

## **BARKING, HAVERING AND REDBRIDGE HOSPITALS NHS TRUST SUMMARY CLINICAL STRATEGY October 2005**

### **Introduction**

This paper outlines the background to the current Clinical Estates Strategy, progress and decisions to date including allocation of bed numbers and clinical adjacencies within the new hospital. It also details the further work required to complete the Clinical Strategy prior to the move.

### **Background**

***At a Trust Management Board Away Day in May 2005 (TMB) and subsequent TMB's, decisions were taken on proposals regarding:***

- the assumptions on which the capacity modelling and therefore the bed numbers have been based.
- clinical aggregations (how patients with different conditions would be grouped for their care)
- the clinical adjacencies between departments.

***The context in which the Clinical Strategy was developed was based around a view of the future in which:***

- day case rates will be optimised.
- minor procedures will be moved to the community.
- 30% of out patients will be delivered in a non-acute setting.
- enhanced community services will permit earlier discharge of patients.
- delayed transfers of care fall to a figure < 10
- use of technology is optimised including in the first instance PACS and ward order reporting.
- hospital at night will be functioning shortly after opening.

***The aims behind the Clinical Strategy are to:***

- ensure delivery of a safe service.
- ensure adequate capacity to meet demand.
- meet the maximum NHS wait of 18 weeks.
- achieve, or maintain recognition or accreditation for regional/sector specialties, such as cancer, vascular and neurosciences.
- optimise the use of scarce resources.
- standardise service delivery across sites; consolidating where possible.

***In addition, eight principles of care were developed and signed off:***

- care will be delivered to the patient, rather than moving the patient to the point of care delivery wherever possible.
- in-patient care will be provided for acute patients only.
- the workforce will be designed to meet care delivery needs, rather than around traditional professional boundaries.
- patients will access their care in the lowest activity and most local environment available
- increasingly the entire patient stay will become tightly managed
- the right staff will be rostered for at the right time
- patients will increasingly exert choice, and will become more involved in care delivery.
- the Care Records Service will, over time, facilitate access to information, wherever needed, in real time.

### **The Clinical Strategy**

The clinical moves which were agreed in order to enable delivery of the aims, are the changes to *in patient* services as follows:

<b>To King George Hospital</b>	<b>To New Romford</b>
Breast Surgery	Vascular Surgery
ENT	Upper GI Cancer
Maxillo Facial	High Risk Obstetrics
Urology	
Gynaecology	
Ophthalmology (day cases)	

Subsequent to the sign off of the Full Business Case for the New Romford Hospital, the Independent Sector Treatment Centre project developed, and will now be fully operational by February 2007.

This will remove circa. 9,500 day cases and in patients from the Trust facilities to the ISTC across the following specialties:

- ENT
- Oral Surgery
- Ophthalmology
- Urology
- Orthopaedics
- General Surgery

(see Appendix 1)

### **Capacity Calculations**

Steps taken to calculate the capacity requirements were as follows:

1. number of patients treated in 2003-04
2. benchmark length of stay and day case rates applied
3. anticipated growth applied through to 2008
4. ISTC activity removed from the Trust capacity requirements.
5. factored in clinical moves resulting from the Clinical Strategy
6. the aggregations or 'groupings' of patients was applied at a site level
7. assumptions for each of the clinical areas were applied, for example maximum length of stay in the short stay area, along with any exceptions

This produced a site based, bed model for each specialty or clinical aggregation.

### **Clinical Aggregations**

Most patients will be cared for in a similar specialty base set up as currently; grouped according to their speciality/disease. Virtually all unscheduled admissions will go through the acute assessment area with a few exceptions and be managed there for up to 72 hours. This includes patients who will be moved immediately to other areas e.g. trauma and MIs. Within the specialty based areas there are some new aggregations:

- gastro-intestinal, which will be comprised of both medical and surgical patients
- muscular-skeletal
- fracture neck of femurs (sited between elderly care and muscular skeletal)
- respiratory
- stroke/TIA.

The full list of clinical areas is in Appendix 3.

### **Clinical Adjacencies**

The co-location of specialities or clinical aggregations was agreed through the TMB and is clinically driven, taking into account key factors such as control of infection.

For detail see Appendix 4.

### **Bed Numbers**

Bed numbers which are to be allocated to each clinical aggregation at the Oldchurch Park site and potentially at the KGH site, if a similar organisation of clinical services is followed, are detailed at Appendix 5. These are adequately robust for planning purposes but are likely to see further modest changes if for example changes to the assumptions around occupancy rates are made.

### **Outstanding Work**

The Clinical Strategy to date, primarily determines the location of in-patient activity. The location for day case and out patient activity is currently being worked on, but is subject to two competing pressures. Firstly, the desire to optimise the use of

manpower expertise and equipment by consolidating and centralising specialty based, day case services where possible. The operational advantages this affords compete against a decentralised approach which facilitates easy, local access for patients who are having less major interventions.

Research to date shows that the choice patients will make when overtly presented with it in December of this year will, certainly at the beginning, be predicated on familiarity and proximity. Although this is expected to change over time, it is vital for the Trust to retain and attract as many referrals as possible. With this in mind it is likely that the allocation of out patient and day case specialities will be broad based geographically, whilst acknowledging the resource consequences this commitment will have. A proposal will be put to the TMB for discussion.

Capacity calculations for Obstetrics still have to be completed. Obstetrics beds were conceded to permit the increase in SCBU cots, the number now is less than the current allocation at Harold Wood. Capacity planning in maternity is complex and members of the Performance and Service Improvement Teams are working with Obstetrics to develop a robust capacity requirement for 2006 and beyond until the development of the low risk birthing units at Barking and potentially Harold Wood.

The King George Hospital Board must debate the merits, potential disadvantages and feasibility of implementing the outlined model of care within the hospital. It is proposed that at a New Hospital Meeting in December key members of the hospital Board attend and the issue is discussed.

### **Summary**

In the future, the impact of *Commissioning a Patient Led NHS* (which opens up the potential for acute Trusts to provide services previously provided by PCTs); Choice at the point of referral, Practiced Based Commissioning, and this amplified by the roll out of full Payment by Results, means that the Trust will be operating in a very different environment of greatly increased risk. In order to not just to survive, but thrive in this competitive arena, the Trust will need to become far more efficient in the way it delivers care, which, over time, is likely to result in a significant reduction in the bed base, and a concomitant investment in manpower and equipment to support improved throughput and outcomes.

The opportunity now presented to work in close partnership with primary care providers and the independent sector and to provide key services in the community that can impact on our effectiveness, makes fundamental changes in the efficiency of our services and the improvement in the standard of care, far more possible.

As Practiced Based Commissioning localities start to exercise the opportunities afforded to them, the Trust can expect to be approached from many angles. The BHRT strategy should be to collaborate and co-operate wherever possible, so that joint ventures start to become the norm, and innovative care models can flourish.

**Appendix 1**

***Trust Activity transferring to ISTC***

Specialty	ISTC Approximate Transferred Activity			ISTC Transferred Proportion of 2004-5 Actual Activity		All Elective	All Spells
	Day Case	Elective	Total	Day Case	Elective		
GENERAL SURGERY	837	529	1366	12.8%	16.8%	14.1%	9.3%
UROLOGY	2504	504	3008	36.1%	32.3%	35.4%	32.1%
ORTHOPAEDICS	1101	1167	2268	47.8%	47.7%	47.8%	29.3%
ENT	212	510	722	22.4%	33.5%	29.2%	24.8%
OPHTHALMOLOGY	1186	1	1187	36.1%	5.9%	36.0%	35.9%
ORAL SURGERY	667	70	737	49.3%	51.5%	49.5%	45.0%
Grand Total	6507	2781	9288	14.1%	22.6%	15.9%	8.2%

## Appendix 2

### **ASSUMPTIONS FOR BED MODELLING**

1. Most unscheduled admissions will be admitted via the short stay acute assessment area; patients will either be discharged from this area or transferred to a specialist area as soon as this is indicated and within a maximum of 3 days.
2. A maximum length of stay of 28 days (including any stay in the acute assessment area) has been assumed for 90% of bed days (but how many patients!) The vast majority of patients are discharged within this time frame already, however, for a minority of patients continuing care in an acute environment is necessary.
3. On site rehabilitation for those 90% of bed days will be limited to a further two weeks. This means that the maximum assumed length of stay for any patient on the acute site will be six weeks.
4. The national median length of stay has been assumed for inpatient admissions.
5. Occupancy levels of 85 have been assumed, well below current levels, to allow flexibility of patient placement and help guarantee elective admissions.
6. All day case patients will be treated within the day case suite and not in the main inpatient areas.

### **EXCEPTIONS**

- Obstetrics, Oncology and Paediatrics will not use the acute assessment facility
- Obstetrics, SCBU and Paediatrics have been modelled at 70% occupancy.
- Cardiac and Orthopaedics are assumed to have a maximum one day stay in the acute assessment area.

