NHS SERVICE DELIVERY AND ORGANISATION R&D PROGRAMME

PROGRAMME OF RESEARCH ON EVALUATING MODELS OF SERVICE DELIVERY

EVALUATION OF CONFIGURING HOSPITALS PILOTS

Background

There is currently a wide-ranging debate about how acute hospital services in the NHS should be provided in the future. This debate is influenced by a number of drivers which mean that alternatives to current provision need to be developed. These drivers include the process of change which needs to take place in order to meet national performance targets on, for example, waiting times; technological and medical advances; and the pressures on the medical workforce as a result of the European Working Time Directive.

Many local health communities are discussing how acute hospital services can be redesigned to address these issues and provide high quality care. The Department of Health established a project in 2002 on 'Configuring Hospitals in Health and Social Care Systems'. As part of this project, a framework has been developed to assist local health and social care communities in their discussions and plans, *Keeping the NHS Local: A New Direction of Travel*, published on 14 February 2003 (www.doh.gov.uk/configuringhospitals). This project is also supporting three pilots which are configuring acute hospital services in different ways. Briefly, these are as follows:

Central Middlesex hospital (Emergency Care and Diagnostic Centre): a local hospital able to deal with emergency and routine cases on a 24-hour basis, and providing a single service for patients with chronic disease. It will have strong network links with surrounding health economy – to a tertiary centre and to smaller hospitals.

Bishop Auckland Hospital: a hospital able to provide all routine care, both medical and surgical, for its local population, and a centre for outreach for more specialised care. 24 hour A&E will be available, with network links to ensure rapid transfer of any patients who need it for emergency surgery or other more specialised care.

West Cornwall Hospital (Urgent assessment, diagnostic and treatment hospital): An innovative approach to providing urgent medical and surgical assessment, as well as planned procedures, in a small remote hospital through new ways of working. Patients will be treated on site or transferred according to their clinical needs.

More information on these pilots is available at Appendix A.

A formative and summative evaluation

The SDO programme is inviting outline proposals for a national evaluation of these three pilots. The purpose of this evaluation is to study the processes and impact of implementing new models of service delivery in the three pilot sites in order to provide broad lessons for the NHS. The evaluation should be able to compare these pilots with other models of hospital care. It should include the following processes and impacts: the consultation and planning processes; patient experience; clinical safety; and investigate the implications of these models for resources, the workforce, and the wider local health and social care system.

The evaluation should be both formative i.e. able to share findings at regular intervals, both to the pilot sites and to the NHS more widely, and summative. The evaluation will be funded for three years. Proposals should address the following:

1. How the three pilots should be set within the national context of acute hospital provision. This should include a broad mapping of the range of models being considered nationally and how these pilots under study compare. Applicants are asked to propose innovative ways of achieving this.
2. How the pilots should be set within the context provided by relevant literature in this country and elsewhere, where appropriate (for example, comparison with other countries which have isolated hospitals e.g. Scotland and or further a field).
3. A comparison of these pilots with other models of acute hospital service provision.
4. How each pilot site's local aims and objectives will be evaluated.
5. How the research study will be able to draw out the common themes across the three pilots relating to the following:
    - the consultation and planning processes (e.g. what were the drivers for change?, how were key stakeholders identified?, how were/are local communities involved?, what has been role of local authorities?)
    - the *process* of implementation of these new models of service delivery (how have the models been implemented? What are the challenges to implementation? How have these been overcome, or not?)
    - the *sustainability* of the new models of service delivery (factors which may facilitate sustainability and those which may act as a barrier)
    - patient experience (e.g. changes to patient journey, patient perceptions of new services etc.)
    - the impact on performance, in particular, meeting NHS Plan delivery targets, achieving National Service Framework standards
    - the impact on clinical safety (e.g. critical incidents, adverse outcomes)
    - the impact on the scope and range of service delivery (e.g. which services have been added, which have been lost), and any impact on access by different population groups
    - the financing and resource issues relating to these new models
    - the impact on workforce (e.g. staff morale, ability to meet the European Working Time Directive, changing [i.e. new or extended] professional roles, recruitment and retention, where feasible, etc.)
    - the impact of the change on the wider health community (e.g. impact on primary care, impact on social care)
6. How the research study will take account of the local *context* of each site and its influence on the design and implementation of the pilot, and any possible implications of this for the generalisability of the findings.

