surgery

Implications

This approach is supported by Local Vascular Review, published in August 2016. This recommended the creation of 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 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

Vascular: Emergency patient flow



Vascular: Elective patient flow