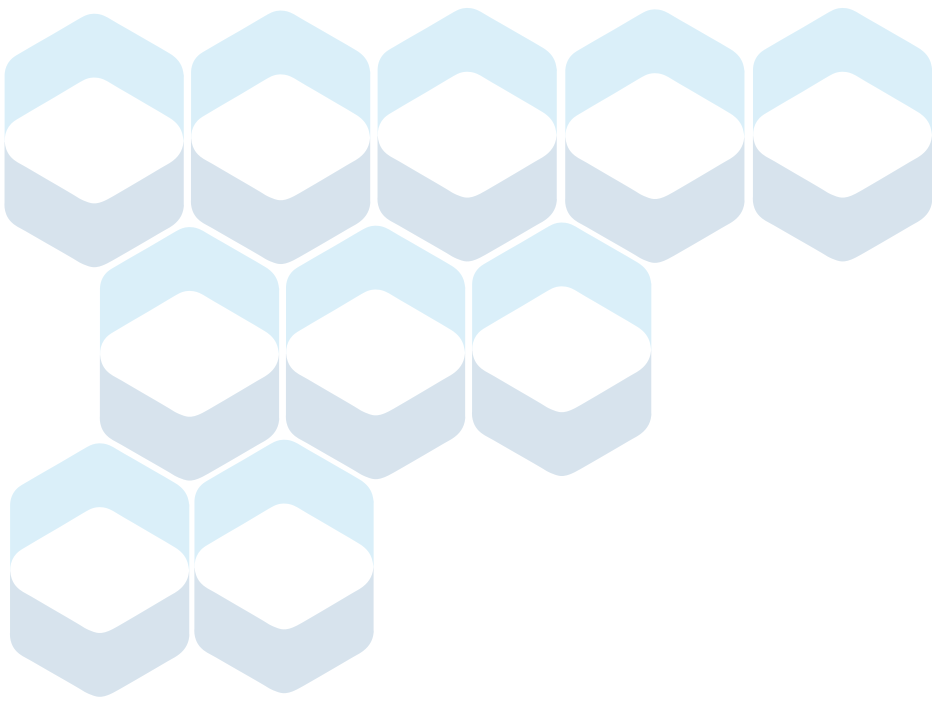

Reducing waiting lists, generating funds, improving lives: establishing a surgical hub

Roundtable discussion, 22 April 2024

British Journal of
Healthcare
Management

Foreword

Following the COVID-19 pandemic, investment in surgical hubs has been important to increase surgical capacity and offer operations to the hundreds of thousands of patients caught in the elective backlog. With more than 100 new sites now operational, these hubs have delivered more than expected, thanks to the innovations of the staff who work in them.

What has emerged with these new models of care for 'high-volume, low-complexity' surgery is that one size does not fit all. The original principle of separation of emergency and elective flows, with 'ringfencing' of elective capacity, has held true, reducing cancellations and supporting activity, despite external pressures such as winter. Originally focusing on less complex procedures, hubs now offer an increased scope of care, including cancer treatments and paediatric surgery.

Surgical hubs can exist within a hospital as a distinct unit, or as a repurposed ward area or theatre. There are also standalone elective surgical hubs on established sites that are not part of the hospital's core estate. Each of these approaches can be successful, improving quality and efficiency, with patients having shorter waits for surgery and being more likely to return home on the same day.

Accredited surgical hub sites submit data that are visible to all, which has supported ongoing quality improvement in theatre utilisation, productivity and day-case surgery. Meanwhile, improvements in patient pathways have been supported by transformations in pre-assessment processes, digital consent and postoperative care.

Surgical hubs can also boost staff morale, with an increase in recruitment and retention of theatre teams, which encourages a productive environment. The early evidence from the NHS and Getting It Right First Time accreditation visits has demonstrated high standards of care, with a focus on teams working together and eliminating inefficiencies in the system. There is pride among the multidisciplinary, multi-professional teams that support the surgical hubs, resulting in a positive patient experience.