7. In addition, specific innovations need to be investigated in each site, as follows:

Central Middlesex

- Integrated acute assessment and treatment with a unified general medicine and A&E team
- Team based working in surgery
- Strong day and night differentiation, with extended working day and a single dedicated night team.

Bishop Auckland

- Sustainability of acute medicine with critical care but without emergency surgery.
- Effectiveness of working in a network with other hospitals (e.g. how effective is the access to a surgical opinion out of hours? What is the effect on relationships between the hospitals in the network?)

West Cornwall

- Reducing avoidable hospital admissions
- Effectiveness of the relationships between the relevant hospitals
- Role of information and communication technology (ICT)

Content of outline proposal

Applicants should demonstrate how they will undertake the research. Methods being proposed should be clearly described, including both qualitative and quantitative methods, where appropriate. Applicants should clearly indicate what process and outcome indicators they propose to use.

Proposed outputs should be listed and should include a plan to share findings at appropriate stages during the research, both to the case study sites and to the NHS more widely. In particular, feedback should be planned before the next stage of the European Working Time Directive has to be implemented in August 2004. Applicants are encouraged to propose innovative methods for providing feedback. Given that the identity of the pilot sites is already known, applicants should propose how they intend to maintain the anonymity of individuals involved in the research.

Applicants will need to demonstrate clear conceptual frameworks to consider the issues raised by this research. Applicants will also be expected to demonstrate that they are able to draw on a broad range of both evidence and theory. Applicants should be able to demonstrate a broad awareness of international research as well as UK-based research in this field.

As this is a large, complex national evaluation, proposals from consortia of academic departments are welcome. It is anticipated that no one department could cover all aspects of the evaluation on its own. Applicants should indicate how they will manage a multi-site, national evaluation. As these pilots are at varying stages of development, it is very important that the successful research team makes contact with the pilot sites as soon as possible to begin fieldwork in order to establish the baseline.

In addition, applicants should indicate how they will:

- Ensure that their team includes researchers whose knowledge and skills are sufficiently broad to deal with the variety of topic areas and methodologies which will need to be considered.

- Ensure the relevance of the research to the pilot sites and the NHS more widely, including bodies at national and local level which have an interest in configuring hospital services, both within and outside the health and social care sectors.
- Demonstrate the involvement of users and other relevant stakeholders at each stage of the proposed research project.
- Liaise with any local evaluations of the pilot sites, where relevant.
- Use local management information, where available and relevant.
- Build in an active programme for disseminating results, in discussion with the SDO Programme and relevant stakeholders.

Applicants should familiarise themselves with relevant research already commissioned by SDO and by other NHS R&D programmes (such as the Policy Research Programme) to ensure that they can demonstrate that their proposal does not duplicate other research.

Outputs

Outline proposals should demonstrate awareness that the *main final product* will be a detailed report that should:

- Critically describe the background and available relevant literature
- Critically describe the methods used in the research;
- Provide a rigorous analysis of the data gathered;
- Draw justifiable conclusions;
- Locate the findings in the current policy and practice context within the NHS.

However, as indicated above, applicants should include proposals to share findings with relevant audiences at appropriate stages, and in innovative ways, during the study.

We anticipate that there might be informal discussions with NCCSDO during the research to clarify issues as they arise. In addition, applicants should note that a steering group for this project will be jointly established between the SDO Programme and the Department of Health's configuring hospitals project.

Applicants should be aware that the SDO Programme is in the process of finalising the commissioning of an evaluation of diagnostic and treatment centres (DTCs) under its programme on evaluating models of service delivery, and the successful research team for this tender will be asked to liaise with the research team undertaking the DTC evaluation.

Guidance Notes

The process of commissioning for each study will be in two stages. At this stage we are requesting applicants to submit **outline** proposals. Outline proposals will be shortlisted, and a number of applicants subsequently invited to submit full proposals.

