



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



An Roinn Sláinte
DEPARTMENT OF HEALTH

SECURING THE FUTURE OF SMALLER HOSPITALS:



A FRAMEWORK FOR DEVELOPMENT

Securing the Future of Smaller Hospitals: A Framework for Development

Introduction

The future organisation of our acute hospitals is a major policy issue for the Government. It is very important that all hospitals provide care in the right way, at the right location, and in a manner that ensures a safe, high quality service for all.

People have a right to know what to expect from their acute hospital services, including what services they will provide. There has been much public debate about the future of a number of hospitals, particularly the smaller ones, and some uncertainty about what will happen to them in the months and years ahead.

The Government is publishing this Framework now to offer clear information about the role of our smaller hospitals and what they will do in the future. *It is an initial blueprint, setting out the main service changes that we see happening over the coming years.* We will build upon the framework as our consultation process continues and as we make further more detailed decisions on individual changes.

- The future of smaller hospitals is safe

It is important to say that the Government is committed to securing and further developing the role of our smaller hospitals. No acute hospital will close. We believe that there is a strong role for smaller hospitals, in which they will provide more services, not fewer. The challenge is to make sure that they provide the right type of services, which can safely be delivered in these settings, so that we maximise the benefit to patients.

All hospitals, irrespective of size, as well as associated GP and community services, must work together in an integrated way. Co-operative working is key to success, and hospitals in each area will need to work all the more closely to meet the needs of patients. This must happen nationwide and within regions with:

- improved speedier communications (to be certain everyone clearly understands their own and each other's roles and how they interact);
- better emergency patient transport and improved access to diagnostic services including direct access for GPs to key diagnostic services
- improved staff flexibility (with more rotation between hospitals of key staff to allow staff to gain more experience and to provide more services locally in smaller hospitals).

- Programme for Government

Under the Programme for Government 2011-2016, we are committed to developing a universal, single-tier health service, which guarantees access to medical care based on need, not income. The Government will introduce a system of Universal Health Insurance which will end the present unfair two-tier service. A key part of the new system will be to develop independent not-for-profit hospital trusts in which all hospitals will function as part of an integrated group. Already, the Minister for Health has announced his intention to establish hospital groups as a first step towards hospital trusts. Each Group will have a management team headed by a Group Chief Executive, with responsibility for performance and outcomes, operating within clearly defined budgets and employment limits.

Another key element is the Special Delivery Unit set up by the Minister to address unacceptable waiting times for services in acute hospitals.

We do not believe that there can or should be a master blueprint for acute hospital services which is drawn up centrally and delivered locally. In addition to the critical need for consultation, any such approach would stifle local innovation. Clearly, the best solutions will vary between regions; there can be no question of a 'one size fits all' approach.

We believe that the best way forward will be for smaller hospitals to operate initially within Hospital Groups and ultimately within the proposed new system of independent hospital trusts. This will be a locally effective way of ensuring that hospitals deliver on the access requirements set by the Special Delivery Unit, within the budgets set by Government and the safety and quality requirements set by Health Information Quality Authority

- The Framework

There is much work to be done on organising our acute hospital services appropriately, to ensure that they are safe, of high quality and efficient. In this Framework we focus in particular on the role of nine smaller hospitals which have been the subject of particular attention from the HIQA:

- **Dublin North East:**
 - Our Lady's Hospital Navan
 - Louth County Hospital Dundalk
- **Dublin Mid Leinster:**
 - St. Colmcille's Loughlinstown
- **South:**
 - Mallow
 - Bantry
- **West:**
 - Ennis
 - Nenagh
 - St. John's Limerick
 - Roscommon County Hospital

Developing our Smaller Hospitals: Key issues

- Safety

Our first and over-riding concern is the safety of patients. Much of the recent debate about the future role of smaller hospitals has been prompted by the need to deliver safe services and to address potentially unsafe situations wherever they arise. As the independent statutory agency, HIQA has made important recommendations in this regard, and we are committed to implementing them. This is about providing safe services to patients, not about cutting services to save money.

We recognise that the safety debate is not confined to smaller hospitals. It is not just a question of dealing with smaller hospitals, nor do we assume that larger hospitals are by definition safer. We need to look carefully at acute hospitals of all sizes to ensure that they meet the requirements of good practice and patient safety. This will be helped by the ongoing work of HIQA including the National Standards for Safer, Better Health Care launched recently, and by the plans to introduce a licensing system for all acute hospitals under the independent direction of a new Patient Safety Authority.

In its reports on hospital safety, HIQA has pointed in particular to the type of patient who can safely be treated in different hospitals, depending on the staffing and facilities available and the volumes of patients seen. Because of their size, smaller hospitals can expect to treat only small numbers of patients with certain complex or acutely life-threatening conditions (e.g. cancer surgery, serious trauma, heart attack, stroke).

This means that clinical staff do not treat certain conditions frequently enough to ensure that they can maintain their skill levels. These small number of patients may also require specialised resources and facilities (e.g. advanced life-support machines, complex surgical facilities), which it may not be feasible to provide in many small hospitals. The result is that for certain conditions, small hospitals cannot ensure the best care. Therefore, patients need to be need to be directed to follow the care pathway appropriate to their needs.

However, we recognise that where it is necessary to transfer the more complex services from smaller to larger hospitals, the transition must be managed safely and carefully. It would be counter-productive, for example, to move services from a smaller hospital before the receiving hospital was in a position to take them. In some cases we need interim measures to mitigate the risk while services remain at a smaller hospital, while planning an orderly transfer of services to a larger hospital over a period of time. In other cases, it has already been necessary to change services immediately in response to concerns about patient safety.

- Quality

In addition to delivering safe services, we want to improve the quality of service. The key drivers of quality will be:

- the HSE clinical programmes which plan a structured approach to channelling patients to the right setting and type of treatment. They are designed to improve quality across all hospitals;
- the National Standards for Safer, Better Health Care;
- the HIQA Ennis Mallow recommendations on the provision of services in acute hospitals; and
- the Programme for Government policy on acute hospital services, including the move to Hospital Groups and then to independent hospital trusts, licensed by a Patient Safety Authority and the ultimate goal of a UHI health system.

The overarching aims of the clinical programmes are to ensure that all patients will experience safe, quality care at the appropriate time in the appropriate environments. This will require care from a senior medical doctor working within a dedicated multidisciplinary team, improved communication and privacy for the patient.

The HSE clinical programmes provide a clear delineation of hospital services based upon the safe provision of patient care within the constraints of available facilities, staff provision, resources and local factors. Under this framework we are placing the future growth in healthcare firmly in local (small) hospitals which will provide ambulatory care (including chronic disease management and day surgery), diagnostics and rehabilitation, with close links to primary health care, for their local population.

The Special Delivery Unit's initiatives to improve the performance of emergency departments, in-patient, day case and out-patient services and diagnostics will be aligned with the role of smaller hospitals as set out in this Framework.

- Access

It is clear from the work of the Special Delivery Unit that smaller hospitals can help deliver faster access for patients by increasing the volume of elective services they provide in selected specialties. This will be an important element in the drive to reduce waiting times for patients. In turn, larger hospitals will need to recognise and utilise these services offered by smaller hospitals, so that they can meet the access requirements for the more complex care that only they can provide.

- Developing the role of smaller hospitals

We can and will expand the services delivered in smaller hospitals, especially in services such as:

- day surgery (e.g. cataracts, hernia repairs, gynaecological procedures, and other surgeries that can safely be done in a day-based environment)
- ambulatory care (including chronic disease management and assessment for older persons)
- medical services (including cardiac failure clinics, cardiac rehabilitation, COPD outreach and clinics, rheumatology, dermatology, diabetic day centre, rehabilitation, and a range of others depending on local policies and protocols)
- diagnostics (including blood tests, X-rays, endoscopy, bronchoscopy and sigmoidoscopy).

