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ACUTE PERSPECTIVE

David Oliver: Could separating NHS "hot" and "cold" inpatient sites work?

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Is it realistic to think of separating NHS hospital sites more effectively for "cold" (elective) and "hot" (acute and urgent) care, so that outbreaks or seasonal surges don't lead to elective care being cancelled or delayed? This month over five million people were waiting for planned surgery, procedures, tests, and outpatient appointments in England—the highest figure on record.[1] The *Times* reported that "NHS chiefs are braced for nine million patients on waiting lists by the end of the year while Sajid Javid, the health secretary, has warned that it could go as high as 13 million."[2]

After previous successful drives by government and NHS leaders to tackle waiting lists, waiting times for planned (elective) care had been deteriorating in the years before the pandemic because of workforce pressures, financial constraints, and insufficient beds, clinics, investigation suites, or diagnostic services such as imaging.[3] The pandemic massively accelerated worsening performance in waiting times and patient numbers and has set back any improvement for years. The Royal College of Surgeons has called for a "new deal for surgery," setting out a 12 point plan to tackle the elective backlog and asking for government backing. This includes major investment, more dedicated separate "surgical hubs," and a big increase from 2.5 to 4.7 beds per 1000 population.[4]

Although we often discuss such care as "routine" to differentiate it from acute care, in reality many of the people on ever longer waiting lists are frightened, worried, and in deteriorating health, their quality of life impaired by a lack of access to treatment. And those waits include "urgent elective" delays for suspected or confirmed cancer. In turn, professional leaders, the press, and the public have expressed concern about mortality and morbidity and the secondary harms of gearing up NHS services to cope with covid surges in people with other debilitating conditions. Government officials, campaigners, researchers, and commentators argue that we've overvalued covid at the expense of all other conditions, with measurable consequences.[5-7]

Health policy and management experts and clinical leaders have argued intermittently that if we could separate "cold" and "hot" hospital sites the capacity in elective care wouldn't be affected by pressures on acute care, including from infectious diseases.[7] In the NHS, the same district general or teaching hospitals normally host emergency departments and acute inpatient and outpatient care at the same facility and site. Often the same clinicians cover both workstreams, and some of the same facilities also cover both—such as investigation suites, radiology services, operating theatres, intensive and high dependency care, transport, porters, and laboratory services. The NHS uses elective care treatment centres (which were a clear priority in the Elective Care Transformation Programme) or private hospitals with no urgent care facilities, and it did so increasingly in the pandemic to contract out elective work or provide space and facilities for its own clinicians to work in.[8]

NHS general hospitals have made serial attempts to "ringfence" elective inpatient and day surgery beds from urgent care, to prevent cancellations.[9] These are often over-ridden under severe pressure on acute admissions and emergency department waiting times, with acute patients spilling over into beds. In effect, in any contest, acute care wins. Again, we saw this during the pandemic. Using dedicated "cold" elective care centres could enable much more intensive use, as all admissions are scheduled and not subject to intrusion from unscheduled acute demand, so every bed and theatre space can be occupied efficiently and appropriately. In a pandemic, such centres would also be easier to protect from outbreaks and the associated bed closures, cancellations, and hospital acquired infections.

However, such facilities often don't have the same access as general hospitals to critical and intensive care, 24 hour onsite emergency cover, or specialist acute input. And some elective inpatients may be very sick from postoperative medical complications. The dividing line between acute and elective care can be blurred. Conversely, removing elective beds from the acute care site potentially creates less spare capacity or flexibility for acute patients when demand surges.

As things stand, I see no prospect of a major increase in capacity or workforce in elective care, let alone a major building and capital investment programme. Elective care and its patients will remain extremely vulnerable to the fallout from surges in acute demand, as well as pandemic or seasonal viruses, even if we catch up on the big and growing backlog.

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1 https://news.sky.com/story/covid-19-nhs-waiting-list-at-record-high-but-hospitals-admitting-more-patients-figures-show-12351537
2 https://www.thetimes.co.uk/article/javid-told-13-million-covid-cases-may-lengthen-nhs-backlog-j38027hk9
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