Applicants must submit proposals using the A4 Outline Proposal application form, which is available as a Word 97 file or Rich text format from:

- The SDO website, at: http://www.sdo.lshtm.ac.uk/hospitalscall.htm, or
- By Email from: damian.o'boyle@lshtm.ac.uk

Please do not use any previously obtained version of an SDO programme application form.

Applicants are asked to submit proposals by **Wednesday 16th April 2003 at 1pm to:**

Mr Damian O'Boyle
Commissioning Manager
NCCSDO
London School of Hygiene and Tropical Medicine
99 Gower Street
London WC1E 6AZ

TWENTY-FIVE HARD COPIES of the completed A4 Outline Proposal application form should be submitted, together with a copy on disk or CD. Please note we will not accept electronic submissions, faxed or hand written proposals. **No late applications will be considered.**

Guidance notes for the completion of the A4 Outline Proposal application form can be found at the front of the application form.

Teams should ensure that their proposal complies with the Research Governance Framework, which can be found on the Department of Health website, or via a link on the SDO website under the 'Call for proposals' page.

At the second stage, successful teams will be required to provide proof of research ethics committee approval for their project, if this is required (information regarding this can be found on the SDO website under the 'Calls for Proposals' page).

The SDO Programme is expecting that proposals will cost between **£300,000 and £500,000**, **over three years,** depending on the size and scope of the proposal. Applicants should note that value for money is an important consideration in respect of this research and they should demonstrate that their proposal meets this criterion. The exact length and cost of the project should be determined by the applicant, as they think appropriate. Applicants should clearly justify the timescale and cost of their proposal. Proposed costs of the project should not exceed the limit stated above.

Following submission of outline proposals, successful applicants will be notified of the outcome in **early-June 2003**. Shortlisted applicants will then be invited to submit full proposals by **late-July 2003.** Applicants will be informed of the outcome of the full proposals by **mid-October 2003**. Please note that these dates are approximate and may be subject to change. Projects should start no later than **11th December 2003**.

Successful applicants will be asked to make a short oral presentation of their completed research to the SDO Commissioning Board. Research outputs will need to be presented both in an academic format and in a format that will be helpful to end-users.

We anticipate that there might be informal discussions with NCCSDO during the research to clarify issues as they arise.

APPENDIX A.

PILOTS

General Information

- Three pilot sites have been established to look at how three service models for smaller hospitals can be implemented, and to evaluate how well they work in practice.

	Medicine		**Surgery**	
	Elective	**Emergency**	**Elective**	**Emergency**
Central Middlesex	Broad range	Treat unselected patients	Broad range including specialist	Yes
Bishop Auckland	Broad range	Treat unselected patients (except upper GI haemorrhage)	Broad range including some specialist	No
West Cornwall	Limited range	Assess unselected patients.Treat selected patients	Limited range	No

- They have much in common with the EWTD pilots (and Central Middlesex is running a EWTD pilot), and we will be building links between them.

- To help them focus on getting their new service models off the ground, we are asking people not to contact the pilots directly for further information. More detailed descriptions are provided on the Configuring Hospitals website (www.doh.gov.uk/configuringhospitals), and we will be posting regular updates there.

- For any specific questions about the pilots, please come to the configuring hospitals team in the first instance – email address: configuring-hospitals@doh.gsi.gov.uk

Central Middlesex Hospital: Brent Emergency Care and Diagnostic Centre

A local hospital able to deal with emergency and routine cases on a 24-hour basis, and providing a single service for patients with chronic disease. Strong network links with surrounding health economy – to tertiary centre and to smaller hospitals.

Background

1. Central Middlesex Hospital, with Northwick Park Hospital, forms the North West London Hospitals Trust. It is a small DGH serving a population of around 220,000. The hospital has 243 beds and manages around 180 emergency admissions per week (10,000 a year). The Central Middlesex also hosts the Ambulatory Care and Diagnostic Centre (ACAD) that provides one-stop elective treatment services.