Capital injection was vital to the establishment of the surgical hubs that are now up and running. In this roundtable discussion, participants consider how new challenges might be met. This includes establishing, running and innovating within a hub, with a sense of realism in the face of current challenges.

As new surgical hubs are launched, the NHS must consider that each hub is capable of continuous transformation and innovation, resulting in more patients being treated in a timely fashion. It is also imperative that hubs are viewed as system assets, working to reduce variation in waiting times for patients, maintain strong links with community diagnostic centres and contribute to one-stop models of care.

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Produced by Mark Allen Medical Communications
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Introduction

On 22 April 2024, senior leaders from across UK healthcare trusts met in Coventry for a roundtable discussion about the establishment and optimisation of surgical hubs.

Chaired by Chris Blackwell-Frost, the meeting began with a question-and-answer session focusing on the surgical hub at South Warwickshire University NHS Foundation Trust, which has highly successful in working through waiting lists and preventing additional acute pressures that arise from cancelled elective procedures. The discussion then transitioned to explore the experiences of all participants. The candid sharing of individual trust and wider system issues, with a combination of learning and advice, provided key insights into the management of surgical hubs and the protection of vital elective capacity. All participants identified and recognised challenges that must still be addressed, and a joint understanding and shared approach was agreed to be the way forward in best practice.

Question-and-answer session

The South Warwickshire surgical hub

The meeting began with a question-and-answer session with Glen Burley and Harkamal Heran, Group Chief Executive Officer and Group Chief Operating Officer (respectively) of South Warwickshire University NHS Foundation Trust (SWFT). Having set up their elective hub on an acute ('hot') site, the trust developed 'operation ringfence'; this approach is the initiative of the wider NHS hospital group, comprising SWFT, George Eliot Hospital NHS Trust, Wye Valley NHS Trust and Worcestershire Acute Hospitals NHS Trust. The initiative aims to demonstrate that the NHS can protect elective capacity and activity, even when bed pressures are very high.

With this philosophy, the SWFT hub has earned a reputation of never cancelling an elective operation because of bed pressures. They were also able to respond rapidly to the COVID-19 pandemic, establishing a green pathway within 2 weeks, avoiding outbreaks of the virus within the hub entirely and meeting their 120% elective recovery target. In 2022, nearly 1100 joint operations were performed in the hub, increasing to 1500 in 2023, with a target of just under 1600 for 2024. The success of the hub has allowed the trust to offer mutual aid, whereby other trusts in surrounding areas can send patients to the SWFT hub to undergo their elective procedures. The hub thus has positive implications for the wider area in terms of reducing waiting times and addressing the elective backlog.

Components of success

The discussion explored the factors that have contributed to the efficient running of the SWFT hub and the effective ringfencing of elective resources, which several of the roundtable participants had found challenging. Five overarching components emerged relating to the hub's success (Figure 1).

The first component related to the physical layout of the SWFT surgical hub. This includes the installation of a mobile unit, located slightly away from the main building, but still on the acute site. To optimise the space, the existing areas were reconfigured so that the elective theatres are now located on the ground floor and joined up to the mobile facility via a corridor. Both Glen and Harkamal emphasised the significant difference made by adding the corridor and the importance of getting the physical configuration right. By setting up the hub as one cohesive space, they were able to achieve substantial efficiency gains.

Second, the trust prioritised staff engagement. Glen described how the physical layout contributed to this, as the cohesive nature of the space means that surgeons feel they are working in their own theatres. Overall, staff have been comprehensively integrated into the hub model, so they take ownership of their patients across the care pathway. The

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team includes transport and pre-op services, as well as a designated booking team, which Harkamal described as 'key to avoiding cancellations during the recent industrial action'. Specific strategies to boost staff engagement have included:

- Rapid mobilisation and commissioning of the mobile facility. Before this facility was added, the hub did not have enough capacity. This, combined with the extent of the care backlog, was a source of stress for surgeons, which made the idea of the mobile unit attractive. Yet, Harkamal emphasised that they had to 'move quickly' to establish the new hub lay out, to reassure staff that they were capable of delivering this increased capacity

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Figure 1. Components of success in the South Warwickshire NHS Foundation Trust (SWFT) surgical hub.

- Leveraging the hub as an asset. Glen described how they incentivised consultants by providing assurance that, if enough elective activity is performed in the hub, the trust will continue to invest in it
- Embedding the 'culture of not cancelling', so that staff are fully supportive of the ethos of the hub, recognise the improvements to patient care and trust that the elective work is viewed as a priority by the organisation.

Third, patient pathways have been optimised in the hub to build an efficient system. For example, the booking team will call patients who are near the top of the waiting list in the evening and ask them to fast until the following morning, so that they can be called in for their procedure if a slot opens up. As a result, the team 'has not wasted a single slot' since the mobile facility has been in place. Additionally, the hub has an accelerated transfer team who act as a point of contact for patients. This means that they do not have to go through the emergency department if they experience problems after discharge. This approach accelerates rehabilitation, with these activities commencing while the patient is in hospital and continuing with the same team after discharge. Glen reported that this system is very popular with patients and has allowed the team to minimise length of stay

Risk stratification is another key element of the SWFT hub system. Dan Coleman noted that surgeons often feel apprehensive about operating on more complex patients in hub sites, because of the risk of patient deterioration. Harkamal highlighted that having the SWFT hub on a hot site has allowed them to treat low- and moderate-complexity patients (ASA 1 and 2) in the mobile facility, with capacity to treat more complex patients (ASA 3) in the main theatre suite. This ability to manage more complex patients was considered particularly important by the roundtable participants, as the care backlogs mean that many patients will have deteriorated while on the waiting list. It is vital that surgical hubs are able to stratify and treat these individuals safely.

The fifth component of success for the SWFT hub is the team's commitment to protecting elective capacity and activity. Glen set out their executive team's ethos that placing acute patients into elective beds is poor care, and emphasised that it is possible to embed this mindset across the wider trust. The roundtable participants agreed that it is crucial to have a strong executive board team that can 'hold the line' and prevent elective beds being filled by acute patients. Harkamal shared how difficult this experience can be for managers when bed pressures are high, but that working with staff to set out 'red lines' to protect elective resources had been helpful.

Roundtable discussion

Following the question-and-answer session, the chair opened up the discussion by asking the participants about the biggest challenges they had faced in establishing and managing their surgical hubs, and how they had worked to overcome these. An in-depth and highly collaborative discussion followed, full coverage of which is outside the scope of this article. However, some of the most prominent themes are discussed below.

Flexible infrastructure and optimisation of spaces

The need for flexible infrastructure that is fit for modern surgery was a key point of discussion. David Woollcombe-Gosson shared his experience at Western Eye Hospital, where a major incident had led to nearly all ophthalmology capacity being lost overnight. They were able to set up an elective site, including a modular facility, which allowed care to continue. However, the need for urgent turnaround meant that the physical configuration of the hub was not planned or optimised. David stated that 'with physical pathways, you are either really efficient or mediocre', describing how 'little bits of friction' can lead to a substantial loss of efficiency.

Similarly, Shaun Stacey highlighted the difficulties caused by the physical layout of one of the hospital sites in his organisation. In particular, the slow speed of the lifts that feed the operating theatres has been a significant source of inefficiency and staff frustration, with theatre lists starting late because patients are stuck in the lift queue. The hospital has

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tried to create holding bays to improve flow, but this has been challenging, as the theatres were not designed to include these facilities.

These experiences underline the need for flexible infrastructure that can allow trusts to respond to changes and unplanned events. Glen stated that:

> **'If I was designing a new hospital site today, I would put tarmac and sockets all over it… Plug and play, that is the kind of flexibility we need.'**

The increasing use of robotics exemplifies this point. Both Dan and David highlighted the benefits that robots can have, particularly in terms of downstream care; Dan had found that use of a robot for head and neck surgery could reduce the average length of stay from 21 days down to 11 days. However, Carl Holland pointed out that these robots take up a substantial amount of space, so theatres may need to be reconfigured to accommodate these developments. Therefore, a flexible design is important not only to optimise surgical hub facilities in the present, but also to 'future proof' them as the field develops.

Once the physical layout of the hub is optimised, the whole pathway needs to be efficient to support the hub. Harkamal recalled that, in a previous workplace, the surgical team was not allowed to send for their first patient if there were high bed pressures. Not only was this frustrating for staff, it also led to 'disharmony and waste'. A strength of the SWFT hub, she explained, was that they always sent for their first patient, knowing that they would be able to give them a bed. Dan raised that one of his sites was experiencing the common problem of surgical beds being filled with long-stay medical patients. This highlighted the importance of establishing the 'red lines' that Harkamal had mentioned previously, to protect elective capacity.

The group acknowledged the difficult decisions that managers often had to make to achieve this, such as increasing the number of medical side rooms or accommodating patients overnight in medical day case units. However, they also discussed the idea of 'parity of risk', highlighting that it is common for elective patients to deteriorate while waiting for care. Harkamal pointed out that taking elective beds for acute medical patients is unlikely to resolve medical pressures but will almost certainly create problems elsewhere. The participants generally agreed that this strong commitment to elective care, among both frontline staff and executive teams, is crucial to ensuring that surgical hub facilities are used efficiently.

Demonstrating value

The discussion turned to the funding of surgical hubs, which participants agreed was one of the greatest challenges that they faced. Robert Hakin spoke about a growing pressure on revenue within the NHS, pointing out that performing a high volume of operations would only meet revenue expectations if the income generated from this activity outweighed the associated costs. While the participants were aware of the wider socioeconomic benefits of treating elective patients, generating revenue was also a key priority.

The group discussed the benefits and drawbacks of the Targeted Investment Fund (TIF), through which NHS organisations can access funding for schemes that support recovery from the COVID-19 pandemic. Although participants felt that this was a good idea, they had encountered difficulties in accessing funding for small or moderate-sized projects, as TIF funding was mainly being granted to projects worth £10 million or more. Jenny Briggs noted that this was a major problem with the TIF. However, she had managed to navigate this by using the large chunk of funding granted to her organisation (£76 million) for projects that are implemented at system level, but can benefit individual trusts. This included the establishment of the organisation's accredited surgical hub at Clatterbridge, which comprises two modular units and can be used by the trusts.

Glen described the TIF funding that SWFT had received as 'enabling', mentioning that they had 'topped up' their proposal by including the mobile facility and its staff in their plan (Figure 2). This allowed them to create a proposal of high enough value to access TIF funding for the hub. Yet, he and the wider group acknowledged the limitations associated

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Figure 2. Interior of the laminar flow mobile facility that forms part of the SWFT surgical hub.

with the TIF's focus on very large projects, especially when investment is needed in maintenance and core infrastructure.

This related back to the pressure to generate revenue – Harkamal noted that the use of TIF funding for SWFT's surgical hub meant that they needed to demonstrate a rapid increase in elective activity. This contributed to their decision to bring in the mobile facility, along with staff insourced from the unit provider (Vanguard Healthcare Solutions Ltd), as this allowed them to increase their activity quickly and significantly. Meanwhile, the physical configuration of the hub and its location on a hot site meant that they could optimise their case mix, including different levels of patient complexity. The participants agreed that this was important, not only in terms of generating revenue, but also to avoid wasting theatre slots. As Glen pointed out, 'cancelling electives wastes money'.

This part of the discussion reflected the need to demonstrate value when implementing a surgical hub. Working through the elective backlog and providing patients with timely access to care is a fundamental goal of the hub model, with the potential to deliver wide-scale socioeconomic benefits. However, managers must also prove the financial sustainability of their individual surgical hubs, all while navigating funding requirements and barriers, including revenue targets, last-minute capital allocations and the capital departmental expenditure limit (CEDL). This makes the process of demonstrating value far from straightforward. Moving quickly to show gains from the hubs was seen as a

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crucial component, further highlighting the importance of implementing surgical hubs with both precision and efficiency. Yet, it was clear that central funding structures need to be improved so that organisations can access the appropriate resources to run high-quality surgical hub facilities.

Fitting surgical hubs into integrated care systems

Integrating the hub

As surgical hubs are often system assets, and several of those implemented (or being developed) by the participants' organisations were being used to provide mutual aid, they need to be optimised within the wider system or area. Jenny Briggs noted that this can complicate the allocation of revenue generated from hubs, raising the question: if a hub is owned by the system, rather than an individual trust, which trust should be allocated the tariff, activity and elective recovery funding (ERF)?

Participants described varied approaches to this issue. In Shaun's organisation, the hub is simply paid for the extra lists that they carry out, generating revenue. Meanwhile, in Jenny's organisation, the trust that 'hosts' the surgical hub facilities is allocated the tariff and activity, and pays the trust that employs the surgeon who uses the hub for their time. However, Jenny found that this encouraged a 'market share mentality' among the trusts, which could be a barrier to integrated working.

Dan reported that the same issues had caused initial reluctance among trust executives to use the three mobile theatres at the Kent and Medway elective orthopaedic centre. In this case, a decision was made at board level to mandate use of the hub. Dan emphasised that the waiting lists had been so long, and the impact on patients so substantial, that a pragmatic approach was needed. Simon Milner, whose organisation was in the process of setting up an elective hub for Bath, Swindon and Salisbury, noted that he was working on agreements that would incentivise the trusts to fill the elective hub theatre lists, so that they could generate the required revenue. As part of this, he was highlighting to the trusts that moving some of their high-volume, low-complexity work to the hub would free up capacity for more complex cases on the main site. He added that providing training on the hub site could also bring in additional funding.

Integrating staff and patients

In terms of the allocation of staff and resources, several participants described systems where the hubs have their own theatre staff (nurses and operating department practitioners), with surgeons employed by a trust coming to use the facilities with their patients. In the SWFT hub, the theatres in the mobile unit are staffed by nurses and operating department practitioners employed by Vanguard Healthcare Solutions Ltd. Harkamal explained that this approach had been chosen to help them rapidly demonstrate increases in efficiency and ensure that the hub was optimised quickly. While the unit was being set up, the SWFT team had worked closely with Cherry Lee, Vanguard's Head of Clinical Services and Practice, to build assurance and engagement with staff. Harkamal noted that the mobile facility team are not seen as a separate entity by those employed by SWFT; instead, the hub and its staff function as one cohesive service (Figure 3).

Some of the participants had experienced difficulties incentivising surgical staff to work in the hubs, which led to a discussion around staff engagement. Janine Nethercliffe and Chris Longster provided insights into the work done at their trust to incentivise staff and increase buy in to the hub model. Janine noted that surgeons value familiarity and usually want to work with their own patients, while Chris highlighted that the additional activity carried out as part of elective recovery has provided significant earning potential for staff. This could be seen as a strength of setting up a hub with its own nurse and operating department practitioner teams, but bringing in surgeons with their own patients. This way, as Glen described, the hub can be seen as an asset for surgical staff. Some of the other strategies used at SWFT to ensure staff buy in are mentioned above, but Cherry also noted that an important part of this engagement was the ethos of protecting elective care – the

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Figure 3. Exterior of the laminar flow mobile facility on the SWFT surgical hub site.

team come to work each day knowing that they will get through their list without avoidable cancellations, which builds their belief in the system.

As Robert pointed out, a common concern about surgical hubs is that patients will not be willing to travel. However, several participants reported that this had not been their experience. Both Dan and Shaun shared that large numbers of patients in their regions had shown willingness to travel to a surgical hub, with Dan estimating the numbers who had travelled in Kent and Medway to be around 13 000. Harkamal emphasised that elective patients are often unwell and in pain, so it is an 'easy answer' for them. She also described how SWFT had worked on a script for their bookers to use when contacting patients from further away to ease their concerns, as well as setting up a transport service to improve equity of access.

This was a highly collaborative part of the discussion, with participants sharing their approaches and offering advice on how to fit surgical hubs into existing structures, while reassuring both staff and patients. Although specific systems of resource allocation will likely vary across organisations, perhaps a more standardised approach would be useful. Several participants described a level of initial apprehension among theatre staff and trust executives, but early engagement and investment in high-quality facilities and pathways that prove the value of the model could help to deliver smooth integration of the surgical hubs into the wider system.

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Considerations for policymakers

To close the discussion, the chair asked participants to share the most important point that they believed policymakers should consider in this election year. Responses related to infrastructure, staff and funding.

In terms of infrastructure, David urged policymakers to understand that it is often the 'less sexy' changes that make the biggest difference in practice, such as investments in estates or digital upgrades. Carl emphasised the need for more space in theatres so that trusts can increase their productivity and deliver high-quality surgical care within the NHS. He added that outsourcing procedures is unpopular among staff. Glen and Dan both agreed that this issue needs to be addressed, as when low-complexity patients choose (or are outsourced to) the private sector, the trust loses the simple cases that act as 'list fillers', which has implications for efficiency. This also reduces training opportunities, as junior staff have less low-complexity procedures to build up their experience. Carl called for on-site solutions to NHS theatre capacity, to address the care backlog without creating these problems.

Several participants agreed with Dan that working to resolve the ongoing industrial action was crucial to preventing elective cancellations. Janine also highlighted the need to reform the pensions system to encourage senior doctors and surgeons to stay in the NHS, noting that these individuals are not only capable of completing surgeries faster, they are also key to training new staff.

In relation to funding, Chris Allam shared powerful insights from Northern Ireland, where there is no specific elective budget. As a result, elective waiting times average at around 6–8 years, with the longest orthopaedic waiting time potentially being as high as 10 years. She emphasised the substantial social and community impact of this, noting that many patients wait so long for care that, when they finally do reach the top of the list, many do not even attend. These insights not only emphasised the need for an elective budget in Northern Ireland, they also provided a potent reminder of the wide-reaching consequences of neglecting elective care.

Conclusions

The key goal of this roundtable was to provide a space where senior leaders could share their experiences of developing and implementing surgical hubs. Following the discussion, several participants commented on how valuable it had been to speak candidly and learn from their peers across the NHS.

The roundtable considered several different elements of optimisation, with an emphasis on the physical configuration of a surgical hub, strategies to navigate complex funding requirements and the integration of the hub into the wider system. Participants were all experiencing ongoing challenges; although these varied, concerns about staff engagement and the barriers imposed by central funding schemes seemed to be the most pressing issues discussed. However, the participants were also able to share advice and strategies to mitigate these problems and continue to push for a strong elective service for patients.

Perhaps the most prominent theme throughout the discussion was the ethos of protecting elective care. The NHS has a long history of cancelling elective procedures when acute bed pressures are high, culminating in the complete suspension of planned care across many services during the COVID-19 pandemic. Yet, the roundtable participants reflected on a shift in philosophy, with the need to consider parity of risk and prevent the deprioritisation of elective patients. This ethos has been key to the success of the SWFT surgical hub, and underpins the rationale behind investment in high-quality facilities, efficient pathways and staff engagement in the hub model. Understanding the benefits of timely planned care across the system, as well as the potential social and economic consequences of neglecting elective patients, will likely inform future efforts to overcome the remaining barriers to optimised surgical hubs.

Acknowledgement
Vanguard Healthcare Solutions Ltd and the British Journal of Healthcare Management would like to thank all the roundtable participants for their valuable contributions to this discussion.

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