East Kent Hospitals University NHS
NHS Foundation Trust

Emergency High Risk Surgery Model of Care
Clinical Strategy

1. Introduction

The purpose of this paper is to detail a serious clinical risk that has arisen in general surgery and to look at the implications of a set of options that remedy the issue. A number of different risks emerge depending on each option and these have been identified in the more detailed analysis undertaken in section six. Each option also has differing revenue and capital consequences which are detailed.

The movement of general surgery has differing implications in particular for the clinical pathways detailed below. Therefore in addition the paper looks to highlight these and outline the current clinical pathway for patients when presenting at all 3 of the hospital sites and any changes that occur as a result of moving general surgery. The specialties identified are:

- Trauma;
- Paediatric surgery (emergency and elective);
- Obstetric surgery;
- Gynaecology surgery (emergency and elective);
- Acute medicine;
- Critical care / anaesthetics; and
- Diagnostics.

The table below details the current situation in terms of general surgical support for each of the specialties and enables an easy reference point for each option relating to changes to these.

Specialties	Current situation
Trauma	WHH is a Trauma Unit and must be supported by an on site general surgeon, if required, within 30 mins of a decision to operate. Currently in hours the on site middle grades assess the patient and contact the on site consultant as required. Out of hours the on site middle grades assess the patient and call in a consultant if surgery is required.
Paediatric surgery	Elective and day case paediatric surgery can be performed on all 3 sites.

	A limited range of emergency paediatric surgery can be performed at QEQM and WHH, due to availability of a paediatric bed base or will be transferred to a tertiary provider depending on age and type of surgery.
Obstetric surgery	Obstetric surgery is currently predominantly supported by Vascular surgery and Interventional Radiology. Both of these services are centralised at KCH.
Gynaecology surgery	Elective and day case gynaecology surgery can be performed on all 3 sites. Emergency gynaecology surgery can be performed at QEQM and WHH due to gynaecology bed base.
Acute medicine	Acute medicine is supported on all 3 sites with the emergency general surgical support at KCH provided by vascular surgery.
Critical care anaesthetics	Provided on all 3 sites
Diagnostics	Provided on all 3 sites

2. High Risk Surgery

The classification of high risk surgery is validated through a number of national reports and papers. The high risk surgical patient has been considered from a clinical perspective in terms of:

- outcome risk, namely mortality;
- consideration for known co-morbidities; and
- types of surgery being performed, that would categorise such a patient as high risk and therefore benefitting from the full resources required to safely manage such patients.

Mortality definition for high risk is summarised in the documents referenced. All patients with a predicted mortality of >5% are considered to require a consultant surgeon and an anaesthetist present at their surgical intervention and most health care systems would accept this level as high risk. The Royal College of Surgeons unscheduled care paper additionally identified high risk as needing to include all predicted mortality, using risk scoring mechanisms of 10% or greater.

The Royal College of Surgeons and the Department of Health have both identified that the patients under consideration were those non-cardiac surgical patients, undergoing major gastrointestinal, bowel or vascular surgery i.e those patients:

- with an age greater than 50 years, undergoing urgent emergency or ‘re-do’ surgery;
- who have acute or chronic renal impairment;

- with diabetes; and
- who have a strongly suspected clinical risk factor for cardiac or respiratory disease.

With reference to procedure type, the paper written by Barrow and Anderson has identified in the emergency surgery review that of the 16 index operations, 14 were associated with mortalities> 10% and all procedures had a mortality rate of> 5%. On this basis, all were considered high risk interventions. Of the interventions assessed, all involved some form of gastrointestinal procedure or high risk hernia surgery or abscess drainage that required a laparotomy.

The same paper helpfully identified that appendicectomy and cholecystectomy (gallbladder surgery) was not included, although a proportion of these patients, because of the co-morbidities as defined in the Royal College and Department of Health document, exists and will stratify a patient with these conditions as potentially high risk.

In summary therefore, the literature from all national sources is consistent and enables EKHUFT to accurately identify those patients that are high risk. In addition, all of these factors have been taken into consideration when assessing the level of activity undertaken with the organisation and therefore the implications for patient pathways and capital and revenue costs.

3. The current pathway

Emergency General Surgery is currently provided at the QEQMH and WHH. The emergency teams provide an assessment and treatment service 24/7 to:

- GP direct referrals;
- self-presenters to the Emergency Department (ED);
- 999 emergency ambulances;
- 111 patients advised to attend; and
- all inpatients.

At KCH, vascular surgeons provide the general surgical advice for inpatients (mainly medical and renal) or self-presenting patients through the Emergency Care Centre.

4. The case for change - national

Recent national evidence has identified how safe surgical service should be delivered in the future.[1] [2] [3] [4] This was further emphasised by the Royal College of Surgeons invited review, commissioned by the Trust in late 2012. Following this the Trust has delivered a program of work to improve general surgical services and implement sustainable models of care to support current service provision.

[1] Keogh report, Review into the quality of care and treatment provided by 14 hospital trusts in England; overview report, July 2013
[2] Francis inquiry report (Mid Staffordshire NHS Foundation Trust) February 2013.
[3] The higher risk general surgical patient, Royal College of Surgeons and Department of Health 2011
[4] Major trauma care in England, National Audit Office, February 2010

As part of this it has been recognised that a negative consequence of the current on call model is that, due to skill mix, there may be multiple and potentially significant delays for patients on an emergency general surgical pathway and emergency treatment by inappropriately skilled surgeons.

The common themes which run through the Trust's Clinical Strategy and underpin the need for change within the organisation are the need:

- for consultant delivered care and senior decision making across all specialties;
- to embed the segregation of elective and emergency services;
- of greater specialism in general surgery; and
- to ensure consistent quality and safety in care 24/7.

Publications from both the Association of Surgeons for Great Britain and Ireland (ASGBI) [5] and the guidelines from the Royal College of Surgeons (RCS) on *"Standards for Emergency Surgical Care* [6] outline that outcomes for patients requiring out of hours surgery i.e. at night and at weekends, are relatively poor, as opposed to those treated during "normal" working hours on weekdays. Essentially the ASGBI and RCS argue that by focussing resources and workforce on delivering elective services to achieve waiting list targets, emergency services have become a second priority. This is further pressurised by sub-specialisation, again often driven by elective demand, which in turn increases pressure on emergency resources.

Against this backdrop, it is important to recognise that 90% of surgical mortality occurs in emergency surgery services. It is also clear from both reports that multiple site provision reduces the number of cases undertaken by surgeons and this in turn impacts on patient outcomes. Finally, there is also evidence at national and indeed international level, that suggests outcomes for patients suffering multiple / complex trauma (i.e. very severe injury) are better when they are treated promptly in specialist centres.

The publication "The Regional Trauma System - Interim Guidance for Commissioners" reflected similar points and standards as those made by the ASGBI and the RCS and last year the William Harvey Hospital (WHH), Ashford, became one of three Trauma Units for Kent and Medway.

Vascular surgery is now a distinct speciality, separate from general surgery. Consultants and junior doctors in vascular surgery are not trained or expected to support provision of emergency general surgery. This has been reinforced as an absolute standard in the specialized commissioning of vascular services standards.

The other important factor to consider, alongside emergency general surgery, is the provision of high risk elective general surgery. The co-location of high risk elective general surgery with the emergency surgery would ensure the best use of valuable resources.

[5] Emergency General surgery: The future a consensus statement, Association of Surgeons of Great Britain and Ireland, 2007
[6] Emergency Surgery standards for unscheduled surgical care, guidance for providers, commissioners and service planners, February 2011

5. The case for urgent change - local

The RCS review of general surgery in EKHUFT together with our own internal analysis clearly identified urgent need for improvement in service provision and set out some specific steps.

Address the sub specialisation issue of breast and non gastrointestinal surgeon provision.

Improve the emergency pathway, making it delivered by appropriate consultants on an inclusive basis and with continuity of care in the pathway – moving to a model of care involving week long provision of emergency services by a dedicated team – in contrast to the day on day off current rota whereby emergency patients lost continuity of consultant delivery of care.

The Trust addressed the breast surgeon issue at QEQM. This is not yet addressed at WHH

The Trust piloted a model to confirm suitability of the RCS recommendation with regard week long continuity of emergency surgery delivery at QEQM. This involved 2 surgeons, uplifted from a middle grade position to a locum consultant. This model has demonstrated the benefit of this form of week long service delivery and can now be used to model a Trust wide emergency general surgery service. However the lack of involvement of definitive consultant general and GI surgeons has been heavily criticised as being inappropriate and unsustainable, in a letter to the CEO and MD from the RCS in January 2014.

This model of care when shared with WHH surgical team, then opened up the clear vulnerability of the breast and endocrine surgeons being able to deliver emergency general surgery, when taking into account the sickest patients to be cared for were those with abdominal gastrointestinal conditions. These surgeons immediately acknowledged that their involvement in emergency general surgery delivery was inappropriate and would be a clinical governance risk. On the WHH site these 3 surgeons need to be replaced in a model of emergency general surgery provision.

EKHUFT vascular service has been required this month to submit its return to specialised commissioning and in it to confirm adherence to the standard of separation of vascular from general surgery. This puts an urgent need on the Trust to re-provide general surgical support on the KCH site, required in the 3 site delivery of medicine and ECC care and now deliver this without involvement of the specialist vascular unit with vascular dedicated consultants and junior doctors.

Additional pressures have been created by the resignation of consultant surgeon and the need to place another consultant surgeon on supervised practice for emergency surgery.

Unless a change to the model of care across the Trust is enacted there is an inability to construct definitive job plans for consultant emergency general and gastrointestinal surgeons which the organisation needs to do to attract and appoint. The Trust Board has fully supported this with the financial support previously given and the Division now needs to realise the full benefit of this by being able to appoint the highest calibre new consultants available.

Currently, at QEQM, there are eight substantive consultant general surgeon posts. Five of these are filled with substantive Gastro - Intestinal (GI) consultants and three are locums. These are the two locum posts funded post the RCS review to facilitate the two breast surgeons coming off the rota and an existing locum post.

Similarly at the WHH there are eight substantive consultant posts. Four of these are filled with substantive GI surgical consultants, one of these is filled by a locum in a substantive post. In addition, following the RCS review, a further locum post was funded. There is also an additional locum post.

Of the eight posts 3 consultants are non GI and include two breast surgeons and one endocrine surgeon, who similarly to those consultants at QE, now accept that they should not be undertaking general surgery on call. Within the eight, one consultant is unable to undertake on call due to restrictive practice and a further consultant has resigned effective from April. In the short term his post will have to be filled with an additional locum consultant ahead of substantive recruitment.

In summary, from April, at the WHH there will be two substantive consultants in post and a further two locums in post who are able to participate in the on call rota. To both replace the breast and endocrine surgeons and provide a viable on call rota, a further three locums will be required. Therefore from April the on call rota is unsafe and untenable and we have to consider how best to provide safe emergency general surgery.

Locum delivery of service is unsafe (training, calibre and competence of personnel) and is associated with significant clinical risk (evidenced with experience within EKHUFT and nationally). It is also very costly as the majority of locums have to be sourced through agency.

Training and the GMC. There have been and continue to be concerns regarding the standards of training and the patient safety aspects of service delivery. This is a known focus of the forthcoming CQC visit. The current position now exacerbated by the workforce pressures will continue these concerns. Any escalation of locum provision of service will be seen by the GMC, HEKSS, the RCS and most likely the CQC as unsafe. Training recognition would also be at risk, as recently experienced in the Trust.

Within the proposed recommendation of change there is a significant opportunity to enhance the training offered by EKHUFT which would be a very significant positive direction. It would better support the educational and University aspiration of the organisation and contribute to a more robust environment that would attract trainees and the satisfaction of external bodies.

The surgical division medical director and director have informed the need for urgent reorganisation to the Trust Executive Team and Trust Board of Directors.

The RCS have similarly informed the CEO and MD. The RCS have supported the work and the direction of change as presented and recommended in this document.

6. The options for consideration

a) To retain the current on call configuration with no additional resource
   - 2 hubs and a spoke at KCH

b) To retain the current on call configuration with additional resource
   - 2 hubs and a spoke at KCH

c) To move to one on call rota, but rotate the site on call between QEQM / WHH
   - 2 hubs and a spoke at KCH

d) To centralise emergency surgery only at a hub. Options include::
   a. QEQM
   b. KCH
   c. WHH

e) To centralise all high risk (elective and emergency) general surgery at a hub. Options include::
   a. QEQM
   b. KCH
   c. WHH

Option A – Do nothing 2 Hubs 1 spoke

This option would retain two breast surgeons and one endocrine surgeon on the on call rota at WHH and would therefore continue to deliver 2 consultant on call rotas in the short term. Board members will remember as part of the RCS report 2 breast surgeons have already been removed from the on call rota at QEQM.

Clinical co-adjacencies:

- Trauma – no change
- Paediatric surgery – no change
- Obstetric surgery – no change
- Gynaecology – no change
- Acute medicine – no change
- Critical Care/anaesthetics – no change
- Diagnostics – no change

Advantages	Disadvantages
Does not require investment	Does not align with national guidance or best practice.
	Unnecessary emergency general surgical pathway delays will continue.
	Does not support development of the breast service.
	Is not clinically sustainable due to the skill set of the surgeons.
	This model does not address the now real issue of delivery of emergency general surgery at KCH.
	This increases the reliance on locum delivery of this service. Continue with 2 locum consultants and further locum replacements
	Emergency surgical training would continue to be compromised relative to the workforce available.
	Continued reliance on locum consultants jeopardises on going training recognition as neither RCS or HEKSS would support this.

Option B – Provide additional investment to maintain 2 sites 2 Hubs 1 spoke

This option would support the two breast surgeons and endocrine surgeon coming off the on call rota at WHH, but would require immediate minimum investment in two additional consultant general surgical posts to support continued delivery of two on call rotas.

Clinical co-adjacencies:

- Trauma – no change
- Paediatric surgery – no change
- Obstetric surgery – no change
- Gynaecology – no change
- Acute medicine – no change
- Critical Care/anaesthetics – no change
- Diagnostics – no change

Advantages	Disadvantages
Does align with national guidance or best practice	Will require additional revenue investment into the service – 2 wte consultant locum posts.
Unnecessary emergency general surgical pathway delays would reduce as all surgeons would be expected to have emergency skills.	This increases the reliance on locum delivery of this service. This would result in 5 locum posts at WHH (2 additional and 1 to cover the resignation)– there would be more locums than substantive general surgeons at WHH.

	This could be partially mitigated by dividing the total locums across both sites. However in any scenario there would be 3 to 4 locums supporting the emergency surgical rota on both sites which could have significant patient safety issues. The division has faced great challenge in recruiting locum surgeons with the correct skills to support patient safety.
Does support development of the breast service.	Access to elective activity and theatres/clinics would be unachievable at WHH for additional locum surgeons. This will result in locums being required to fulfil emergency rota's but not able to contribute to elective services.
	Use of multiple locums is not clinically sustainable and is potentially unsafe
	This model does not address the now real issue of delivery of emergency general surgery at KCH.
	Increased reliance on locum consultants significantly jeopardises on going training recognition as neither RCS or HEKSS would support this.

Option C – rotate the emergency surgical hub 2 Hubs 1 spoke

This option would support the two breast surgeons and endocrine surgeon coming off the on call rota at WHH but would continue to require delivery of 2 on call rota's. This would be required as high risk emergency and elective patients would concentrated on the on call site for the duration of the take and would therefore require 24/7 consultant support for continuity of care to support patient acuity. It would not be appropriate to delegate this responsibility to the middle grade tier when the on call site rotates. The model would involve the base for the provision of general surgery on call rotating between QEQM and WHH and either a weekly or mid-weekly basis.

Clinical co-adjacencies:

- Trauma – no change
- Paediatric surgery – no change
- Obstetric surgery – no change
- Gynaecology – no change
- Acute medicine – no change
- Critical Care/anaesthetics – Increased support required on the on call site – likely increase in ITU beds during on call days with a decrease when on call rotates to other site.
- Diagnostics – Increased support required when on the on call site.

Advantages	Disadvantages
Does not require significant investment	Does not align with national guidance or best practice.
Unnecessary emergency general surgical pathway delays would reduce as all surgeons would be expected to have emergency skills.	Operationally complex to implement and manage and would be a patient safety risk.
Does support development of the breast service.	High risk elective patients on non on call site would require on call cover (all tiers)
	Investment in additional beds for on call period would be required, including ITU. Escalation flexibility would be significant and difficult to manage
	This model does not address the now real issue of delivery of emergency general surgery at KCH.
	Support from the Ambulance Trust is unlikely
	Poor local access for patients and likely transfer back to local site when stable.
	Reputational risk to the Trust due to public perception
	Training would not be improved and could be undermined as alternating the emergency surgical provision across sites would result in loss of continuity of care for admitting teams.

Option D – centralise emergency surgery 1 Hub 2 spokes (for emergency gen surg)

This option would centralise emergency surgery (not high risk elective) at one of our 3 sites (3 sub options) which would support the two breast surgeons and endocrine surgeon coming off the on call rota at WHH and would deliver a single consultant on call rota for the Trust at the hub. A second consultant would need to be on standby to be available to support the spoke sites if the emergency consultant was not available to give advice.

In a single hub and 2 spoke model of care the 2 spokes would be supported by consultants and their teams during normal working hours (Mon to Fri) and middle grade cover out of hours. If the hub was at WHH or QEQMH then KCH would require an additional middle grade / SHO tier to manage surgical patients safely, as the current cover provided by the vascular team is unsustainable.

In this option however, there would be a separation of high risk emergency surgery and high risk elective surgery. Whilst high risk emergency surgery is central, high risk elective surgery continues on 2 sites. This raises clinical governance concerns as high risk elective patients also require the same level of medical and resource support as the high risk emergency. This would likely require further expansion of the medical workforce to support this activity.

<u>Paediatrics and gynaecology support if the Hub were KCH</u>.

Paediatric emergency day case activity (abscess and scrotal conditions) could be managed at KCH in addition to WHH and QEQM. In-patient paediatric emergency general surgery (e.g. appendicectomy) would be managed at WHH and QEQM by the surgical teams on site and available to support these patients. A review of the emergency theatre operating log has shown

that very few children are operated on out of hours and these would be managed within the day activity. The Hub model has the 2nd consultant cover arrangement who could attend remote sites if absolutely required. Tertiary centre transfer could also take place, as is current.

If the hub were at KCH, potential patients with gynaecological conditions, should they attend KCH would be assessed by general surgery to rule out a general surgery condition. If then presumed or proven gynaecological a consultant to consultant communication would be had an appropriate management plan confirmed, including transfer to a gynaecology base if indicated (see core principles re: communications).

If the Hub were at KCH, on site day time surgical support would be available at QEQM and WHH, as with paediatrics. Similarly a review of emergency theatre activity in gynaecology identifies uncommon out of hours gynaecology emergencies and those performed did not usually require general surgical input. However in this rare circumstance the same arrangement as in paediatrics with regard the 2nd on call Hub surgeon attending would be available.

Clinical co-adjacencies:

- Trauma – no change.
- Paediatric surgery – no change.
- Obstetric surgery – no change
- Gynaecology – no change.
- Acute medicine – Transfer of patient if immediate surgical intervention is required.
- Critical Care/anaesthetics – Increased bed capacity at on call site with a decrease on spoke sites.
- Diagnostics – Increased support at on call site with a decrease on spoke sites.

Advantages	Disadvantages
Delivers a single consultant on call rota	Capital investment is required to centralise emergency surgery on any of the 3 sites.
Unnecessary emergency general surgical pathway delays would cease.	High risk elective patients on spoke sites would predominantly managed by middle grades out of hours.
Does support development of the breast service	Some or all of the surgeons will have to relocate their base for on call.
It is clinically sustainable	Potential increased medical workload on surgical hub site (non-surgical acute abdominal conditions)
Does align with national guidance and best practice for emergency surgery.	
There is a training benefit for tiers of junior doctors with access to the activity and experience an emergency hub would offer.	

Option E – centralise all high risk general surgery 1 Hub 2 spokes (for high risk)

This option would centralise emergency and elective high risk surgery at one of our 3 sites which would support the two breast surgeons and endocrine surgeon coming off the on call rota at WHH and would deliver a single consultant on call rota for the Trust at the hub.

In a single hub and 2 spoke model of care the spokes would be supported by consultants and their teams during normal working hours (Mon to Fri) and middle grade cover out of hours. If the hub was WHH or QEQM then KCH would require an additional middle grade/SHO tier to manage surgical patients safely as the current cover provided by the vascular team is unsustainable.

Paediatrics and gynaecology do not have a bed base at KCH and therefore in a situation where emergency general surgical intervention was required, an on call consultant surgeon would travel to the QEQM/WHH.

Clinical co-adjacencies:

- Trauma – no change
- Paediatric surgery – no change.
- Obstetric surgery – no change
- Gynaecology – no change
- Acute medicine – Transfer of patient if immediate surgical intervention is required.
- Critical Care/anaesthetics – Increased support required at hub site with a decrease on spoke sites.
- Diagnostics – Increased support at hub site with a decrease on spoke sites.

Advantages	Disadvantages
Delivers a single consultant on call rota	Significant capital investment is required to centralise high risk emergency and elective surgery on any of the 3 sites.
Unnecessary emergency general surgical pathway delays would cease.	Some or all of the surgeons will have to relocate their base for on call.
Does support development of the breast service	Potential increased medical workload on surgical hub site (non-surgical acute abdominal conditions)
It is clinically sustainable	
Does align with national guidance or best practice	
Supports centralised management of all high risk patients.	
If the hub is at KCH then surgery will align with vascular and urology	
KCH is geographically central	
If KCH then current middle grade/SHO could be utilised to provide resident on call at KCH	
There is a increased training benefit for tiers of junior doctors with access to the activity and	

experience an emergency and high risk elective hub would offer.	
It enhances the opportunity to utilise current funded and available medical workforce to provide extended hours of working.	

7. Estate Implications

The high level estimated capital and revenue costs related to the estate options are summarised below by option. It is important to note that in relevant options a revenue charge of £500,000 has been included for the current Pod theatre at the WHH.

Option	Short term Solution	Gold Standard / Longer Term Solution
Options A & B • Capital • Revenue	 £20,000 £500,000	 £800,000 £500,000
Option C • Capital • Revenue	 £960,000 £1,000,000	 £1,620,000 £1,000,000
Option D - QE • Capital • Revenue	 £460,000 £500,000	 £1,120,000 £500,000
Option D – K&C • Capital • Revenue	 £340,000 £500,000	 £390,000 £500,000
Option D - WH • Capital • Revenue	 £500,000 £500,000	 £0[7] £500,000
Option E - QE • Capital • Revenue	 £1,640,000 £1,000,000	 £3,940,000 £1,000,000
Option E – K&C • Capital • Revenue	 £1,540,000 £1,300,000	 £3,990,000 £1,300,000

[7] The £500,000 capital spend in the short term solution for the WH assumes a further 2 beds are used for the ITU from CCU. This would require the movement of CCU Step Down beds on to a ward. The longer terms solution does not remedy this move.

Option E - WH		
• Capital	£1,050,000	£3,400,000
• Revenue	£1,000,000	£1,000,000

The capital work at the WHH involves creating additional ward capacity in the Arundel Unit. The Unit currently has no medical gasses, ventilation or the correct bed head services for an acute setting. The work to put this in place would take a minimum of six months as the infrastructure to the building would need to be undertaken at the same time to enable this to happen. This essentially rules the WHH out as a site as the additional beds and ITU could not be provided in the short term to support a service move by May.

There is a similar time constraint around the costed delivery of a Surgical Assessment Unit (SAU) at both QE and K&C. However, the solution for the SAU at the WHH has been to co-locate the Unit on the CDU with very minimal capital works. If the same assumption is made for these two sites, the May deadline would be achievable on both. Initial work post the Board's decision has identified a short term option that looks deliverable by May at K&C and this is being pursued.

8. Core principles

The following points are core principles of any change and will underpin the service reconfiguration in order to improve patient outcomes and service efficiency:

a. Regardless of the hub site, the initial assessment of surgical attendances will be delivered as now with rapid transfer to the hub if urgent surgical intervention is required.
b. The hub site(s) would require the provision of Surgical Assessment Units to support the decision making, flow and appropriate admission of surgical patients.
c. Consultants will work in teams to provide care and incorporate enhanced recovery into patient pathways.
d. Service Improvement will be crucial to support the rapid development of emergency pathways such as cholecystectomy, 'hot clinics' and non-operative conditions.
e. Diagnostic protocols will need to be developed. This may reduce the overall bed requirement. Protocols for imaging need to be developed. The use of CT scanning and/or ultrasound is useful in the diagnostic pathway and should occur without undue delay. Contrast scans (IV or Oral or both) may be appropriate.

f. Robust transport and retrieval services to support and hub and spoke model will be required to support urgent transfer for immediate surgical intervention if required.

<u>The Ambulance / Transport Service</u>

g. Protocols to define which patients should be diverted straight to the Hub will need to be developed in association with SECAMB. Less than 10% of acute abdominal pain requires urgent surgical attention. It will be essential that this group of patients can be triaged to the Hub, and ideal that other groups can be sent to the hub without unnecessary delay

h. Patients presenting with non-specific abdominal pain to the surgical Hub that do not require admission for observation must have the ability to return either to the referring hospital, or back to their home. Immediate transfer arrangements must be established. Once a patient has been deemed to require transfer to the Hub this should occur without delay. The Trust will look at recovery transport service. This will be required for safe patient transfer in

EKHUFT, irrespective of models of care as it already works across multiple sites and requires transfer arrangements.

Communication

i. It will be essential to ensure that communication between clinicians is robust, rapid and reliable. Vidyo, VC – or similar should be embedded. Vital-Pac has been implemented across the Trust and iPad technology should be utilised to its full capacity.

j. All Investigations – Point of Care and others should be visible from any site on PACS/PAS etc.

k. GP "hot line" to ensure rapid communication between GP's and Consultants can take place

l. Spoke to Hub communication will be essential and done at consultant level

m. Communication and hand-over tools will need to be developed to allow for team working. Clear agreed protocols of care will need to be developed.

8. Recommendations

The Surgical Division raised the issue of the impending clinical risk with the emergency surgery rota at WHH and this was then discussed at length by the executive team. Presentation of the issues and all of the potential options with the relevant advantages and disadvantages were analysed in depth with the senior divisional management and clinical team.

An extraordinary Board Meeting was held on Friday 14th February 2014 and the recommendation to centralise all high risk elective and emergency high risk surgery at the Kent and Canterbury Hospital (option E) was made to the Trust Board. The Trust Board accepted that the potential patient safety issues that would result if no action was taken were unacceptable and endorsed the recommendation.

A fully constituted Public Board is now asked to formally agree the above decision.