Challenges

2. In common with many hospitals of its size, Central Middlesex has comparatively small numbers of specialists, and junior and middle grade doctors in all the major specialties, in particular surgical discipline. Sustaining emergency care in the context of the requirements of the Working Time Directive (WTD), and increasing sub-specialisation, therefore presents a major challenge.

Aims & proposed changes to working patterns

3. The Brent Emergency Care and Diagnostic Centre (BECaD) is being developed as a service model to support a major hospital redevelopment. The aim is to provide a new model for the DGH that can provide sustainable assessment and treatment for the local catchment population. It involves a fundamental redesign of patient process and staff roles based on the use of care systems, pathways and protocols.

Service portfolio

4. Services provided at the BECaD will include acute medicine, surgery, gynaecology and trauma and orthopaedics and inpatient paediatrics but not consultant led obstetrics. Elective inpatient provision will be also be maintained for urology. Short-stay and day surgery will be provided for a full range of specialties from the ACAD, Expert consulting services (replacing existing outpatient clinics) will be offered in all major medical and surgical sub specialties and in paediatrics. Services will be linked to specialist centres such as vascular surgery an a maxi-centre at Northwick Park, and cardiac services at St.Mary's Paddington.

Service model

5. The future service model depends on a high degree of service redesign and significant changes in working patterns. Ultimately Central Middlesex propose to make PRHOs and SHOs supernumerary, and change the working patterns of middle grades and consultants to achieve WTD compliance as part of the redesign of the whole service model. Key features include

    - streaming within A&E

- unified general medicine and A&E teams to provide an integrated acute assessment service with senior clinical leadership
- patient-led single service for chronic disease
- team based working providing protected emergency cover
- strong differentiation between day and night working with an extended working day and hospital wide night team
- Devolved management of surgical theatres and beds with out of hours working minimised in line with best clinical practice as per NCEPOD recommendations.

6. The A&E of the BECaD will have two front doors. NHS Direct and London Ambulance service will direct patients to the appropriate setting. Patients with minor injuries and complaints will be treated in the urgent treatment centre. This unit will be primary care led and staffed by a team of urgent care specialist including GPs and practice nurses as well as emergency nurse practitioners. There will also be built-in primary care follow-up including registration and significant social care input. Patients with more major complaints will be treated in the Major Assessment Centre which will become part of the new integrated acute assessment service.

Integrated acute assessment service

7. There will be a clear division in the hospital between the management of patients who are acutely ill (in the acute assessment service) and those in the recovery phase (in the step-down service. In both areas, medical and surgical patients will be treated together.

8. The acute assessment service will bring together A&E, Assessment Unit, ITU, CCU and HDU with acute medical, surgical and care of the elderly inpatient beds. This will involve merging the A&E team and the acute/critical care team, with 24 hour middle grade anaesthetic cover. Extending the working day (including for consultants) to minimise out of hours working and merging these frontline teams will deliver a consultant led system with middle grades covering a shorter night shift. The team will be supported by "major nurse practitioners".

9. The acute assessment area will be covered by medical consultants working for a 7-day period, in rotation, alongside A&E specialists and intensivists. The team will be able to call upon specialist opinions in surgery, T&O, gynaecology and urology. The aim will be to have early input from middle grade staff to provide an expert opinion. There will be 24-hour pathology and radiology support with extended day *access to* MRI, CT, ultrasound.

Chronic disease service

10. In the step-down service, primary care, intermediate care and step-down wards for older patients will be combined to provide a single service for patients in recovery. Staff in this service will have the opportunity to rotate between inpatient and community jobs, and case-management will ensure consistency of care before, during and after admissions.

Chronic disease service

11. A major feature of the BECaD is merging primary and secondary care to provide a single service for patients with chronic disease. This follows a disease management model, with patients taking a large part in determining their care and having direct access to specialists. Care will be provided under shared protocols and using shared information, with a greater menu of interventions. The outpatient department is replaced by an Expert Consulting Centre used by integrated teams.

Team based working in surgery to provide protected emergency cover

12. To ensure a rapid emergency response, surgery will be working on a team basis with a "surgeon of the day". A middle grade surgeon will also be assigned each day to booked work and separately to theatres. Work on rotas indicates that this alignment can be key to achieving a compliant approach.