This will vary across hospital sites.

In each case above, we are referring to the hospital-based aspects of care or diagnosis. We are conscious, of course, that a significant amount of services in this area can and should be provided in the primary care setting.

Much of this type of work is still carried out largely in the bigger hospitals, despite the other pressures facing them. It makes little sense to retain all of these services in bigger hospitals when they can safely be carried out in the smaller facilities. Transferring even some of this work frees the larger units to concentrate on the treatments that only they can provide. It also brings more services closer to local communities, since they will not have to travel to the larger hospital for them.

We also recognise that some services cannot safely be provided in smaller hospitals, and that they need to be moved in a planned way to the larger hospitals best placed to provide them. Again however, we will not assume that larger hospitals are automatically safer. They must be properly organised and all hospitals will ultimately be subject to licensing requirements for quality and safety.

- The links with Primary Care

It is vital to link the role of smaller hospitals closely with the provision of primary care. Smaller hospitals can provide accessible health care and ancillary services to meet the needs of defined local populations, particularly in remote areas. They should be seen as a logical extension of Primary Care, where they have huge potential to enable GPs and primary care teams to support patients within their own community. Rehabilitation is a major role of smaller hospitals, and they should offer a wide range of health promotion, diagnostic, emergency, acute and convalescent services, as well as providing premises for consultant out-patient clinics and out-of-hours treatment centres.

The influence and involvement of primary care and general practice in small hospitals will mean a welcome change of emphasis towards “small can work”. Flexibility should be a key feature of service planning delivery.

Being small in size should be viewed as providing immense capacity for flexibility and change, with each hospital evolving in a unique way to meet local needs and closely linked to primary care teams and health and social care networks. This will enable a fusing of traditional boundaries between primary and secondary care, and the establishment of an integrated policy for health and social needs.

- European Working Time Directive

One of the key factors influencing the type of services that can safely be provided in individual hospitals is the availability of medical staff. Some services can only be provided when appropriately trained and experienced medical staff are present. This has important implications for the services that smaller hospitals can provide, especially at night time and weekends.

The European Working Time Directive (EWTD) sets down strict limits on the average working hours permitted for NCHDs. This limits the scope for more extensive rosters, especially in smaller hospitals. Ireland has recently been formally requested by the European Commission to detail how it will implement the Directive in relation to NCHDs. While some progress has been made in recent years, there is more to be done to achieve full compliance. For this reason, the EWTD will be one of the most significant drivers of change in our acute hospital services as a whole.

- Costs and Logistics

It is clear that we are operating within very difficult financial circumstances. The changes emanating from this Framework will have to be implemented during a time of reduced budgets for health care overall, and in particular a reduction for acute hospitals as we continue the shift in emphasis to community-based services including primary care.

The costs of transferring services must be identified in advance, and a decision taken on how to address these. We will prioritise changes that can be achieved without extra cost. This may occur, for example, where staff (or staff sessions) are transferring with a specified volume of service, and the receiving hospital has the capacity to deal with this by a transfer of the corresponding budget. Our priority will be to increase the number of patients treated in smaller hospitals, but this may be done in a number of ways, including with reduced budgets, for example, by reducing staff cover at less busy times for elective work such as at nights and weekends.

Where extra costs cannot be avoided, these will be quantified, and an approach to dealing with them identified, e.g. through savings elsewhere. In any event, we will adhere to a clear set of principles underlying resource issues:

- the transfer of services will entail a transfer of the corresponding budget
- there will be agreement on where to apply any savings achieved from the reorganisation of services between smaller and larger hospitals
- we will pursue the use of alternative community-based services to help reduce resource requirements overall.

In order to ensure public confidence in the proposed changes it will be important that a number of essential arrangements are in place in advance of any changes to the services. It will also be important that relevant ambulance bypass protocols are developed and implemented, that the capacity of the larger hospitals to take on the additional work has been verified, and that issues regarding emergency patient transport have been addressed.

- The Challenge of Change

Changes to the way hospitals provide services are always difficult and must be implemented carefully to ensure that the result is both safe for patients and efficient for the taxpayer. We will ensure that all changes

- are delivered to secure patient safety, including implementation of the recommendations of HIQA;
- meet the needs of patients in the best way in the right location;
- are provided in a way that enables hospitals to deliver services within budget;
- are implemented using the practices and protocols of the clinical programmes so as to facilitate service transfers in both directions (big to small and vice versa) and
- are implemented with the full involvement of local communities.

This will need well co-ordinated clinical and management action.

- Consultation

The HSE is now engaging in a consultation process to help inform the details of the service changes. The consultation process will seek to:

- get feedback from all stakeholders, starting with the professionals in each hospital who deliver the service.
- listen to, and address as much as possible, the concerns of stakeholders.

There will be a structured process of feedback, so that key messages are captured as an input to the change process.

Conclusion

This Framework is the first of its kind to describe a genuinely positive role for smaller hospitals in the future. We have set out as much information as possible based on the plans to date, and we will develop these further in the months ahead. We do not have all of the answers at this stage, nor would we expect to have. Nonetheless, we will continue to consult with local communities, health professionals and other stakeholders on the details as the change process develops.

Above all, we will seek to explain what is happening, when and why.

In Part Two we describe the type of services that can and should be provided in our smaller hospitals. This is based closely on the work of the HSE's Clinical Programmes. The exact services to be provided in each smaller hospital will vary according to local circumstances, but the approach set out in Part Two provides the major principles and criteria on which the development of acute services should be based. The consultation process will help us finalise the exact range and type of services that will be provided in each case.

Part Two

Services in Smaller Hospitals (Model 2 Hospitals)

1. Introduction

Smaller hospitals are very well regarded by the local population and general practitioners. More recently, there have been very significant developments in healthcare delivery particularly in the context of shifts to day surgery and ambulatory care and the centralisation of low volume high complexity care into larger centres. In this context, it is necessary that we redefine the role of the smaller hospitals so that they continue to play a central part of the Irish Healthcare system.

This Framework for Smaller Hospitals defines the role of the smaller hospitals. It outlines the need for smaller hospitals and larger hospitals to operate as a single Hospital Group. It defines the need for the smaller hospital to be supported within the Hospital Group in terms of education and training, continuous professional development, the sustainable recruitment of high quality clinical staff and the safe management of deteriorating and complex patients. The Framework also outlines in detail the wide range of services that can be provided within the smaller hospital and that can be transferred from the larger to smaller hospitals within the Hospital Group.

The successful implementation of the Framework for Smaller Hospitals, within the context of Hospital Groups, provides the opportunity to deliver safe and effective care at the lowest level of complexity and closest to the patient's home. It also provides the opportunity for smaller hospitals to have a sustainable and central role into the future.

We now identify the activities that can be performed in smaller hospitals in a safe and sustainable manner so that a high volume of care can be provided locally. It will be necessary to transfer a significant amount of this type of activity from larger to smaller hospitals to ensure patients receive their treatment locally and to create capacity in the larger hospitals to accept the smaller volume higher complexity care. It is recognised that appropriate streaming of patients into smaller and larger hospitals is already in existence and these practices should continue where they are operating safely and effectively.

2. The organisation of hospital services

2.1 The models of hospitals

The acute medicine programme defined hospitals as model 1-4 based on the type of activity that can be provided.

Model 1 hospitals are community hospitals where patients are currently under the care of resident medical officers. These hospitals do not have surgery, emergency care, acute medicine (other than a select group of low risk patients) or critical care.

Model 2 hospitals are discussed in detail below. These hospitals can provide the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, a large range of diagnostic services (including endoscopy, laboratory medicine, point-of-care testing, and radiology (CT, US and plain film X Ray)) specialist rehabilitation medicine and palliative care.

