Oifig an Stiúrthóra Náisiúnta
Géaroibríochtaí
Aonad 4A, Áras Dargan, An Ceantar Theas,
An Bóthar Míleata, Cill Mhaighneann, Baile
Átha Cliath 8, D08 NN9V

Office of the National Director
Acute Operations
Unit 4a, the Dargan Building, Heuston
South Quarter, Military Road,
Kilmainham, Dublin 8, D08 NN9V

www.hse.ie
@hselive
t 01 795 9972
e acutehospitals@hse.ie

Deputy Darren O'Rourke
Dáil Éireann
Leinster House
Dublin 2

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To ask the Minister for Health the difference between a model 2 and model 2S hospital; and the measures required to upgrade a standard model 2 to a model 2S hospital. - Darren O'Rourke

Dear Deputy O'Rourke

The Health Service Executive has been requested to reply directly to you in the context of the above Parliamentary question, which you submitted to the Minister for Health for response.

Response:

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 and 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 is 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. 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.

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. 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, (DOSA).

Recommendations for setting up 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 do not 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 service.

• 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 criteria are outlined in Appendices of the Securing the Future of Smaller Hospitals – A Framework for Development (1)

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 INEWS (Irish National Early Warning Score) 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 19 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 INEWS) 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.

Acute Surgery model of care 2013

In addition, the National Clinical Programme in Surgery (NCPS) has identified the need for a Model 2S hospital, which, like the standard Model 2 hospital, will not take unscheduled patients, but offers the potential to provide elective surgery of greater complexity than day procedures, on fit patients who require a hospital stay after their surgery. A Model 2S hospital would require additional staff cover and be geographically close to a Model 3 or 4 hospital. In order to efficiently network the different hospital models, specialty provision and capacity issues on all sites will need to be addressed. This is outlined in the Acute Surgery Model of Care (2) .

1. HSE. SECURING THE FUTURE OF SMALLER HOSPITALS - A FRAMEWORK FOR DEVELOPMENT: Department of Health; 2013 [Available from: https://assets.gov.ie/12170/91124d282ee84248b929698e050dedc5.pdf.
2. NCPS. Model of Care for Acute Surgery 2013 [Available from: https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/model-of-care-foracute-surgery.pdf.

I trust this is of assistance to you.

Yours sincerely,

Nessa Lynch,
General Manager,
Acute Operations