Strong day/night differentiation with extended working day

13. At night, the on call nursing, medical and surgical team will merge to form one integrated team, allowing co-ordination of investigative effort. The team will be led by a middle grade physician and may include administrative support. The workload of the team will be reduced through core specialties working an extended day. This pooled resource will free up time for doctors to be used for more intensive training or rest periods. Ultimately this will make all medical and surgical SHO posts WTD compliant.

Devolved management of surgical theatres and beds

14. Management of outpatients, elective in patient beds and theatre time will be devolved to the surgical teams within the Expert Consulting Centre led by a new Team Manager, a role currently being piloted within orthopaedics.

Outstanding issues

15. The main issues around this example are likely to be the adequacy of out of hours surgical and anaesthetic cover. It will be important to establish that rotas provide adequate training; and that the range of surgical cover is sufficient.

Progress Report on Central Middlesex Hospital pilot site – January 2003

16. The Project started in September 2000 and after a process of planning and testing has reached the point of agreeing a service model. The project has now started the process of implementation through a number of pilots.

17. The pilots currently underway include the development of the Chronic Disease Practitioners and support teams for the Expert Consulting Centre, the introduction of a

Major Practitioner system in A&E and the introduction of step-down case managers with 2 GP practices.

18. The redesign project is linked to a hospital rebuild under PFI, which has been designed to deliver the model and is at preferred bidder stage (building planned to start July 2003). The project is also linked to national initiatives (the Changing Workforce Programme ¾ complete, and the WTD pilot about to commence).

19. The project including the hospital rebuild is managed by a project Director with a team of clinical re-designers to run the hospital reconfiguration work.

Bishop Auckland Hospital

A hospital able to provide all routine care, both medical and surgical, for its local population, and a centre for outreach for more specialised care. 24 hour A&E available, with network links to ensure rapid transfer of any patients who need it for emergency surgery or other more specialised care.

Background

1. Bishop Auckland Hospital is one of three traditional DGH serving a large rural area with a population of 125,000 in County Durham and Darlington.

Challenges

2. The clinical sustainability of services at Bishop Auckland, the smallest of the three hospitals, with the narrowest range of emergency medicine is under threat and this in turn presents major capacity issues for the other two hospitals. In the light of these pressures, the County Durham and Darlington Health Authority asked Professor Ara Darzi to advise on clinically sustainable options for the provision of general acute services across County Durham and Darlington.

Aims & proposed changes to working patterns

3. In the light of Professor Darzi's review the [local NHS?] has been developing a proposed service model based on the three hospitals working together as one integrated health care system to serve the needs of the people of the whole area.

Service portfolio

4. Proposals for service provision between the three hospitals are:

    - University Hospital of North Durham and Darlington Memorial Hospital will continue to provide a full range of acute services
    - elective medicine will be integrated across the 3 hospitals, with some sub-specialisation in each one, for example diabetes, endocrinology, coronary angiography and stroke.
    - surgery will be provided in a county-wide network with some sub-specialisation of elective surgery encouraged, e.g. vascular services.
    - Bishop Auckland will offer a reduced range of acute services but still retain an A&E and critical care capacity (see table below)
    - digital imaging should be installed to link the three hospitals.

Service model for Bishop Auckland

A&E

5. Bishop Auckland Hospital currently has a doctor led A&E service. Local GPs have expressed openness to exploring greater co-operation between the primary care out of hours centre and the A&E department, which are already co-located. There is a view that the doctors in A&E could be integrated with Medicine to make the posts more attractive and offer a wider range of experience.

Medicine

6. General acute medical services, including emergency cardiology, respiratory medicine, gastrointestinal services and stroke will continue at Bishop Auckland. Clear protocols for upper gastrointestinal haemorrhages will ensure that patients will transfer to Darlington Memorial Hospital should they require surgery.

7. Likely options for medical sub-specialisation at BAGH include the management of acute stroke, inpatient haematology, diabetology and endocrinology. Other sites will develop different sub-specialties (e.g. coronary angiography).