Model 3 hospitals will provide 24/7 acute surgery, acute medicine, and critical care.

Model 4 hospitals will be similar to model 3 hospital but will provide tertiary care and, in certain locations, supra-regional care.

2.2 Overall governance

- All hospitals (ranging from model 2 to model 4 hospitals) must operate within single Hospital Groups.
- Smaller hospitals provide a unique and essential opportunity for the undergraduate and post graduate training of all our healthcare professionals. To ensure these benefits are realised, education and training should be organised on a network basis across the Hospital Group. In addition staff working within smaller hospitals need to be full participants in network-based continuous professional development programmes.
- Smaller hospitals need to be full participants in a comprehensive clinical governance infrastructure for the Hospital Group.
- Doctors (including consultants and junior doctors) should be appointed to single departments which operate across the Hospital Group. Junior doctors should rotate across the Hospital Group as part of their training.
- A single executive structure and function should be implemented across the Hospital Group to ensure that the hospitals operate as effectively and efficiently as possible. There should be GP representation in the governance structures.

3. The Model 2 Hospital

3.1 Characteristics:

The future growth in healthcare will be in the services such as ambulatory care (including chronic disease management and day surgery), diagnostics and rehabilitation which will be based in model 2 hospitals. As a result of these emerging models of healthcare delivery and the ageing population, the total volume of activity of the model 2 hospitals will grow substantially. Model 2 hospitals will be part of a network of hospitals operating as single departments such that:

1. linked specialist services to these units will be under the governance of a single directorate embracing the model 2 Hospital with linked model 3 or model 4 hospital(s);
2. this single governance will be reflected in the appointment of Clinical Directors across the Hospital group and make provision for staff to move between sites, as appropriate; and for care to be provided on two sites there must be access to the full records on each site, including letters, clinical notes, operating notes, laboratory and other data.

3.2 Overview of services at a Model 2 Hospital

- The hospital will have a daytime Urgent Care Centre comprising a Medical Assessment Unit and Local Injuries Unit which will be open where feasible 7 days a week.
- Subject to local consultation consideration should be given to supporting the provision of on site GP out of hours services as already exists in a number of locations.

- Pre hospital care needs to be developed with appropriate linkages to primary care, especially GP out of hours services in rural areas. GPs will refer selected medical patients (i.e. unlikely to require high intensity cardiopulmonary and/or neurological support) for assessment in the MAU during daytime hours.
- Patients will self refer to the daytime Local Injury Unit or co-located GP OOH services
- The hospital will see and admit medical patients on a 24 hour basis. It will provide in-patient and out-patient care for low risk differentiated medical patients who are not likely to require full resuscitation. All patients will have an appropriate care plan.
- The hospital will provide day surgery and will have the capacity to admit some of these patients overnight based on pre agreed criteria (as discussed below in relation to surgery).
- The hospital will be able to provide the vast majority of outpatient services.
- Patient flow will be enhanced by expanded nursing and therapy practice (e.g. nurse prescribing of medicinal products and ionising radiation/X-rays and therapy facilitated discharge). These services will be developed in response to service need.
- All model 2 hospitals must have an in-house clinical pharmacy service or formal access to, and reporting relationship with, the service in a model 3 or model 4 hospital.
- The Hospital Group must have a person trained and responsible for infection prevention and control on site and formal access to advice from a consultant microbiologist/infectious disease physician.

3.3 Medical and Critical Care Services for a Model 2 Hospital

- This hospital will not have an ICU, so the patient will be assessed and tracked using the national early warning score and where appropriate, this score will prompt an acute medicine response and if necessary, transfer to the associated model 3 or model 4 hospital.
- The following applies to anaesthesia/ critical care requirements of Model 2 Hospitals
 - An adequate retrieval service needs to be in place to allow model 2 hospitals accept low risk medical inpatients due to the potential that these patients may deteriorate and require urgent critical care and transfer into the associated model 3 or 4 hospitals
 - Medical staff who are providing inpatient and walk-in treatment within the model 2 hospital need to be Advanced Cardiac Life Support certified and have completed the BASIC (Basic Assessment and Skills in Intensive Care) course or equivalent.
 - Medical staff who are training in acute medicine support should ideally rotate through critical care rotations and such rotations should be developed and implemented
 - The implementation of the new roles for model 2 hospitals will require a plan for managing anaesthetic/critical care requirements of patients in each location. The redeployment of anaesthetic staff to cover the enhanced critical care activity in the model 3 and 4 locations should not occur until on site medical staff in the Model 2 hospitals are Advanced Cardiac Life Support certified and have completed the Basic Assessment and Skills in Intensive Care or equivalent, and that the retrieval service to the associated model 3 or 4 hospital is in place.
- A patient's condition may deteriorate and after treatment, patients with acuity of ICS Level 2 unstable or Level 3 (ref appendix 17.9 of Acute Medicine Programme document) will require critical care retrieval and transfer to ICU in a model 3 or model 4 hospital.

- There will be guaranteed acceptance of transfer of all patients who deteriorate by the associated model 3 or model 4 hospital (bi-directional patient flow must also occur as required).
- Patients requiring palliative care, respite, rehabilitation and pre-discharge care and low risk differentiated patients with direct GP to consultant referral (via MAU) can be admitted to this hospital.
- Patients will be admitted from the MAU under the care of a named consultant, and out-of-hours selected medical patients can be admitted by agreement between the G.P. and the on-call medical team/consultant.
- The medical department and medical staff need to be part of a wider rotation under the governance of the acute medicine service in the linked model 3 or model 4 hospital. During the day there will be appropriate NCHD presence in the MAU and wards.
- The medical staffing at night will be a resident medical registrar/SpR +/- a senior house officer (both of whom are advanced cardiac life support [ACLS] certified with formal assessed training in airway management). In addition there will be a consultant on-call.
- Nurse staffing at night will include a nurse manager/supervisor for the nursing services.
- Therapy staffing will be senior grade to staffing complement managed across hospital group to ensure appropriate expertise and supervision on model 2 sites. Clinical specialists in model 3 and model 4 hospitals will provide advice and/or support as required.
- Standards of care should be measured and should be comparable to those delivered in model 3 and model 4 hospitals.
- The following day services are appropriate based on local need and capacity:
 - Day services/ambulatory care assessment for older persons
 - Antenatal care/postnatal care
 - Gynaecology Clinics
 - Full range of Endoscopy (Bronchoscopy, Cystoscopy, Colonoscopy, OGD, Sigmoidoscopy),
 - PEG tube insertion
 - Non-invasive cardiology
 - Cardiac failure clinic
 - Cardiac rehabilitation service
 - Venesection, infusion and transfusion therapy
 - Bone marrow aspiration and trephine biopsy
 - Abdominal paracentesis and thoracentesis
 - Lumbar puncture
 - Diabetic day centre including foot care and eye care
 - Rheumatology day services/Clinics
 - Dermatology day services/Clinics
 - Oncology/haematology day ward/Clinics
 - Mental health day services/Clinics
 - COPD outreach/Clinics
 - Pulmonary rehabilitation/Clinics
 - Hepatology day services/Clinics
 - Diagnostic imaging
 - Rehabilitation day services/Clinics
 - General Rehabilitation medicine
 - Prosthetic and Orthotic clinic
 - Other services, depending on local policies and protocols.