### Appendix 3

<b>Dental Specialties</b>
<b>ENT</b>
<b>Gastro Intestinal</b>
<b>Diabetes/Renal/Endocrine</b>
<b>Neurology</b>
<b>Neurosurgery</b>
<b>Obstetrics</b>
<b>Oncology/Haematology</b>
<b>Ophthalmology</b>
<b>Orth/Rheum/MusculoSkeletal</b>
<b>Fractured Neck of Femur</b>
<b>Paediatrics</b>
<b>Respiratory</b>
<b>SCBU</b>
<b>Stroke &amp; Transient Isch Attack</b>
<b>Surgical - other</b>
<b>Urology</b>
<b>Gynaecology</b>
<b>Vascular</b>
<b>Critical Care</b>
<b>Short Stay Acute Assessment</b>
<b>Rehabilitation</b>

**Quadrant****4<sup>th</sup> Floor**

<u>North West (B)</u>	Trauma & fractured neck of femur (B1) Stroke (B2)
North East (C)	Coronary Care, step down (C1) Potential space for Cath Lab (C2)
South West (A)	Complex care of the elderly (A1) Complex care of the elderly (A2)
South East (D)	Cardiac (D1) Respiratory (D2)

**Quadrant****3<sup>rd</sup> Floor**

<u>North West (B)</u>	Immunosuppressed Cancer (B1) Cancer/ Renal (B2)
North East (C)	Shell space – to be utilised at an agreed date after opening (C1&2)
South West (A)	General Medicine including diabetes (A1&2)
South East (D)	General Medicine including respiratory (D1&2)

**Quadrant****2<sup>nd</sup> Floor**

<u>North West (B)</u>	Orthopaedic elective and vascular elective (B1) ? Surgery (B2)
North East (C)	Surgery acute assessment beds (C1) GI (med & surg) (C2)
South West (A)	Neurosciences (assuming business case approved and additional bed requirement) (A1&2)
South East (D)	Pathology (D1&2)

**Quadrant****1st Floor**

<u>North West</u>	Children's inpatients - ? bed release from centralisation of gynae
North East	Theatres
South	Outpatients, day surgery, pre-assessment and maternity

**Quadrant****Ground Floor**

<u>North West</u>	Cancer day care, medical records, neurophysiology, nuclear medicine and medical photography
North East	Critical care (A&E, acute assessment, ITU and HDU) children's injuries, walk-in injuries and primary care
South	Cardio-respiratory, outpatients, pharmacy, radiology, dialysis and integrated therapies

## In Patient Bed Allocations

## Appendix 5

<b>Specialist Aggregations Oldchurch Park</b>	<b>Beds</b>
Breast	0
Cardiac	54
Complex Elderly	48
Dental Specialties	0
ENT	0
Gastro-intestinal	59
Diabetes/Endocrine/Renal/Other Medical	77
Neuro	21
Neurosurgery	33
Obstetrics inc Delivery rooms	60
Oncology/Haematology	41
Ophthalmology	0
Orth/Rheum/MusculoSkeletal	54
Fractured Neck of Femur	18
Paediatrics	23
Respiratory	36
SCBU	25
Stroke & Transient Ischaemic Attack	13
Surgical - other	9
Urology	0
Vascular	22
<b>Total</b>	<b>593</b>
ITU/HDU inc neuro	35
Coronary Care inc. 9 step down beds	17
Short Stay (inc. 4 gynae)	90
Rehabilitation	60
<b>Total</b>	<b>795</b>

n.b

- most specialties will have a proportion of the short stay acute assessment beds
- most specialties will have a proportion of the rehab beds
- there are **87** day case beds in addition to above
- these bed numbers inc. the additional critical care and 9 CCU step down beds but NOT the 60 shell space beds

## Appendix 5

<b>Specialist Aggregations King George/Barking Hospital</b>	<b>Beds</b>
Breast	11
Cardiac	45
Complex Elderly	38
Dental Specialties	0
ENT	7
Gastro-intestinal	45
Gynaecology	24
Diabetes/Endocrine/Renal/Other Medical	49
Neuro	12
Neurosurgery	0
Obstetrics inc Delivery bed state says 48 obst &? delivery	62
Oncology/Haematology	0
Ophthalmology	0
Ortho/Rheum/Musculo Skeletal	32
Fractured Neck of Femur	18
Paediatrics	21
Respiratory	31
SCBU	13
Stroke & Transient Ischaemic Attack	13
Surgical - other	6
Urology	34
Vascular	0
<b>Sub Total</b>	<b>455</b>
ITU/HDU	8
Coronary Care	8
Short stay	74
Rehabilitation	51
<b>Total</b>	<b>596</b>
n.b	
<ul style="list-style-type: none"> <li>• most specialties will have a proportion of the short stay acute assessment beds</li> </ul>	
<ul style="list-style-type: none"> <li>• most specialties will have a proportion of the rehab beds</li> </ul>	
<ul style="list-style-type: none"> <li>• there will need to be <b>29</b> day case beds/trolleys in addition to above</li> <li>• bulk of ENT beds are now within paediatrics</li> </ul>	