8. Bishop Auckland will retain a critical care facility including coronary care, high dependency and some intensive care beds and will develop 24-hour on-site anaesthetic cover. The key requirement is for resuscitation and ventilation facilities.

Surgery

9. Bishop Auckland will be developed as a specialist centre for elective surgery, functioning as a Diagnostic and Treatment Centre for patients from across County Durham and Darlington. The main service provision will be focused on orthopaedics, urology and general surgery.

10. Some intermediate (short stay) procedures could be undertaken in most surgical specialties at Bishop Auckland. Clear protocols will be developed to identify suitable patients. This could include a high-throughput athroplasty unit (focusing on hip and joint replacements) and intermediate urology procedures (e.g. transurethral resection of prostates).

11. Surgeons undertaking elective procedures at Bishop Auckland will continue to provide opinions for medical colleagues, removing the need for patients to be transferred to another hospital for an opinion.

Maternity and paediatrics

12. Services at Bishop Auckland will also include a midwife-led maternity unit and a 9am-9pm consultant led paediatric unit. Between 9pm and 9 am the paediatric unit will provide

nurse led inpatient beds with consultant on-call support. Patients who require a consultant or emergency treatment would be referred to Darlington Memorial or UHND.

Workforce issues

13. There is an opportunity with all the above service changes to provide different roles such as nurse consultants in critical care, and RMO for on-call surgical cover, GP specialists for minor surgery, therapy consultants and practitioners to improve rehabilitation. These options are being explored between the Trust and PCTs.

14. The new services will require new ways of working, the development of networks and greater specialisation. It will be important to ensure sufficient resources are available that create the "head space" for such developments and that there are people with the right skills to facilitate change.

Progress Report on Bishop Auckland Hospital pilot site – January 2003

15. The Secretary of State's office approved the reconfiguration of services in September 2002. In terms of emergency medical care, Professor George Alberti is visiting Bishop Auckland General Hospital on Friday, 24th January to receive a presentation on innovative ideas from the local community to introduce a more integrated emergency care service. This will include improved primary care integration with the A&E service and improved integration between A&E, medicine and critical care. Work on the implementation will be taken forward by the reforming emergency care steering group.

16. Sub-specialisation has developed for some services. For cardio-angiography, South Durham residents will primarily receive their service from Darlington Memorial Hospital. This development was approved in the summer and is planned to be operational from January 2004. North Durham residents will continue to receive their service from the University Hospital of North Durham and an extension to this service has been approved.

17. A single strategy for diabetes has been approved for County Durham & Darlington in the last fortnight.

18. A clinical action team to take forward the surgical service including vascular surgery will hold its first meeting on 21st January. The timetable for taking this forward is dependent on capacity being released on the Darlington Memorial Hospital site for general surgical patients and critical care patients, and revenue to support the critical care service.

19. Recommendation on how to retain a robust and sustainable critical care service have been developed in conjunction with the Critical Care Network, the Royal Colleges and the clinicians in Bishop Auckland General Hospital. This will require revenue support from the Primary Care Trusts and additional posts to be allocated by the Royal Colleges. It is hoped to gain approval over the next few months.

20. Digital imaging will be in place at Bishop Auckland General Hospital from June 2003. Links with the other two acute sites will be dependent on future funding.

21. Increased acute activity, such as orthopaedics and urology started on the Bishop Auckland General Hospital site in early January and is an integral part of the DTC development.

West Cornwall Hospital: Urgent Assessment, Diagnostic and Treatment Hospital

An innovative approach to providing urgent medical and surgical assessment, as well as planned procedures, in a small remote hospital through new ways of working. Patients would be treated on site or transferred according to their clinical needs.

Background

1. West Cornwall Hospital is located in Penzance, 35 miles from the Royal Cornwall Hospital (Treliske Hospital) in Truro, which forms part of the same NHS Trust.

Challenges

2. West Cornwall is a small, very remote hospital. It faces real challenges in maintaining clinical standards within workforce constraints. At the same time, centralisation of services is particularly problematic because of the large distances to other hospitals.