- The following additional services apply to Model 2 hospitals

Specific issues relating to Model 2 hospital services

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|--------------------|---|
| Acute cardiology | Patients should be managed according to referral guidelines and clinical protocols. An out-patient clinic session should be provided by a visiting cardiologist one day per week to review the results of non-invasive tests. Patients with acute presentations should be transferred to a model 3 or model 4 hospital according to protocol. |
| Ambulance services | Ambulance services will develop protocols for ambulance transfer to and between hospitals in consultation with GP's and Hospital staff. |
| COPD | In-patients will have care up to, and including, non-invasive ventilation (NIV) where appropriate based on careful patient selection. |
| Diagnostic imaging | Plain film X-ray, ultrasound and CT-scanning including CT or US guided procedures. The diagnostic imaging service should provide at a minimum timely and direct access to GPs for plain film X-ray and ultrasound. There will be an on-call diagnostic imaging service with access to 24-hour reporting for specific modalities from the model 4 hospital. The on-call diagnostic imaging service on site will support GP OOH services. |
| Heart failure | A heart failure service will be established under the governance of a lead consultant physician. Selected heart failure patients with a clearly defined care plan who develop decompensated heart failure may be admitted. There will be a rapid access clinic for out-patient IV therapy to stabilise patients with deteriorating heart failure. A full out-patient service for diagnosis and specialist review will be provided. |
| Palliative care | Patients with palliative care needs may be managed in model 2 hospitals with appropriate support from the specialist palliative care services as required. Services provided in model 2 hospitals should be sufficiently flexible and integrated with specialist palliative care services to allow rapid and efficient movement of patients from one care setting to another depending on their clinical needs and personal preferences. Admission criteria, discharge protocols and interface with specialist palliative care services will be according to agreed national palliative care programme protocols. Specialist Palliative Care services may be developed locally and linked to Model 2 hospitals. |
| Rehabilitation | The Model 2 hospitals can function as a regional centre for specialist rehabilitation. Patients will be treated by a local specialist rehabilitation team which may be led by consultants in specialties other than Rehabilitative Medicine (e.g. neurology / stroke medicine) and staffed by therapy and nursing teams with specialist expertise in the target condition with support from specialist rehabilitation medicine services... Patient goals are typically focused on restoration of function / independence and co-ordinated discharge planning with a view to continuing rehabilitation in the community. |

3.4 Emergency Medicine Services

A Local Injury Unit (LIU) will be located in a model 2 Hospital and will aim to provide unscheduled emergency care for patients with non-life threatening or limb-threatening injuries, as conveniently as possible, while ensuring patient safety and equitable standards of care within an Emergency Care Network. LIUs will be open to new patients where feasible 0800 – 20:00 hrs (or 18:00hrs) followed by two-hours of ongoing clinical work for the completion of patient care. Appendix 1 lists the conditions which will be seen in a Local Injury Unit and sets out the benefits of this.

General issues relating to Local Injury Units

- A Local Injury Unit will be located in a model 2 hospital and will be part of an emergency care network and linked to a lead Emergency Department within each network.
 - The Local Injury Units will operate under the clinical governance of the Network Coordinator for Emergency Medicine.
 - There will be no Clinical Decision Unit on site.
 - Administrative functions will be centralised within the network and only direct patient contact administrative function (i.e. reception) will be based at the Local Injury Unit.
 - Telemedicine may contribute to clinical care in the Local Injury Unit
 - The unit will be open to new patients for limited hours' access, followed by two-hours of ongoing clinical work for the completion of patient care .
 - Patients may self-present or be referred by GPs with non-life-threatening or non-limb-threatening injuries.
 - Patients whose care needs cannot be met at these units will be transferred directly to networked Emergency Department.
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- Paediatric patients (i.e. aged under 16 years) may attend, according to network protocols. The Network Co-ordinator in EM and the PEM Lead Clinician will develop protocols and procedures to ensure the safe management of children who access care at Local Injury Unit. All clinical staff in units accepting children will be trained in paediatric life support and in the recognition of non-accidental injury. These units will be integrated into regional and national PEM networks.

Interdependencies for Local Injury Units

| Specialty | Interdependency |
|--------------------|--|
| Acute Medicine | There will be an MAU on site |
| Critical Care | There will be no critical care facility on site. |
| Acute Surgery | Surgical consultation may be required from time to time and straight forward surgical therapy, if appropriate, may be carried out locally. (e.g. drainage of a peri-anal abscess) |
| Diagnostic Imaging | On-site immediate access to plain X-ray, ultrasound and CT where feasible 08:00 to 20:00hrs (or plain X-ray until 22:00hrs depending on hours of opening), seven days a week. Reporting of images through network. |
| Primary Care | Potential role for GPs, who wish to do so, to work in Local Injury Units. In addition there are potential benefits for LIU to develop in partnership with the local General Practice community. |

- A protocol needs to be put in place which will allow for the provision of basic medical/nursing assessment and appropriate treatment of a patient who attends the hospital out of hours. This protocol needs to be developed in conjunction with GP out of hours service.

Workforce issues for Local Injury Units

- Local Injury Units will be under the governance of Consultants in EM from the lead ED in the Hospital Group. There will be at minimum two half-day sessions of Consultant presence in any week, provided by one or more Consultants.

Network Consultant staffing arrangements will include this commitment to Local Injury Units.

- NCHDs, primarily middle-grade doctors, will contribute to patient care and a middle grade doctor will be present on site at all times. Medical staff may rotate to EDs in the Group, according to local arrangements.
- The recruitment and clinical supervision medical staff working in Local Injury Units will come under the governance of the Coordinator for Emergency Medicine in the Hospital Group.
- Teams of Advanced Nurse Practitioners (ANP) will provide most of the clinical care in these units and will work within the network clinical governance structures. Highly skilled, experienced ANPs will be needed to work in these units as there will not be a Consultant in Emergency Medicine on-site.
- Nursing staff will provide a supporting role for ANP and medical staff.
- Dedicated administrative staffing for patient reception and registration will be required for the duration of hours of opening of the unit, seven days a week.
- There are potential benefits to Local Injury Units being developed in partnership with the local General Practice community. In addition, there is an opportunity for GPs who wish to do so to work in Local Injury Units. The governance, training and work practice details will be developed in consultation with the relevant stakeholders.
- Staff will rotate through networked units for education and CPD. CPD and education will be provided within the Emergency Care Network and through e-learning and other linked supports. All staff will rotate from the Local Injury Unit to the network centre for mandatory training, education and CPD.

Patients whose care needs cannot be met at a Local Injury Unit

- A protocol needs to be implemented to direct the initial assessment and transfer of patients whose care needs cannot be met at the Local Injury Unit.
- A protocol also needs to be put in place which will allow for the provision of basic medical/nursing assessment and appropriate treatment of a patient who attends the hospital out-of-hours. This protocol should be developed in conjunction with GP out-of-hours services.

3.5 Surgery¹

From a surgical perspective Model 2 Hospitals can be further divided into:

- Those that only perform Day Surgery – **Model 2D**
- Those that perform Stay Surgery (as well as Day Surgery) – **Model 2S**
- Those that are more than 60 kilometers (Remote/Rural) from the nearest Level 3 or 4 hospital – **Model 2R**

Surgical services in Model 2D and Model 2R hospitals

Surgical services and activity planned in Model 2 hospitals should take account of and complement the nature of Medical services which exist in their unit. Good management of surgical services demand that:

- The Department of Surgery should be managed under the governance of a single unit including the Model 2 hospital and the linked Model 3 or 4 hospital(s).
- This governance structure should be overseen by a single Clinical Director, with surgical (Consultants, NCHDS, Nursing) and other staff moving between sites, as appropriate. It is important for the department to be able to

¹ Reference from *Elective Surgery: Model of Care* September 2011

communicate and work as a single unit. In addition, clinical staff must have sufficient working time in the larger unit so that they don't deskill in the management of more complex cases.

