

High Level Operational Policies

The Process Boards also established a number of high level operational policies and principles that will determine the working of the new model of care in the preferred option. The summary of the high level operational policies are as follows:

1. Emergency Care – Operational Principles.

- Ambulance crews will generally take unsorted (i.e. patients not referred by GP's) emergency patients direct to A&E, but in some cases may take patients to the emergency assessment unit, following consultation with hospital colleagues, or to a specialist area with the agreement of the receiving area.
- Walk in patients will attend A&E where a proportion of them will be immediately redirected to primary care. This may be an on-site unit (and if so this is likely to be adjacent to A&E) or form part of normal primary care arrangements. Other patients will be assessed in A&E following triaging.
- GP's will send emergency patients direct to one of a number of areas, following consultation with hospital colleagues:
 - Emergency Assessment Unit including Elderly Assessment Unit
 - Paediatric Assessment Area
- Children with major or minor injuries/trauma will be assessed and treated in the A&E in discrete family and child-orientated waiting and treatment areas, which will have sufficient audio-visual separation from adult areas.
- Women with complications in early pregnancy will be directed to an assessment area adjacent to the gynaecology acute beds.
- Burns patients will be treated according to national protocols i.e. all cases will initially be seen in A&E either in Broomfield or elsewhere and transferred to the Burns Unit if necessary.

In order to maintain high throughput and quality of care it will be necessary to make appropriate arrangements to ensure discharged patients leave the hospital site as soon as is practicable. This will include:

- An area for patients to wait for transport from the A&E/Emergency assessment area.
- Rapid access to semi-planned ambulance transport. This may require an extension of non emergency transport services out of hours.

Patients arriving at A&E will initially be triaged by senior nurses under protocol and will either continue to be assessed, stabilised and treated in A&E or redirected to:

- The resuscitation area or to primary care, on or off site (as described above).
- To the Paediatric Unit for children with medical or non-trauma surgical conditions.
- To the Assessment and Critical Care area, in which patients will be assessed, admitted, transferred or discharged within 4 hours. This

area will include ITU, HDU, CCU and general beds for patients meeting the definition of critical care previously described.

- To the Elderly Assessment Unit which will receive new and returning cases and aim to avoid admission for both.
- To the Observation Area for observation for up to 24 hours. Example conditions are minor head injuries and overdoses.
- To an acute bed or emergency theatres where it is clear which specialist care is needed (e.g. fractures to an orthopaedic bed) and where the patient meets the acute complex patient definition.

The Emergency Assessment Unit will hold patients for a period of intensive diagnostic workup following which they will either be discharged (possibly to attend an urgent OPD the next day) or admitted to an appropriate acute bed. This period will typically be within 24 hours, with a maximum of 48 hours.

- The majority of patients will receive immediate treatment in the A&E or primary care unit and be discharged from these areas.
- Some patients, for example trauma patients, will need resuscitation/stabilisation and commencement of treatment prior to transfer to critical care/emergency theatre.
- The Assessment Unit will admit both medical and surgical cases and will treat a number of patients whose condition enables a predictable short stay of less than 48 hours and for whom admission to a specialist bed is not necessary. Examples are orthopaedic manipulation or renal colic.
- A number of patients will be transferred to an acute bed as soon as this is necessary.

The following diagram depicts the emergency care model as described above. The numbers denote expected patient treatment numbers.

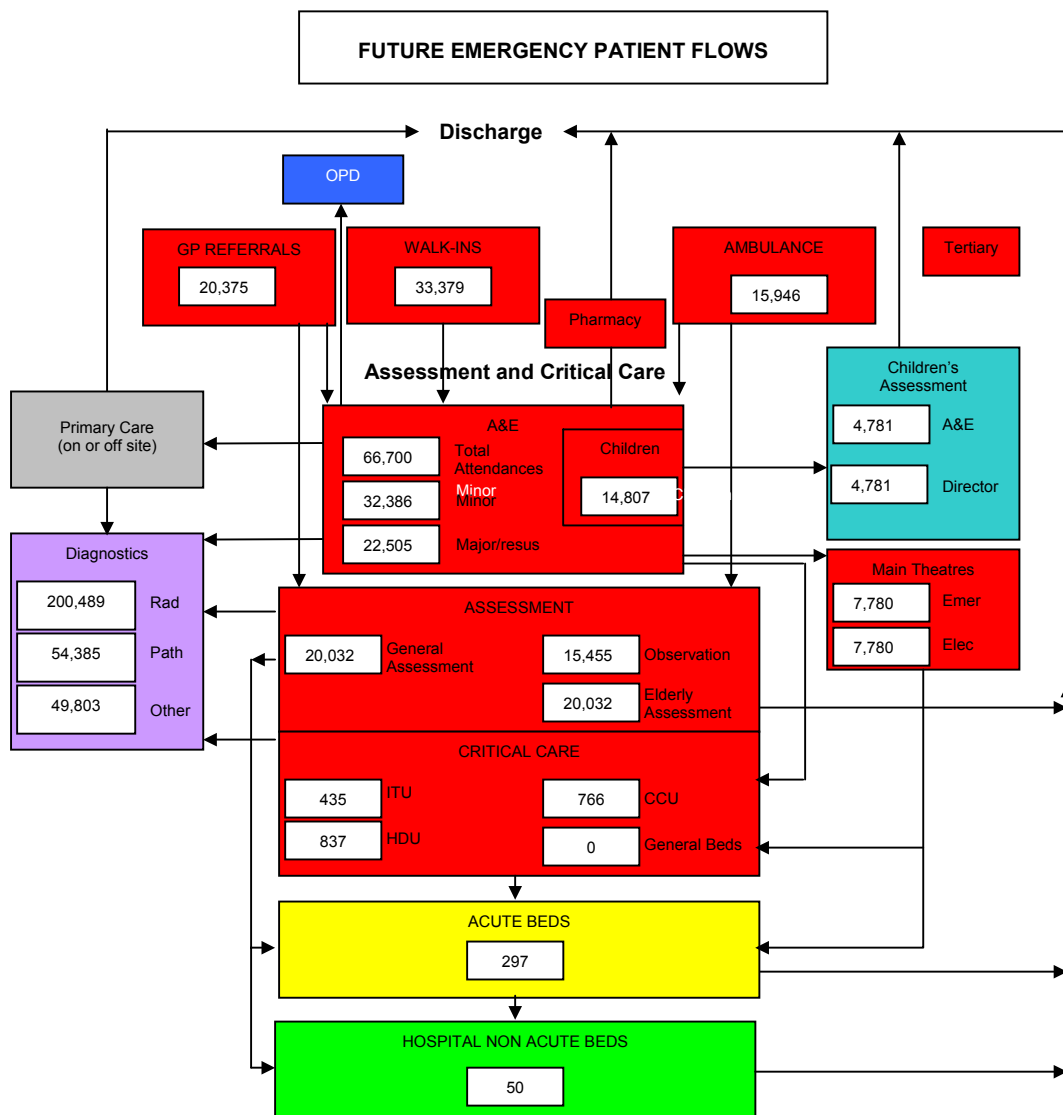


Fig 2.2: Emergency Patient Flows

Note – some patients e.g. obstetrics deliveries and tertiary burns will go direct to the appropriate acute bed. The Burns Unit will perform a critical care function but is not necessarily physically located in the Assessment and Critical Care area shown above.

2. Elective Care – Operational Policies

Patients' contact with the hospital for elective care will be limited to the minimum practicable number of visits for consultation, diagnosis, treatment and follow-up care. To this end, the following principles will apply throughout the Trust:

- Patients will be pre-assessed prior to admission and admitted on the day of their procedure. This is common practice now and whilst it is acknowledged that there will be exceptions, same day admissions will be standard practice.
- GP's will have direct access to pre-assessment (bypassing outpatient consultation) for a number of routine procedures. However GP's will not send patients direct to the procedure room without pre-assessment.
- GP's will have the opportunity to undertake a range of procedures themselves in the DTC. In these cases pre-assessment may take place in primary care.

- Patients will be admitted to the DTC unless their case is highly complex and/or likely to require a high level of nursing or medical supervision, in which case they will be admitted to a main inpatient ward.
- Most DTC patients will be admitted and discharged on the same day. Those who are not discharged will stay no more than two nights. In a small number of cases (for example, patients with post-operative complications) transfer to a main inpatient ward will be required.
- Patients admitted to main inpatient wards will stay for the minimum number of nights necessary to complete their treatment and acute aftercare. Following this they will be:
 - Discharged home
 - Transferred to a discharge lounge
 - Transferred to care elsewhere in the hospital (e.g. Hospital Non Acute Care)
 - Transferred to care off-site (e.g. Intermediate Care)

3. The Diagnostic and Treatment Centre (DTC)

The following overall principles will apply to the Diagnostic and Treatment Centre where most elective patients will receive their care:

- Although the Diagnostic and Treatment Centre will consist of a number of areas, the unit will be managed as a discrete entity.
- The unit will see planned booked elective patients and semi-scheduled emergency cases (e.g. ENT emergency day cases) for which sessional provision will be made. Whilst semi-planned cases who have presented in A&E may attend the DTC, the overriding principle is that elective patients come first and semi-planned cases will only be treated if this does not impinge on planned care.
- The unit will have one central reception and main waiting area although the individual functional elements will each have sub reception/waiting/lounge areas.
- Access from the unit to the main hospital will be necessary in the event of an emergency.
- All day care patients (excluding burns and obstetrics patients) will access the DTC via the main entrance. Patients (some accompanied) will, on arrival, proceed to a central reception/waiting area for registration and direction to the appropriate treatment/investigation area.
- All relevant reports and case notes will be assembled in advance of attendance at the DTC. These will be sent to the appropriate sub waiting reception point.
- Ambulance transport arrangement will be co-ordinated with the appointments and booked admissions system to ensure a smooth flow of patients. Patients awaiting transport from the DTC will wait in a transport lounge waiting area.

- A short stay elective admission is defined as that which has a predicted maximum duration of a 2-night stay. The role of pre-admissions is vital in ensuring that the elective process runs efficiently and that the patient experience is a positive one. The following operating principles apply to day and short stay elective procedures:
 - All patients attending for day or short stay procedures will be admitted to a reception/pre operative lounge on the day of their procedure.
 - Short stay elective patients will not be admitted to the ward until after surgery.
 - With the exception of obstetrics and burns, all other elective surgical admissions with a maximum of 2-night stay will be managed in the DTC.

- Adults and children will have separate reception and recovery areas. These will be served by generic treatment facilities, i.e.
 - Day theatres (unless workload is sufficient to make a paediatric theatre or theatres viable).
 - Endoscopy rooms
 - Minor treatment rooms

- Pre-admission or pre-assessment clinics will be run to enable investigations to be undertaken and patients to be screened for anaesthetic or other risk factors prior to admission as an inpatient or as a day case. Such clinics have been shown to reduce both patient and hospital cancellations and the principle of admitting all but the most dependant patients on the day of surgery is feasible and working in many American and British hospitals. The Trust will follow this principle and will admit elective patients on the day of procedure, unless there are overriding clinical reasons why this should not take place.

- The pre-admission preparation area within the DTC will also provide pre-assessment for those elective patients whose stay will be greater than 2 nights. As well as improving efficiency, and the patient's experience, by reducing the use of inpatient beds, pre-assessment opens up opportunities for other benefits which the Trust wishes to take advantage of. For example, many patients need information and reassurance, which it is not always easy to provide in a high turnover pre-assessment clinic. It is therefore proposed that in addition to the clinical function of the unit, patients will also receive personal care in a number of ways which might include:
 - An information service provided face to face, through literature and electronically, which will help answer patient's queries or concerns about their condition or treatment.
 - A virtual, or in some cases, actual tour of the facilities they will be using when they return for admission and the chance to meet those who may be caring for them when they return.

- Some pre-admission already takes place off-site. For example, elderly patients undergoing joint replacements have their assessment undertaken in their own homes. This enables their overall circumstances to be assessed and action taken pre-operatively to put in place help which is going to be needed post-operatively (e.g. home adaptations, carer support). This model will be progressed for other specialties where appropriate.
- It is also recognised that not all patients undergoing procedures in hospital will need to attend a pre-assessment clinic (for example, relatively young and fit plastics or gynaecology patients) and may instead be telephone triaged or be assessed and give consent in outpatients.
- The pre-assessment process will be nurse-led and nurses will administer all aspects of the process and not just the nursing assessment, under protocol and with clear triggers to involve medical staff where necessary. Where doctors see patients before surgery all necessary completed test results and assessments will be available to them. In practice this may mean that hospital based pre-assessment will be spread over the best part of a day with tests in the morning followed by seeing the surgeon in the afternoon.
- At various points throughout the day patients will have the opportunity to find out more about their condition or procedure as outlined above. This service will need to be supplemented with other ways to help patients relax or pass the time and the environment will therefore be both conducive to this and appropriately equipped with, for example:
 - Television/video/radio
 - Reading materials
 - Games (especially in the paediatric area)
 - Café/restaurant areas
 - On-line access.
- Children will be pre-assessed within the paediatric day surgery area to which they will return on the day of surgery. This will provide child-friendly facilities, including recreation facilities, for children who may be in the unit for most of the day.

The pre-admission patient flow is depicted in figure 1.

Patient Flow – Pre-admission

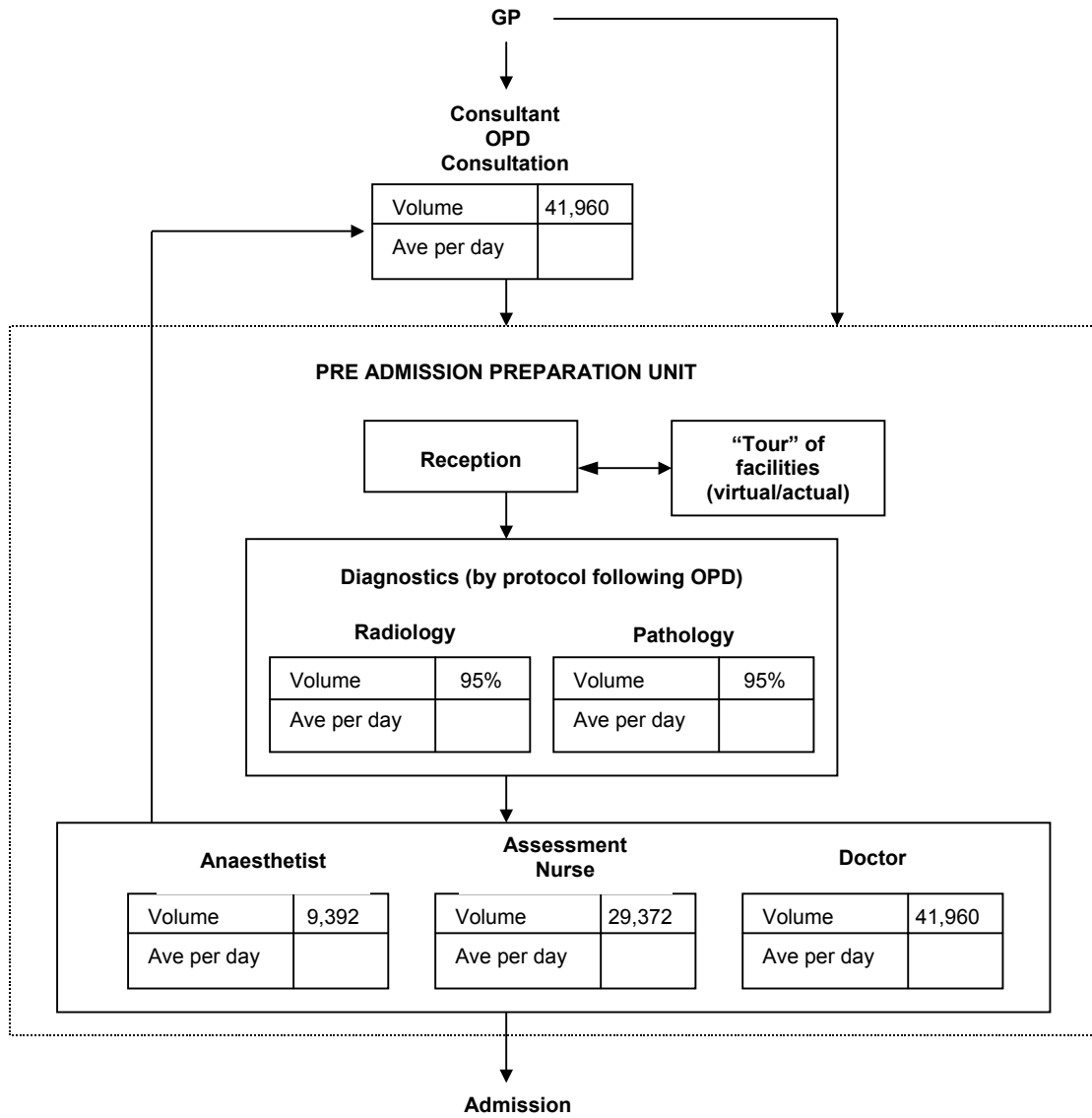


Fig 1: Pre-admission Patient Flow

- The short stay Inpatient and day case surgical patient flow can be described in the following diagram.

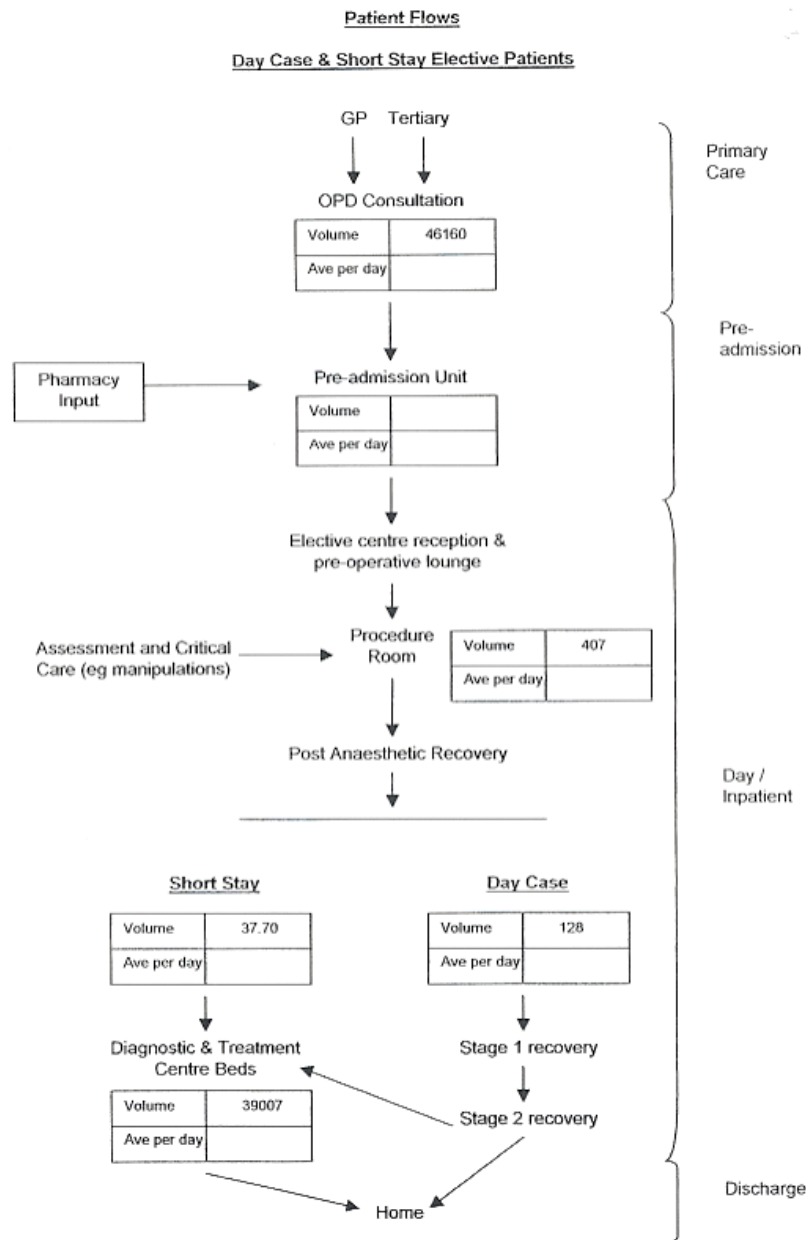


Fig 2: Day Case and Short Stay Elective Patient Flow

4. Outpatient Service

- The Trust views outpatient service as extremely important as they often represent the first “point of contact” with patients and will form a strong element of the integrated approach to patient care both internally and externally with GP’s and community services.
- The outpatient department will be a dedicated area within the DTC providing consultation, examination and minor treatment facilities for adult patients.

- Children will be seen in dedicated outpatient facilities in the paediatric zone for all specialties. In addition, consideration needs to be given to having the ENT/Audiology as a linking department (but not thoroughfare) between the DTC and paediatric zone, given the high numbers of children attending this department and the need to avoid duplicating staff and equipment. Also with large numbers of children attending the fracture clinic opportunities to co-locate close to the main Orthopaedic outpatient area will be pursued.
- The function of the outpatient department is to provide medical and other professionals facilities in which they can assess patients referred from general practitioners. This assessment can take many forms:
 - Diagnostic assessment
 - Assessment of suitability for and preparation for procedures to be undertaken at a later date.
 - Scheduled investigations
 - Minor treatments
 - Follow up to treatment and previous consultations
- The opportunity will be taken to co-locate clinics which are closely associated with each other and to offer both joint clinics and provide the opportunity for cross referral during clinic. In the case of the latter, provision will be made in the clinic schedule for an anticipated number of cross referrals to be seen immediately rather than come back for a separate appointment in the future. Diagnostic tests will be made available by protocol to support this and to ensure as far as possible that patients receive one stop care.
- To improve patient experience, facilitate one-stop clinics and co-locate specialities where cross referrals are often necessary the following outpatient clusters have been agreed with clinicians.

1	2	3
Trauma and Orthopaedics Rheumatology Anaesthetics (Pain) Hands Neuro Physiology Neuro Neuro Surgery	Plastic Surgery (excluding Hands) Dermatology	Elderly General Medicine Cardio Chest Nephrology Rehab Haematology Clinical Haematology
4	5	6
Paediatrics * ENT Oral Surgery Orthodontics Cleft Orthoptics	Ophthalmology	Endoscopy
7	8	9
General Surgery Urology Gynaecology Oncology	GU Medicine	Antenatal

* Occupying same or adjacent space

Table 1: Grouping of outpatient specialities

- Grouping specialties in this manner will provide opportunities for consultant to consultant referrals to be managed on the same day. This will prevent unnecessary further outpatient appointments for patients, reduce follow up attendances and will improve the timeliness of care for the patient. The grouping will also assist with multidisciplinary care needed for cancer patients.
- Patients will receive therapy input as part of their overall assessment and treatment service. However, repeated follow-up therapy will be undertaken in the main therapy unit and not the DTC.
- The pharmacy service will utilise modern information and other technology and be protocol driven. This will enable a greater proportion of pharmacy items to be prepared in advance and reduce delays in the system.

5. Hospital Non-acute Care

- The overall philosophy of the hospital non-acute care facility is to provide whatever patients need to get them home or to a stage of their care outside hospital. This will mean varied and sometimes intensive activities will be provided for both inpatients and day attendees both in the facility and often in an acute care area prior to transfer to the facility.
- The facility will only provide a service to those patients for whom access to these hospital-based facilities is necessary. Where patients can be cared for post acutely in the community, they will be. The service will cater for both those patients requiring active rehabilitation (see below) and those in need of further hospital based care before discharge.
- Patient numbers will be sufficient to justify the provision of a dedicated Stroke Unit within the facility serving patients who will have had the acute management of their stroke within the Assessment and Critical Care Area.
- It is assumed that some admissions will be made of palliative care where such patients will benefit from the services offered in the non-acute facility but that the majority of palliative care patients will be cared for in the hospice. A hospital based palliative care service might then be integrated with pain relief services.
- Admissions protocols will ensure the facility does not receive inappropriate referrals and that appropriate care is provided within the community and other units. Patients will therefore be admitted to the facility with a clear, timed care plan and not because there is nowhere else for them to go. In order to achieve this, admission protocols will need to be supported by a range of alternative services for patients who might otherwise inappropriately be admitted to (or stay too long in) the facility. These include (not an exhaustive list):
 - Intermediate Care services
 - Back Pain Clinic
 - Community Rehabilitation Team
 - Community Rehabilitation Consultants

- Elderly Assessment Unit
 - Social Services
 - Discharge Team
- The facility will receive patients from:
 - An acute inpatient bed
 - The Assessment and Critical Care area (including the Elderly Assessment Unit)
 - Out of district referrals where local patients have received care elsewhere and are returning for local rehabilitation (e.g. cardiac and neurosurgery and also patients who have become ill whilst staying outside the area)
 - Consultant referral following an outpatient clinic or domiciliary visit
 - GP's will not have direct access but will refer urgent cases to the Emergency Assessment Unit.
 - In some cases it may be appropriate for the Hospital Non Acute team to provide a service to a patient who has remained in situ on an acute ward rather than transferring to a bed in the hospital non-acute facility. Such patients will include:
 - Elderly, confused patients for whom a further move may adversely affect their health and well being – in such cases the Hospital Non Acute Team will provide care to the patient and support to the ward staff, for example by taking over arrangements for transfer of the patient to intermediate care.
 - Patients requiring the simultaneous input of both acute and rehabilitation staff and for who continued stay on the acute ward is preferable to transfer.
 - Patients who are expected to be discharged in one to two days and for whom a further move is therefore neither efficient nor desirable – such patients may also fall into one of the other two categories above.

As well as being the receiving unit for many patients requiring continued but non-acute hospital care the Facility will also have major role in Ambulatory Rehabilitation and non-acute care. For example, patients returning to the hospital on a day basis following an acute episode will not go the Diagnostic and Treatment Centre (DTC), but will instead attend the main therapy department which will be situated within the Hospital Non Acute Facility.

The patient flow map shown in figure 3 outlines the key patient groups to be admitted to the hospital non-acute area, their source of admission and destination on discharge.

Patient Flows

Hospital Non Acute care

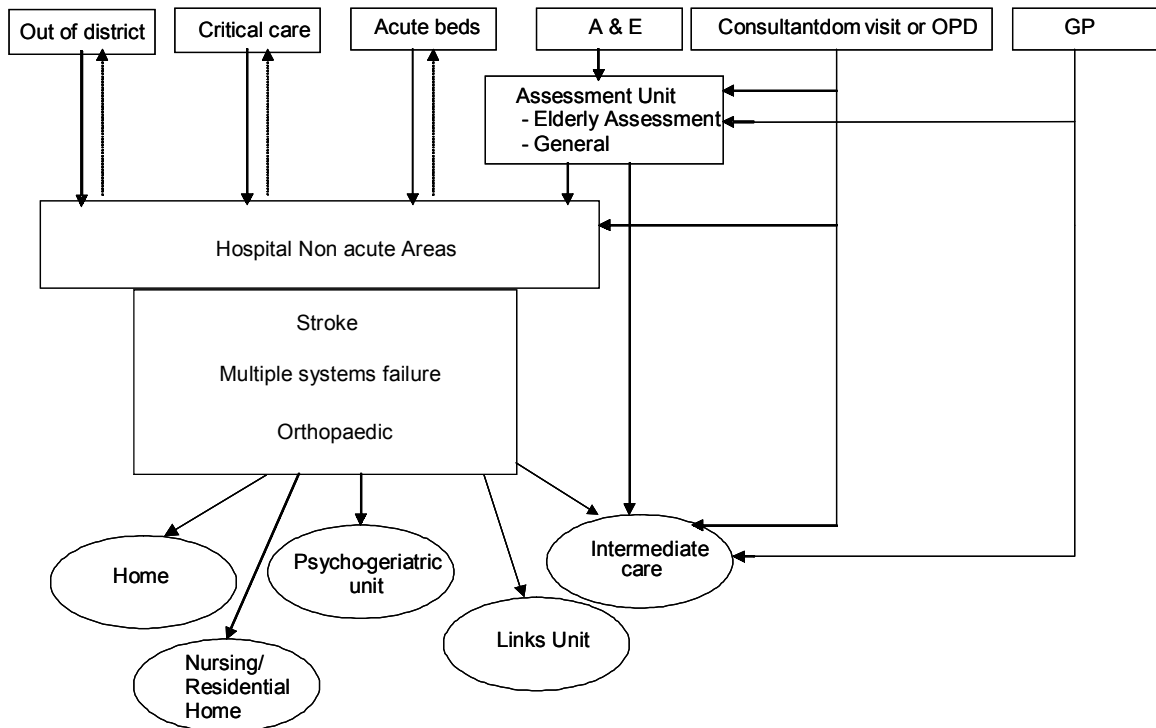


Fig 3: Hospital Non Acute Patient Flow

6. Women's and Children's

- The agreed admissions policy for Maternity will be:
 - Elective Admissions: Will be admitted to the delivery suite.
 - Emergency Admissions: Women in established labour will be admitted directly to the delivery suite.
 - All other women: Will be assessed by a midwife (and by medical staff if indicated) in an assessment room adjacent to the delivery unit. This will increase privacy during the admission process for questioning and examination and enable scanning and appropriate investigations to be performed in the room and avoid unnecessary admissions to the ward. Women will then be either admitted to the Delivery Suite or to an Antenatal bed if required, or discharged.
- The following are the main inpatient groups for gynaecology:
 - Elective Inpatients (over 2 night stay)
 - Elective Medical Terminations of Pregnancy (TOPs)
 - Emergency Admissions

- The majority of elective work in Gynaecology will be day or short stay (2 nights or less). Those elective cases requiring a longer bed stay would be co-located with emergency gynaecology beds. Currently approximately 6.4 patients per week require admission to hospital for medical Termination of Pregnancy (TOP). These numbers are projected to increase, balanced by a reduction in surgical TOP admissions. These patients will be admitted to gynaecology inpatient beds.
- The current sources of emergency referrals to the gynaecology unit include:
 - General Practitioners
 - The Accident and Emergency Department
 - The Antenatal Clinic
 - The Early Pregnancy Assessment Unit (EPAU)
 - Inter departmental transfers
 - The Day Surgical Unit
 - The family planning service
- Many of these patients will be assessed and treated in a gynaecology emergency area close to other gynaecology beds.
- The increasing focus of gynaecological care being around day care and short stay means that this specialty will be a major user of the DTC

7. Paediatrics

- Dedicated paediatric facilities will be provided for all specialties. The paediatric service will provide outpatient, medical day case and inpatient services from an integrated department including:
 - Inpatient accommodation
 - Outpatient accommodation
 - Assessment accommodation
 - Medical day case area
 - Neonatal unit
- Paediatric surgical day cases will be managed in a discrete paediatric area of the DTC in order to achieve close proximity to theatres.
- Elective inpatients will be admitted directly to the ward. The majority of emergency inpatients (GP referrals and “yellow cards”) will be admitted direct to the assessment areas sometimes following a period of assessment or stabilisation in A&E. Inpatients who leave the ward for surgery or other procedures will return to the ward as soon as practicable where they will continue their recovery.

- Children who are critically ill and who require ventilation, or other forms of intensive care, will be stabilised either in main ITU, or in high dependency beds on the ward, before being transferred to a unit with paediatric intensive care facilities.
- Appropriate provision will be made for adolescents in the unit. This is likely to mean both a higher proportion of single rooms and a separate adolescent recreation area.
- The agreed admissions policy for paediatric day cases is:
 - Medical day cases will be pre-assessed in, admitted to, treated in and recovered in the Day Case area of the paediatric zone.
 - Surgical day cases will be pre-assessed in, admitted to, treated in and recovered in the paediatric area of the DTC.
 - Some day cases will be admitted to the assessment/DTC initially and transferred to the inpatient area if unfit for discharge.
- It is intended that all children attending as outpatients where practicable will be seen in the consult/examination facilities within the integrated paediatric area. Instead of ward attenders there will be open access sessions in the outpatient area for appropriate patients to attend. Other patients would attend the assessment area.
- There will be a separate paediatric waiting area which will be located in the DTC.
- The assessment unit will receive emergency referrals from GP's, self referrals (patients holding yellow cards) and A&E. The diagram showing the model of care described above is attached at Appendix 2.6.
- The following diagram depicts the model of care for paediatrics described above.

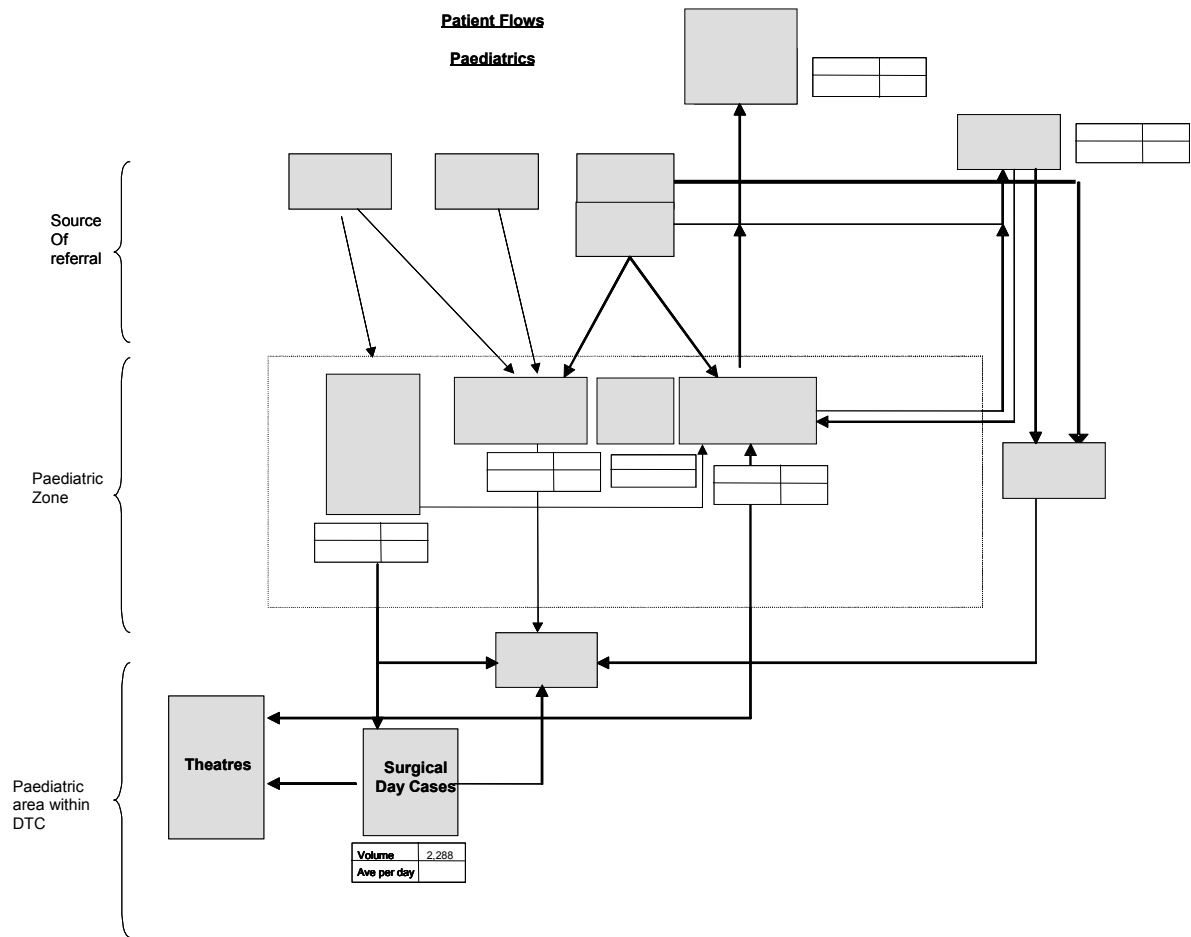


Fig 4: Paediatric Patient Flow