Aims & proposed changes to working patterns

3. West Cornwall Hospital is to pilot a Local Medical and Surgical Assessment Unit as part of its plans for an Urgent Assessment, Diagnostic and Treatment Hospital. The focus is on providing comprehensive assessment services, accepting that some treatment for acutely ill patients may have to be provided elsewhere. The aim is through maintaining 'front door' services close to home, and integrating primary and hospital care, to reduce avoidable admissions while increasing the number of patients using the hospital.

Service portfolio

4. The Local Medical and Surgical Assessment Unit will be linked to a doctor-led urgent treatment centre, selected medical and surgical admissions, high dependency care and a diagnostic and treatment centre including day surgery provision.

Service model

5. The Local Medical and Surgical Assessment Unit is based on a model (the Local Medical Emergency Unit) developed by Andy Black of Durrow Consultancy, working with a group of small hospitals under the auspices of the Nuffield Trust. The main features of this model are

- very well developed linked working between a small hospital and a larger remote centre - in this case West Cornwall Hospital and the Royal Cornwall Hospital in Truro
- high quality digital links to allow joint assessment of patients by staff in both locations
- assessment based on primary care record
- minimum pre-assessment selection of patients
- escalation protocols to ensure patients needing acute care are transferred rapidly to the larger hospital
- direct admission to wards in larger hospital

Before assessment

6. A key feature of the Local Medical Emergency Unit model is that it should receive unselected primary care, ambulance and self-referrals for assessment. The rationale for this is that staff working in hospitals dealing only with selected categories of patients can become de-skilled. It would not be appropriate for a small hospital to receive and expect to retain all unselected patients for treatment. But effective, rapid assessment may be provided earlier at a local hospital. If this can be of exactly the same quality as in the main hospital, and with no detrimental effect on treatment, there is no reason not to take any patient to the local hospital.

7. In practice there will be some circumstances – such as major trauma – when patients must be taken direct to a larger centre. Determining what pre-selection of patients is necessary will be explored as part of the West Cornwall pilot.

Assessment process

8. The Assessment Unit will be staffed by resuscitation-trained nurses who rotate regularly through the A&E department at the Royal Cornwall Hospital. When a patient arrives at the Unit, staff there will call up the patient's primary care record and contact the duty doctor at the Royal Cornwall Hospital. The duty doctor will communicate with staff and the patient at West Cornwall via a digital link allowing them to view images and receive results of investigations.

After assessment

9. Based on the assessment made, the patient may be able to return home under the care of their GP with support from community nursing. A key objective is to reduce unnecessary hospital admission, accelerate access to emergency assessment, diagnosis and treatment and care for as many patients as possible in their own homes of communities.

10. Some patients will, however, need to be admitted to a hospital bed. Clear protocols will be used to determine whether admission to a bed at West Cornwall is clinically appropriate. Where patients need to be transferred to the Royal Cornwall Hospital for

further investigation or treatment, this will be on the same basis as if they had been assessed in Royal Cornwall's A&E and they will be admitted direct to a ward. In many cases, treatment can be started by nurses in the Assessment Unit or paramedics transferring patients to the Royal Cornwall.

Workforce issues

11. This example depends on significant changes in working patterns, and on the development of real partnership between the hospitals involved. International experience of effective virtual clinical practice is limited but increasing.

Issues for pilot evaluation

12. The West Cornwall pilot will provide an opportunity to explore how the relationship between the two participating hospitals works in practice, issues around remote working and the core conditions for pre-assessment selection. It will also give some pointers to the scope for generalising from this example.

13. Evaluation of the West Cornwall pilot will focus on the key objective of reducing avoidable hospital admissions and the development of these "virtual clinician" skills. This will depend on achieving a quality of assessment at West Cornwall Hospital equivalent to that in the Royal Cornwall Hospital, taking account of both technical and organisational factors.

Progress Report on West Cornwall Hospital pilot site – January 2003

14. The steering board has been formed with wide membership from the local community. A series of meetings are underway and discussion with the key clinician involved with the services is just beginning.

15. It is hoped that in spring 2003 the IT infrastructure will be installed and early service experimentation should begin thereafter.

Addendum

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene & Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk.