Split Sites: Divide and Conquer?

Published 12 September 2019

More trusts are turning to the 'split site' model to redesign how and where they deliver services. Such re-engineering requires skilled leadership, and staff and public engagement, but is this a panacea?

In 2016, Gloucestershire Hospitals NHS Foundation Trust was, according to **Chief Executive Officer Deborah Lee**, facing a number of pressures: "*Not only were we in financial special measures, there were rising waiting times and increasing numbers of operations being cancelled at short notice in a number of services including orthopaedics, £6 million of NHS work was being done in the private sector, productivity wasn't what it could have been and we were not serving staff or patients well.*"

Taking a cue from the NHS good practice Getting It Right First Time (GIRFT) programme lead, **Professor Tim Briggs**, along with Lee's previous experience of seeing the success of splitting trauma and orthopaedics in North Bristol NHS Trust, the Trust worked at rapid pace to separate orthopaedic services onto two sites: one 'hot' site predominantly for trauma, and a 'cold' for planned surgery. Outpatients and day surgery remained on both sites, which was considered important for maintaining local access to services and supporting training.

By May 2018, after six months of split site working, the Trust was achieving its four-hour A&E trajectory for the first time since 2010, pre- and post-pilot mortality from a fractured hip has reduced by more than 25%, on the day cancelled operations have reduced from a weekly average of 9.75 to 0.5, waits for trauma have improved and routine waiting times are falling. Bucking the national trend, the Trust saw a 14% increase in joint surgeries in Winter 2018 over 2016, despite using fewer beds and theatres.

At least six other trusts, including organisations in Cornwall, Lincoln and Kent, who want to go down the split site route, are now '*buddied*' with Gloucester, which is an "official exemplar site", says Lee.

LTP revival

Splitting services is not new, indeed other countries adopted the idea of elective only units for joint replacement and other routine procedures, but it has been refreshed in the NHS Long Term Plan. The Plan indicates that providing planned services from a cold site guards against the capacity being taken up by emergency admissions, reducing the risk of last-minute cancellations.

Meanwhile, the Plan says that managing complex, urgent care on a separate hot site allows "*improved trauma assessment and better access to specialist care, so that patients have access to the right expertise at the right time*".

NHS England says it will continue to back hospitals that wish to pursue this model, but in those locations where a complete site shift to cold elective services is not feasible, it may also introduce a new option of 'A&E locals', the details of which are yet to be unveiled.

Clinical buy-in

Lee says the fact that the Trust operated from two large sites, Gloucestershire Royal Hospital and Cheltenham General Hospital, led to wasteful duplication: "*We were trying to do everything on the two sites and that caused problems. By the time we found ourselves in financial special measures, we had seen what North Bristol had done, so split sites stacked up.*"

Lee says the Trust had been "*dancing around*" the idea of splitting services for a decade, "*but a lot of clinical voices meant we never made any progress*".

It was the combination of pressures that persuaded the Trust to consult staff. "*The first step was to get clinical buy-in – we needed the commitment to do it.*"

Part of the difficulty was the simple logistics of getting the Trust's 27 orthopaedic surgeons together. Once they were all gathered, Lee says the meetings threw up some really challenging conversations:

"*There were lots of people doing private practice in the room, lots of older established consultants who were very resistant to the model and on the other hand some younger people who really thought it was the way to go.*

"It was a real personal leadership piece with Tim (Briggs) and myself running big events in hotels in Gloucestershire explaining to people why we should be doing this."

Duplication

Lee stresses that there were no significant costs involved, rather "*it was about re-arranging what we had*".

The only expenses went on creating an MRSA-free environment on one ward, a fair bit of time for project management costs and, more significantly, re-writing job plans for 27 consultants and their juniors.

"*That was probably the most onerous task. There were lots of concerns about teaching and trainees, so it took time making sure that the operating model of the service didn't undermine the ability to deliver teaching as well as care."*

Over 18 months later, Lee says the move has completely changed the way people work: "*One week you are part of the hot team at Gloucester doing theatres, A&E and wards and the next you're in Cheltenham doing four arthroplasties on a list.*

"What's fascinating is that the vast majority of the team think it's great. We had 27 applicants for our orthopaedic vacancy because it's gaining repute as a great place to work. We have 70% of our surgeons doing four arthroplasties per list, who were doing 2.5 before the change. We were operating on New Year's Day when most trusts were sunk by winter pressures."

One of the criticisms of the model is that it does require a duplication of some emergency services on the elective site in case things go wrong.

"*Both sites have a critical care unit so if a patient has a pulmonary embolism that is still treated there, not down the road at another hospital*," argues Lee. It's not without its challenges but has been "*by-and-large a success*".

DAC Beachcroft Partner, Alistair Robertson, who specialises in NHS service reconfiguration says early and well-publicised engagement with the public and other stakeholders, including the local authority, is vital:

"It is especially important where removing some services from one site might be perceived as a downgrade or an excuse for cuts. And it's not just the public, but clinical commissioners who would want reassurances that a cold site would have emergency cover should something go wrong.

"Reorganisations of this nature are ripe for challenge, and lack of (adequate) consultation is almost always first on the list."

He says it is vital that in preparing for any restructuring of this nature that trusts ensure that the rationale meets the Government's four tests set out in the NHS Mandate: strong public and patient engagement; consistency with current and prospective need for patient choice; clear, clinical evidence base; and support for proposals from commissioners.

Robertson also notes the fifth test subsequently added by **NHS England Chief Executive Simon Stevens**: "*Where there are proposals that cut beds, trusts must demonstrate that there is additional added capacity in the community to match the closures.*"

No single solution

Nigel Edwards, Chief Executive at the Nuffield Trust, says there are a variety of different models of split site ideas around the world, including the South West London Elective Orthopaedic Centre:

"These seem to work very well with a standard processing system that reviews patients very quickly and provides low infection rates, and does not get affected by loss of capacity due to winter pressure.

"In places like Gloucester, the theory is that you will still have to have some elective work at the hot site, especially for complex procedures. With a big bowel resection on a cold site, for example, you might still need a critical care unit if complications occur."

Edwards' main concern is whether the expense of duplicating some emergency services is outweighed by consistent better outcomes: *"I would like to see whether there is a higher or lower perioperative risk after a split."*

The Royal College of Surgeons supports reconfiguration of surgical services so long as they are underpinned by strong clinical evidence, and accompanied by meaningful public and stakeholder consultation.

College President, Professor Derek Alderson, says that split sites can enable a greater volume of elective surgery to take place, helping reduce waiting times: "*The GIRFT programme has recommended that commissioners and providers develop elective orthopaedic services on cold sites, or within existing hospitals that have a robust 'ring-fenced policy' that can function separately from the main hospital.*

"Given the record elective waiting list reported in June 2019 (4.3 million patients) – we need to look urgently at how to

increase the volume of elective activity across the system. This will take both political will and meaningful engagement with clinicians, patients and the public. It cannot be forced upon local areas, but it is essential to addressing the problem of so many people waiting in pain, often with their condition deteriorating."

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