- For patient care to be provided on more than one site, a robust mechanism needs to be planned and delivered such that full patient records, including letters, clinical notes, operating notes, laboratory and other data are available in a timely manner, in order to deliver a safe service⁹
- Out-patient, pre- and post-operative care and Pre-admission Assessment should be provided at either site for all patients requiring surgery.
- All surgery should be supported by a Pre-operative Assessment Clinic.
- Factors to consider in patient selection are shown in **APPENDIX 2** – taken from the Elective Surgery, Model of Care. As a general rule, patients for Day procedures should be expected to make a rapid recovery allowing for speedy discharge home.
- Surgical procedures that are carried out must only be those appropriate for Day Surgery. (See **APPENDIX 3**)
- There should be capacity as well as policies and protocols to provide for overnight admission of an agreed percentage of patients (no greater than 20% - this percentage should improve over time as delivery improves).
- There will be no Critical Care back-up or support on site. There will be no out-of-hours anaesthesia service. Patient assessment and tracking will be through the National Early Warning Scoring System (NEWS) prompting a defined response and if necessary, transfer to the associated model 3 or 4 hospital. Agreed transfer protocols and service will have to be in place to support these stand alone day surgery units. It is not appropriate that the service is hoping to rely on existing personnel and emergency ambulance service to support their elective work. The use of existing personnel would mean that the elective list would grind to a halt. The use of emergency ambulance services would introduce unacceptable, unquantifiable delays into the service.
- Out of hours surgical staffing should include an appropriately qualified senior nurse (COMPASS certified in NEWS) with cover by medical registrar/SpR and SHO if required. Given that there will not be any surgery out of hours, any patients who develop serious complications will be transferred, and that those that remain will have minor issues only. It is not therefore necessary to sustain on site (overnight) surgical trainees except, perhaps, in Model 2R hospitals when they might also cover a minor injuries unit.
- Similarly, a Consultant Surgeon and Anaesthetist on call (and free to attend) would be not be appropriate. Access to a (telephone) opinion from a senior on-call Surgeon or Anaesthetist as needed (Consultant or SpR) at the linked Model 3 or 4 Hospital and the facility for early ambulance transfer and mandatory acceptance when required should be the recommended approach.
- There should be access to Endoscopy and other specialist services as deemed appropriate.
- Care will be provided for surgical patients requiring palliative, respite, rehabilitation and pre-discharge care.
- The hospital Minor Injuries Unit will require surgical consultation from time to time. Patients requiring acute surgery should be transferred to the local Model 3 or 4 hospitals. Protocols for management of minor urgent procedures (for example, those requiring relatively minor procedures under GA such as

suturing or abscess drainage) should be developed and defined at a local level. It would be hoped that there would be scope to deal with these minor emergencies on site, rather than transfer to local Model 3 or 4 unit. Consideration might be given to the reservation of an emergency theatre slot on one list on a daily basis.

Specifics Issues Regarding Day Surgery in Model 2D and 2R Hospitals

Surgical complexity

The complexity of surgery that can be carried out in Model 2D and 2R hospitals is limited by the lack of an Critical Care services, particularly anaesthesia, imaging and diagnostic services. In addition, there is an expectation that all patients should anticipate a rapid recover and speedy discharge home with easily managed post-operative pain.

Procedures and patient selection

Suitable Patients for Day Surgery are described in **APPENDIX 2**. Procedures appropriate for Day Surgery are outlined in **APPENDIX 3**.

Overnight stay requirements

The definition of a day case patient by the HSE on HealthStat is one “who is admitted to hospital on an elective basis for care and/or treatment which does not require the use of a hospital bed overnight and who is discharged as scheduled”. It is important to emphasis the distinction between the unanticipated admission of day surgery patients (due to relatively minor and predictable "complications" such as nausea, pain management etc.) and 23-hour surgery patients who require a planned overnight stay either because the surgery is of greater complexity or the patients level of fitness demands it. Providing care for patients who will, by definition, require an overnight stay falls outside the scope of Model 2D and 2R hospitals.

The deteriorating patient

Complications during the early post-operative period after Day Surgery are most commonly related to pain, post-operative nausea and vomiting (PONV), urinary retention or bleeding. Pain and PONV should be managed according to protocol. Urinary retention requires catheterization. Bleeding may be internal or external and should be managed by first aid measures and recourse to the surgical team. Patients who have procedures with a potential to bleed significantly should not be carried out in Small Hospitals but there should be facilities for blood to be grouped and held in the nearest blood bank. If blood is not stored on site, consideration has to be taken of how long it will take to get to your unit in case of emergency. Consideration needs to be given locally as to the desirability of always having a supply of Group O Negative on site.

Deterioration may also arise as a result of medical problems. During out of hours, surgical patients should be managed an appropriately qualified senior nurse, as stated in 10 above. It is accepted as part of the Model 2 protocol, that there should always be trained ACLS providers on-site. In addition, a locally developed NEWS, Emergency Response System, as appropriate to the hospital model should be in place with advice from senior on-call clinical decision makers from and transfer to the linked Model 3 or 4 Hospital.

The Escalation Protocol will include a point at which a decision may be made to transfer/retrieve the patient to a Model 3 or 4 Hospital. This should be protocol driven with transfer facilitated by the regional Critical Care retrieval service.

It is clearly not possible to guarantee that such transfers would be delivered by the same personnel involved in delivery of the day surgery theatre list.

Complications occurring after discharge

Support must be provided to patients who are discharged from a Model 2D or 2R hospital Day Surgery Unit for the first 24-hours after surgery. This is in addition to support available to patients from their Primary Care services. This should include the issuing of contact telephone numbers to patients at the time of discharge, including out-of-hours. Patients needing urgent assessment or readmission should be provided with a fast track care plan to the hospital and, if necessary, arrangements made for re-admission, assessment or transfer to a Model 3 or 4 Hospital.

Non-consultant doctor surgical staffing and training

Model 2 hospitals will provide useful experience for training purposes (exposure to day cases, pre- and postoperative clinics, diagnostics etc) as well as requiring other service needs such as NEWS. Providing out of hours cover to such low acuity sites with minimal supervision, however, offers poor training value.

Surgical Services in a Model 2S Hospital

The Model 2S Hospital is proposed for use in certain circumstances. These would be Model 2 Hospitals which work geographically close to and administratively part of a group or network with a Model 3 or 4 hospitals. The purpose of a Model 2S hospital would be to provide additional designated capacity for elective surgery for the parent Level 3 or 4 Hospital. A Model 2S hospital would have all the features of a regular Model 2 hospital undertaking the agreed basket of day case procedures. In addition, it would seek to expand its workload to include more complex elective surgical procedures in otherwise relatively fit patients. This would be subject to local agreement between management and clinicians (anaesthesia, surgery & nursing) as to what could be safely delivered within the context of local staffing, capacity and peri-operative care.

A Model 2S hospital, from a surgical perspective, is an elective hospital which, as with all Model 2 hospitals, receives no unscheduled, undifferentiated medical or surgical patients. From a medical perspective the service that is delivered should be identical to that described above for a standard Model 2 hospital except for the presence of a **Surgical Observation Unit** which would be exclusively required for surgical patients.

The concept behind a Model 2 hospital is to provide an elective surgical unit with designated or protected beds - beds that may be otherwise difficult to rely on in the neighbouring Model 3 or 4 hospitals. The surgery and anaesthesia programmes support the good practice principle that elective surgical services should be separated from emergency admissions whenever possible. In addition, a physical separation of services may help in dealing with differences in clinical management that arise between elective and emergency care, as well as facilitating the fixed designation of beds. Finally, MRSA-protected elective wards avoid admissions from the emergency department and transfers from within/outside the hospital

As well as separating elective from emergency care, elective surgical procedures can be divided into minor, intermediate and complex. Most minor and intermediate

surgery should be performed as day procedures. This activity can and should be performed in a Model 2S hospital, in the same manner as planned for Models 2 and 2R hospitals.

Model 2S hospital will have the potential to locally decide on the feasibility and capability of their unit to carry out intermediate and complex surgery, which could not be carried out on a day case basis and would require in-patient stay and accommodation. These patients would still be worked up as for day care, with a planned admission on the day of surgery. (DOSAs admissions)

Surgical Services in a Model 2S Hospital:

- The Department of Surgery should be managed under the governance of a single unit including the Model 2 hospital and the linked Model 3 or 4 hospital.(s)
- This governance structure should be overseen by a single Clinical Director, with surgical (Consultants, NCHDS, Nursing) and other staff moving between sites, as appropriate. It is important for the department to be able to communicate and work as a single unit. In addition, clinical staff must have sufficient working time in the larger unit so that they don't deskill in the management of more complex cases.
- For patient care to be provided on more than one site, a robust mechanism needs to be planned and delivered such that full patient records, including letters, clinical notes, operating notes, laboratory and other data are available in a timely manner, in order to deliver a safe service⁹
- Out-patient, pre- and post-operative care and Pre-admission Assessment should be provided at either site for all patients requiring surgery.
- All surgery should be supported by a Pre-operative Assessment Clinic.
- Patient selection issues for day care management are shown in **APPENDIX 2**.
- Those for same day admission are listed in **APPENDIX 4**.
- Surgical procedures suitable for day cases management are listed in **APPENDIX 3**. Less than '5-day care' surgical procedures could include intermediate or complex operations carried out by a variety of surgical specialties including General, Gynaecology, Maxillofacial, Otolaryngology Ophthalmic, Plastics, Vascular and Urology. They should be appropriate to less than 5-day stay surgery in a Model 2S hospital, not anticipating admission to HDU or ICU post-operatively.
- Local implementation teams should, following multi-disciplinary collaboration, develop the capacity, policies and protocols to manage post-operative overnight admission on a planned basis, taking into account their specific situation and service configuration. All plans should deliver best practice in relation to patient safety and clinical risk management.
- No patient should have a planned, anticipated need for HDU or ICU care post-operatively.
- Patients requiring specific fluid management or analgesic requirements (PCA, Patient controlled Anaesthesia or, if decided upon and justified locally, a nurse provided epidural service) should be managed in a Surgical Observation Unit (SOU - 3-4 bedded).
- The NEWS "Emergency Response System" will facilitate post-operative patient assessment and tracking. There should be a defined response to a critical event (surgical complication/ deterioration in respiratory function, GSC etc) with early transfer and mandatory acceptance to Critical Care in the

associated model 3 or 4 hospital. This should be protocol driven with transfer facilitated by the regional Critical Care retrieval service

- Out of hours staffing should include an appropriately qualified senior nurse (COMPASS certified in NEWS) and an experienced, resident NCHD (SHO at >BST 2 or Registrar), surgical or medical or equivalent doctor - provided he/she is working with appropriately trained nurse in post operative care. In the case of non-surgical cover there should be clear protocols for communication and escalation.
- A senior on-call Surgical or Anaesthetic opinion should be available as needed (Consultant or SpR in last their 2 years of training). This should be provided by the on-call team at the neighbouring Model 3 or 4 hospital and this needs to be protocol driven and managed locally assuring a rapid, safe and appropriate response. Patients who have a surgical complication out-of-hours that cannot be managed on the ward of the Model 2S hospital should be transferred without delay to the neighbouring Model 3 or 4 Hospital where there should be access to specialist services.
- All patients should have a discharge plan developed from the outset of their surgical journey.
- Care will be provided for surgical patients requiring palliative, respite, rehabilitation and pre-discharge care. The Hospital Minor Injuries Unit will require surgical consultation from time to time. Patients requiring acute surgery should be transferred to the local Model 3 or 4 hospitals. Protocols for management of minor urgent procedures (for example, those requiring relatively minor procedures under GA such as suturing or abscess drainage) should be developed and defined at a local level. It would be hoped that there would be scope to deal with these minor emergencies on site, rather than transfer to local Model 3 or 4 unit. Consideration might be given to the reservation of an emergency theatre slot on one list on a daily basis.

4. Developing Smaller Hospitals: Some Practical Examples of Service Enhancements

Work is in progress on developing a detailed plan for service enhancements in each of the nine smaller hospitals that are covered by this Framework. These plans are based on detailed local analysis of the services in place and what can be provided in the future. The projected activity levels will be outlined in detail in each plan.

Mallow General Hospital

As an example, the following outlines the projected activity changes associated with the implementation of this Framework in one exemplar site – that of Mallow General Hospital (MGH).

- Emergency Department Attendances

An audit was conducted on the patients currently attending the Emergency Department (ED) at MGH (11,400 patients per year in 2010). When the proposed changes are implemented it is projected that in excess of 80% of the patients presenting to the ED will continue to be seen either in the Local Injury Unit or in the Medical Assessment Unit.

- Outpatient Attendances

It is planned to transfer outpatient clinics from the larger hospitals in Cork city to MGH. It is projected that there will be a minimum increase in outpatient attendances of 10% (1000 patients) per year at MGH.

- Surgery and endoscopy.

It is projected that emergency surgery (1000 patients per year) and complex surgery (300 patients per year) will transfer to the larger hospitals from MGH. Day case surgery (900) and endoscopies (1000 patients per year) will transfer from the Cork City Hospitals to MGH.

- Acute Medicine

A new medical assessment unit will open with projected activity of 1400 patients per year. In addition, low risk differentiated medical patients will continue to be admitted to MGH. On the basis of local analysis, 80% of patients will continue to be admitted (approximately 2000 patients per year).

- Radiology services

The projected activity for radiology investigations is likely to increase and is projected to be 25,000 cases per year

Overall on the basis of the local analysis, the number of patients attending as day case or inpatient admissions at MGH is anticipated to increase from 6,500 cases per year to 7,400 cases per year after the implementation of this Framework.

Louth County Hospital, Dundalk

There is also an opportunity to learn from the experience of smaller hospitals where the profile of services has already been changed in line with the Framework. In these locations, day case activity has moved from larger to smaller hospitals and more complex activity in the opposite direction. As a result, high volumes of services are still being delivered locally but they are safe and sustainable.

Louth County Hospital increased its day case activity from 4,249 cases per year in 2006 to 7,116 cases in 2011. This compensated for the cessation of approximately 4,000 emergency admissions per year leading to an overall reduction in total day case and inpatient activity from 9,708 to 7,462 patients per year. The closure of the emergency department was associated with a significant reduction in attendances and admissions but 50% of cases are still successfully managed at the Local Injury Unit where 7,938 patients were treated in 2011.

Louth County Hospital is the regional centre for colposcopy services as part of the cervical cancer screening programme. It has also been designated as a regional centre for the Colorectal Screening Programme and it is projected that this will result in an additional 2,000 colonoscopies per year when the screening programme is fully operational.

5. The Critical Links with Primary Care

It is well recognised that primary care can safely manage locally the majority of patients who require only a routine, straightforward level of urgent or planned care. Treatment can be delivered at home or as close to home as possible. The aim of developing primary care is to provide up to 90% of the health and social care in local communities. This will be achieved through an increase of activity in a primary care setting and the redirection of health services away from acute hospitals to the community.

Key to service integration is the promotion of capacity building in the community. This includes the use of smaller hospitals in a local community where appropriate. Patients in an integrated system are more likely to receive the type and quality of care they need, when they need it, in the most appropriate setting and from the most appropriate health professional.

Effective integration of care is easier to achieve where primary care team professionals assume key significance in the healthcare system through their role as gatekeepers to specialist referral.

Out-reach clinics in primary care will be an important means of developing more effective patient care. For example, at least a proportion of the return visits to out patient departments are for the purpose of monitoring, which could be just as effectively and much more cheaply carried out in primary care. Anti-coagulant therapy is one example of a treatment currently confined to out patient departments in Irish hospitals at present but which could be carried out in the more appropriate setting of primary care.

A number of other areas of primary care can benefit both primary care teams and the smaller hospitals working together more effectively. These include:

- more structured chronic disease management interactions that are better planned and managed;
- more opportunities for patient education and self management classes in the hospital with shared primary care responsibilities for providing this education service;
- opportunities for GPs and other primary care professionals to work in the Urgent Care Centres and as part of out-reach teams;
- better opportunities for GPs to refer to low complexity day procedures and access beds for procedures;
- enhanced opportunities for primary care professionals to play a role in palliative, rehab and pre-discharge care;
- IV therapy provision;
- minor Surgery provision;
- nebuliser treatment in the case of acute asthmatic attack; and
- Specialist therapy Treatment.

In addition, the management of chronic diseases is a clear example where close co-operation between primary care and smaller hospitals can bring very positive results. Chronic disease forms the backbone of much workload in general practice, making the extension of primary care work into a smaller hospital a logical step. Many patients with a chronic disease do not require the high technology of higher level hospitals and engagement in smaller hospitals can promote innovation and enhanced service delivery more easily than in larger settings with huge benefit both to patients and hospitals alike.

Finally, it is important to acknowledge the existing links that already exist between primary care and smaller hospitals. We want to cultivate and increase these links to the benefit of all patients. The strengths of existing arrangements, which we will seek to develop further, include:

- local services: smaller hospitals provide more convenient services and less costly access for their local population. The theme of patient choice is welcomed and at the heart of general practice. direct and timely access to key diagnostic services
- appropriate services: smaller hospitals will provide a range of safe and appropriate services often with considerable cost benefits. The range of services can evolve to meet local needs and will not require the large capital outlay essential for many larger hospitals;
- modern staffing structures: smaller hospitals could link with out-of-hours primary care services based in these hospitals
- improved skill mix: GPs working with smaller hospitals value the close relationship they can develop with visiting consultants, and may be able to work alongside those consultants as GPs with special interests. Long before this role was conceived, most GPs used their smaller hospitals to carry out many minor operations; and-
- extended outpatient services: these can benefit patients as there is often easier access at a convenient location (especially for older people), and peripheral clinics reduce the pressure and congestion at the larger hospitals. For medical staff, the contact and communication is improved between GP and consultant.

Appendix 1: Conditions Suitable and Unsuitable for Care in a Local Injury Unit

Adult Patients: Conditions Suitable and Unsuitable for Care in a Local Injury Unit

| What the Local Injury Unit does treat | What the Local Injury Unit does not treat |
|---|---|
| ✓ Suspected broken bones to legs from knees to toes | ✗ Conditions due to “Medical” illness e.g. fever, seizures, headache. |
| ✓ Suspected broken bones to arms from collar bone to finger tips | ✗ Injuries following a fall from a height or a road traffic accident |
| ✓ All sprains and strains | ✗ Serious head injury |
| ✓ Minor facial injuries (including oral, dental and nasal injuries) | ✗ Chest pain |
| ✓ Minor scalds and burns | ✗ Respiratory conditions |
| ✓ Wounds, bites, cuts, grazes and scalp lacerations | ✗ Abdominal pain |
| ✓ Small abscesses and boils | ✗ Gynaecological problems |
| ✓ Splinters and fish hooks | ✗ Neck/back pain |
| ✓ Foreign bodies in eyes/ears/nose | ✗ Pregnancy related conditions |
| ✓ Minor head injury (fully conscious patients, who did not experience loss of consciousness or vomit after the head injury) | ✗ Pelvis or hip fractures |

See notes below.

Paediatric Patients: Conditions Suitable and Unsuitable for Care in a Local Injury Unit

| What the Local Injury Unit does treat | What the Local Injury Unit does <u>not</u> treat |
|--|--|
| <p>Any child aged 5 years or older with:</p> <ul style="list-style-type: none"> ✓ Suspected broken bones to legs from knees to toes ✓ Suspected broken bones to arms from collar bone to finger tips ✓ Any sprain or strain ✓ Minor facial injuries (including oral, dental and nasal injuries) ✓ Minor scalds and burns ✓ Wounds, bites, cuts, grazes and scalp lacerations ✓ Splinters and fish hooks ✓ Foreign bodies in eyes/ears/nose ✓ Minor head injury (fully conscious children, who did not experience loss of consciousness or vomit after the head injury) | <ul style="list-style-type: none"> ✗ Any child of any age with a “Medical” Illness e.g. fever, seizures, respiratory symptoms ✗ Any child younger than 5 years ✗ Any child aged 5 years or older with: <ul style="list-style-type: none"> ✗ Non-traumatic limp or non-use of a limb ✗ Injuries following a fall from a height or a road traffic accident ✗ Serious head injuries ✗ Abdominal pain ✗ Gynaecological problems |

See notes below.

Notes on Conditions Suitable and Unsuitable for Care in a Local Injury Unit

1. Patients should be advised to contact their General Practitioner for advice if they are uncertain whether to attend a Local Injury or Emergency Department.
2. These protocols are intended for use in Local Injury Units, linked to Emergency Departments and operating within the governance framework of an Emergency Care Network.
3. The protocols should be supported by network clinical guidelines. Doctors, Advanced Nurse Practitioners and Nurses working in Local Injury Units should have direct access to clinical advice from a Consultant in Emergency Medicine from the lead network ED.

4. These are not exhaustive lists, but aim to direct patients with single, isolated and uncomplicated injuries to these units. Audit of patient outcomes and monitoring of Local Injury workload will indicate the need for review of these lists, as part of the governance function of the network.

Benefits that can be achieved through the implementation of Local Injury Units

For patients:

- Patients will receive the same standards of injury care across the network, due to shared protocols, staffing and clinical governance arrangements.
- Patients will not have to travel to larger units for injury care.
- Patients will avoid delays that might be experienced in larger EDs.
- Unscheduled, local ED access is assured for patients with injuries that are non-life-threatening and non-limb-threatening.

For the healthcare system:

- The model secures future involvement in the provision of emergency services for smaller hospitals.
- Existing ED infrastructure will continue to be used for the benefit of patients.
- The units will be open during the times when most ED attendances occur.
- Central larger EDs will be protected from the increased demand that would be caused by redirection of patients with injury if all services were centralised.

For emergency care staff:

- Staff can continue to engage in a component of emergency medicine without transferring to centralised units due to complete centralisation of services.
- Staff will have enhanced access to training and CPD through rotation within network.
- Trainees in EM and ANP candidates can gain experience in injury care.

For the National Ambulance service:

- More acute injury care delivered locally, thus reducing the need for patient transfers.

Appendix 2: Suitable patients for surgery in a Model 2 Hospital²

Selecting patients for day surgery can be facilitated through use of protocols. Suitability for same day discharge is dependent on patient, anaesthetic procedural and social factors.

Patient Factors:

- Age – there is no upper age limit. Patient selection should be based on physiological status, not age, i.e. the patient should be mentally sound, reasonably independent and active or under appropriate care.(4)
- There is a lower age limit for day surgery admission. The infant / child must be older than 56 weeks post-conception i.e. 16 weeks in an infant born at term.
- Good exercise tolerance – a patient should be able to climb stairs without having to stop.
- BMI – Obesity is not an absolute contra- indication for day care. In general, patients with a BMI >30 should have an assessment by an anaesthetist, unless clearly stated by local protocol for BMIs >30.
- Patients with a BMI >30 should have an assessment by an anaesthetist.
- The patient should not have a major pre-existing disability.
- ASA grade – patients should be ASA grade 1 or 2 or selected ASA grade 3. Patients with conditions NOT suitable for day surgery in a model 2 hospitals are outlined below

Anaesthetic Factors:

- Difficult airway – i.e. large goitre / tumour causing deviation or compression of airway, restricted neck movement or mouth opening.
- Personal or family history of malignant hyperpyrexia.
- Previous personal history of previous reaction to anaesthesia – type of reaction should be assessed and flagged with anaesthetist.
- Details of any unexplained, significant morbidity during or after anaesthesia in the patient, a relative should be noted and discussed with anaesthetist.

Cardiovascular

- Poorly controlled blood pressure (BP>170/100)
- Congestive cardiac failure
- Unstable angina
- MI within previous 6 months (14)
- Symptomatic valvular heart disease
- Patients who have a pacemaker or automotive implantable cardiac defibrillator
- Poor exercise tolerance

Respiratory

- Poorly controlled asthma needing oral steroids, frequently or within last 3 months, frequent hospital admission or home oxygen
- Poorly controlled COPD
- Sleep apnoea

Neurological

- Poorly controlled epilepsy
 - CVA/TIA within the last 1 year

² Extracted from *Model of Care for Elective Surgery*, National Surgical Programme, September 2011

Endocrine

- Poorly controlled thyroid disease
- Poorly controlled diabetes

Haematological

- Coagulopathies, INR>1.5, Platelets <100 (
- Cancer metastasis
- Recent chemotherapy or radiotherapy

Musculoskeletal

- Rheumatoid arthritis – not a contra- indication, discuss with anaesthetist
- SLE
- Myopathies

Gastrointestinal

- Risk of regurgitation is not a contra-indication for day surgery, but clear documentation of the risk is required, with appropriate management of the day of surgery

Miscellaneous

- MRSA infection
- Latex allergy

Medications

- History of drug abuse
- OCP within 6 weeks
- MAOIs

Procedural factors:

- The procedure should have a low complication rate, and be unlikely to cause loss of independence or incontinence.
- Abdominal and thoracic cavities should only be opened with minimally invasive techniques.
- There should be minimal blood loss expected and no routine requirement for fluid replacement post-operatively.
- The length of procedure should be expected to be less than two hours.
- The procedure should be unlikely to result in severe post-operative pain or nausea.
- The procedure is unlikely to cause loss of independence or incontinence

Social factors:

- The patient must have transport organised to take them home, and be accompanied. They cannot drive themselves.
- A responsible adult must be available to be in the patients' home for 24–48 hours post-operatively.
- The patient must have access to a telephone in the initial 48 hours post operatively.
- The journey time from the hospital to the patient's home should not exceed 60 minutes.
- Patients who are suitable for day surgery in a model 2 hospital, other than for social factors, can be admitted as an inpatient if appropriate).

Appendix 3: Suitable procedures for Model 2D and 2R Hospitals

It is possible for 75% of all elective operations to be carried out as a day case surgery. The following procedures represent the majority of these day case surgical procedures and are suitable for a model 2 hospital subject to appropriate patient selection.

1. Orchidopexy
2. Circumcision
3. Inguinal Hernia Repair
4. Anal Fissure Dilatation or Excision
5. Haemorrhoidectomy *
6. Laparoscopic Cholecystectomy*
7. Varicose Vein Stripping or Ligation
8. Transurethral Resection of Bladder Tumour
9. Excision of Dupuytren's Contracture
10. Carpal Tunnel Decompression
11. Excision of Ganglion
12. Arthroscopy
13. Bunion Operations
14. Removal of Metal-ware
15. Extraction of Cataract with/without Implant
16. Correction of Squint
17. Myringotomy
18. Tonsillectomy*
19. Sub Mucous Resection
20. Reduction of Nasal Fracture
21. Operation for Bat Ears
22. Dilatation and Curettage/Hysteroscopy
23. Laparoscopy

The British Association of Day Surgery (BADs) has produced a wider list of procedures which may be suitable for day surgery in 50% of cases and these cases may be suitable for a model 2 hospital subject to appropriate infrastructure, expertise and protocols (to be determined locally by the Clinical Director in conjunction with clinical staff) and subject to appropriate patient selection (see appendix 3)

1. Laparoscopic hernia repair
2. Thoracoscopic sympathectomy*
3. Submandibular gland excision
4. Partial thyroidectomy*
5. Superficial parotidectomy
6. Wide excision of breast lump with axillary clearance
7. Urethrotomy
8. Bladder neck incision
9. Laser prostatectomy
10. Trans cervical resection of endometrium (TCRE)
11. Eyelid surgery
12. Arthroscopic meniscectomy
13. Arthroscopic shoulder decompression
14. Subcutaneous mastectomy
15. Rhinoplasty
16. Dentoalveolar surgery
17. Tympanoplasty

NOTE:

- This list is not exhaustive. The question, “Is this patient suitable for day surgery?” should be replaced by: “Is there any justification for admitting this case as an inpatient?”
- Procedures marked by * will require clear arrangement for management of surgical complications out of hours including surgical cover on site either in the model 2 hospital or an associated hospital within the network and within reasonable travel distance of the patient.
- While the patient selection criteria outlined in Appendix 3 may be helpful for some of these procedures they do not apply universally. Therefore patient selection for these procedures needs to be determined by the Consultant and Clinical Director

The following procedures are suitable for model 2 hospitals and can be carried out in an endoscopy, outpatient or minor operations unit but should not usually be performed in Day Theatres.

Endoscopy

Bronchoscopy
Colonoscopy
Cystoscopy
Oesophagogastroduodenoscopy
Sigmoidoscopy

Outpatients

Colposcopy
Hysteroscopy
Local anaesthetic minor operations
Sigmoidoscopy
Pain management procedures and nerve blocks
Urodynamic tests

General Practice or Minor operations unit

Minor procedures (including those outlined above under section titled out-patients)

***Please Note:** A number of above procedures and investigations which in adults would generally be carried out in a minor operations unit or outpatient department cannot be performed on children because of the requirement for sedation or general anaesthetic e.g. oesophagogastrosocopy, colonoscopy, suturing of lacerations, dental extractions.

APPENDIX 4 - Suitable patients for Stay Surgery in a Model 2S Hospital

Suitability for surgery in Model 2S Hospitals will be decided in the Surgical and Pre-Anaesthetic Assessment Clinics. This will be based on patient factors, procedure factors and social factors on the lines as set out below.

Patient Factors:

The following factors cover some issues to be considered in patient selection. It is up to individual units to develop their own selection criteria depending on individual local unit capability:

- Age – there is no upper age limit. Patient selection should be based on physiological status, not age, i.e. the patient should be mentally sound, reasonably independent and active or under appropriate care. It needs to be decided at a local level if there are sufficient resources, clinical/nursing, to deliver a paediatric surgical day service according to patient safety and clinical risk management.
- Exercise tolerance – should be good, for example, a patient should be able to climb stairs without having to stop.
- BMI –Patients with a BMI ≥ 30 would benefit from pre-operative assessment.
- ASA grade –ASA grade 1, 2 and some ASA grade 3 are suitable. It will be up to individual units to decide locally, what's suitable for their unit.

If medical co-morbidities exist, these should be well controlled. Some examples include: diabetes - Hb1AC $<8\%$; patients with cardiac conditions epilepsy and asthma. Individual protocols need to be developed by local implementation teams to decide what's safe in your unit.

Procedure Factors:

- The procedure should have a low complication rate, and be unlikely to cause loss of independence or incontinence.
- Abdominal and thoracic cavities can be opened as part of the elective procedure.
- Anticipated blood should be factored in as part of the surgical plan.
- Requirements for post-operative fluid replacement and/or invasive monitoring or analgesic interventions should be available and planned for.
- The length of procedure should be expected to be less than four hours.
- Any procedure that anticipates HDU, ICU or ventilation requirements should not be performed in a Model 2S hospital.

Social Factors:

- The patient should not have a major, pre-existing disability
- Patient consent should include an informed awareness that, should a significant complication arise, they may require transfer to another hospital.

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