Trust Policy		Worcestershire Acute Hospitals NHS Trust

Countywide Emergency Surgery Triage Clinic

Department / Service:	General Surgery
Originator:	Mr. Anthony Perry
Accountable Director:	Amanda Markall
Approved by:	Divisional Management Team
Date of Approval:	19TH October 2017
Review Date: **This is the most current document and should be used until a revised version is in place**	19th October 2019
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	ED/SCUDU
Target staff categories	

Policy Overview:
In line with FoAHSW and to address concerns raised by our CQC reports, the Trust will implement the plan agreed by all stakeholders to centralise all inpatient emergency general surgery at the Worcestershire Royal Hospital site on (20th Nov 2017). Sitting alongside the acute inpatient take (led by the admitting consultant of the week), the directorate of general surgery will establish a new innovative emergency surgery triage clinic for adult referrals which will be delivered by a second consultant GI surgeon. The aims of this new service are to improve patient flow, speeding the investigation and assessment of some patients, preventing admission and managing some conditions in an ambulatory fashion. This document provides an outline of how this will function

Key amendments to this guideline

Date	Amendment	By:
October 2017	New Document approved	TLG

Contents page:

1. Introduction

In line with FoAHSW and to address concerns raised by our CQC reports, the Trust will implement the plan agreed by all stakeholders to centralise all inpatient emergency general surgery at the Worcestershire Royal Hospital site 20th November 2017. Sitting alongside the acute inpatient take (led by the admitting consultant of the week), the directorate of general surgery will establish a new innovative emergency surgery triage clinic for adult referrals which will be delivered by a second consultant GI surgeon. The aims of this new service are to improve patient flow, speeding the investigation and assessment of some patients, preventing admission and managing some conditions in an ambulatory fashion. This document provides an outline of how this will function

2. Accommodation

As part of the Trust's winter plan and reorganisation of the Emergency Department, we will be provided with 2 fully equipped consulting rooms. There is a separate waiting area for the 2 consulting rooms. This area will be used between the hours of 8000 to 1800 hours, Monday to Friday.

The consulting rooms will have computers with full access to the trust's IT systems, printer, and telephone landline/fax.

- An examination/treatment trolley with overhead light and the equipment/ability to undertake simple investigations and/or treatments such as:
- Rigid sigmoidoscopy/proctoscopy
- blood tests
- urinalysis
- ECG
- wound/stoma dressings
- suture removal
- simple aspirations eg seromas
- LA I&D eg collections or abscesses

The reception will be a stand-alone facility and will be manned by a HCA who will be dual trained to provide both clinical and admin support. This was not initially funded as part of the winter planning bid due to location change and the Directorate would be keen to pursue any additional monies available from winter funding slippage.

3. Workforce

Leadership

Medical clinical leadership for the ESTC will be the clinical leads for emergency surgery (currently shared between upper GI and lower GI clinical leads). The advanced Nurse Practitioners are led by the Matron for general surgery at WRH. Operational leadership of the Unit will be under the direction of the directorate manager for general surgery.

Clinical Supervision of/ultimate responsibility for junior doctors and their decisions will be taken by the admitting consultant at WRH.

ESTC clinical staffing
Consultant Gastrointestinal Surgeon via shared rota
Advanced Nurse Practitioner
HCA (who will be able to assist with observations, patient monitoring, assisting with patient flow between departments

4. Implementation

In view of the short lead-in time for the full county-wide changes to occur it is intended that there will be two phases:

- In phase one (Monday 20th November 2017 until week commencing 8 January 2018) the clinic will run from 08:00 to 18:00 Monday to Friday
- In phase two (from 8th Jan 2018) the clinic will run from 10:00 to 18:00 Monday to Friday **to allow a ward round on base surgical wards (Beech in the main) to enable daily consultant ward round of all patients. Post take patients will continue to be seen by the on-call surgeon.**

5. Referral Process & Pattern of Referral

GP Connect will be implemented if possible from the outset. The service will run this through a single mobile phone (with answerphone facility) which will be held by the Consultant of the week responsible for the Emergency Surgery Triage Service. There will be landline number in the clinic/ EAC and the ANP will be contactable by bleep.

Traditionally the most junior members of the team received the emergency referrals and the automatic default is to accept and admit all patients for assessment. In order to maximise the benefits of the new service, it is necessary for the ESTC Consultant to be the gatekeeper for the acute general surgery emergency take. There is published evidence that suggests this senior triage of calls reduces the number of attendances, but will also maximise the number of patients that are seen in the triage clinic.

A referral proforma (separate attachment) which should be available in electronic and paper forms will be filled in.
This referral form includes the exclusion criteria for ESTC. As there is no facility to keep patients on trolleys, this pathway is only suitable for ambulatory patients who are able to sit and wait, similar to an outpatient clinic. Systemic signs of sepsis or on going diarrhoea and vomiting are also exclusions.
The service is for adult patients and the existing well-established paediatric emergency referral pathway via the Paediatricians on-call will remain in place.

Following clinical discussion and senior triage, the possible outcomes are:

- Simple advice/signposting to other services
- ESTC attendance
- Direct admission to the admitting emergency surgery team (via SCDU or ED depending on clinical stability). The details of the accepted admission will be passed to the admitting surgical team and SCDU/ED.

Out of hours/ weekend referrals to the WRH/AH surgical teams can be considered for next-day ESTC if appropriate. The referral proforma will need to be completed (including patient telephone

number) and e-mailed to an ESTC generic e-mail address. The ESTC team will contact the patient the following morning to pull them into the clinic at an appropriate time.

If the patient is referred by their GP to the surgical team out of hours, the default position is that the patient will go to SDCU, unless their condition requires resuscitation in which case they will remain in ED.

GP/Community Referrals

All GP calls throughout the county will be directed via the main WRH switchboard to the mobile phone which will be answered by the Consultant Surgeon between 0800 and 1800. In case of difficulty (eg with signal coverage) the ANP bleep or clinic landline can be used for back-up.

Out of hours the GP/community referrals will go through to the WRH admitting team (via 688 or 699 bleeps)

Referrals from A&E at WRH

- Monday to Friday 08:00 to 18:00 Following ED assessment suitable ambulatory patients are to be referred to the ESTC directly. Outwith these times suitable referrals can be made either via the admitting WRH team, or by e-mailed referral proforma, as above.

- Referrals from A&E majors/resus, critically ill patients or those with potentially life threatening conditions clearly requiring emergency inpatient admission should be referred directly to the admitting surgical team via bleep 688 or 699. Specialty response time should be within 60 minutes, as per the trust's professional standards.
  If there are significant delays or difficulties with getting hold of the inpatient team or with the referral process, then the ESTC Consultant could be notified to help identify the blocks and to co-ordinate the patient's assessment and appropriate transfer from ED.

Referrals from A&E at Alexandra Hospital

West Midlands Ambulance Service will bring all emergency general surgery problems directly to Worcestershire Royal Hospital. There will be some patients who present via A&E at the Alexandra Hospital (eg incorrect triage, or as walk-in patients).

In phase 1, following triage and assessment by A&E, the onsite on-call middle grade for general surgery should be contacted via switchboard. They will see and assess patients in A&E within 30 minutes of referral and will be able to co-ordinate further care (via ESTC or admitting team at WRH).

In phase 2, rota changes for the Alexandra middle grade would mean that referrals from A&E will be made in the same way as referrals from WRH A&E(above)

There will be no facility to admit patients to the Alexandra Hospital site.

Referrals from other inpatient specialties

At WRH in patient referrals should be made to the admitting surgical team via the SHO (bleep 688) or Specialist Registrar (bleep 699). Consultant reviews for these patients will involve the admitting WRH consultant of the week.

At AH inpatient referrals should be made to the surgical middle grade surgeon (via Alex switchboard) who will available 7 days per week. Following assessment and/or investigation and dependant on the nature of the condition, the middle grade surgeon will decide which further pathway is required. This may involve an on-site GI consultant (Monday to Friday), weekend WRH ward round consultant or the admitting WRH consultant. If necessary either the consultant will travel to the see the patient at the AH or the patient will be transferred to the WRH as necessary.

As these patients are not ambulatory the ESTC consultant would have no role in their assessment.

Patient assessment in ESTC

Assessment for attending patients should commence within 30 minutes of their arrival.

All patients will have a baseline set of observations and NEWS score including:

- height, weight, BMI
- pulse,
- blood pressure,
- respiratory rate,
- temperature,
- oxygen saturations.

A full clinical assessment with history and examination will be performed by the ANP/Consultant team and fully documented.

Further investigations will be dictated by this and may include:

- Urinalysis (with BHCG for women of childbearing age)
- blood glucose levels,
- ECG
- Venous/arterial blood sampling.

Requests will be made via the Trust's ICE system.

Plain radiology can be ordered via ICE and performed at the A&E radiology unit.
Rather than timed radiology slots, there is a commitment to carve out up to 8 ultrasound slots per day and throughout the day, for ESTC patients. They will be requested on the ICE system and patients will present to the level 1 radiology ultrasound department to sit to wait for an appropriate slot before returning to the clinic.
There will be one or two CT slots per day, which will have urgent priority in radiology

As soon as they are available, the results of the various investigations will be collated and a management plan formulated by the Consultant Surgeon.

Potential outcomes

- Discharged , either with no further follow-up or elective or ANP-led telephone follow-up

- Discharged with ambulatory treatment (patients discharged with FP10 prescriptions) and for a planned review back in the ESTC

- Discharged with planned elective surgery to most appropriate site and avoiding WRH site as much as possible (ideally TCI date to be arranged and patients sent home with Electronic Consent and information sheets).

- Discharged with return to SCDU/TAU for emergency theatre (main CEPOD /CEPOD surge or urgent slot on elective list at WRH). The patient should be given electronic consent and information and the case will need to be booked on the usual theatre booking process via the acute admitting team. The admitting consultant of the week will be responsible for the patient's treatment upon admission via SCDU or TAU.

- Typically for general cases (eg I&D absceses, diagnostic laparoscopy, laparoscopic appendicectomy) will be the admitting Consultant of the week who will be responsible for the care of admitted patients.

- It is anticipated that a flexible arrangement throughout the week will be adopted by the admitting surgical team and the ambulatory clinic team so that surgical sub-specialty expertise can be brought to bear on the treatment of emergencies. Mutual agreement by the consultants will determine who is best able to admit, treat and be responsible for each case.

- If the ESTC consultant is operating in CEPOD theatre, then the other consultant of the week (ie: on-call consultant) will be responsible for the ESTC duties.

- Immediate admission to an inpatient bed for SCDU

  Patients should only be admitted if their medical needs cannot be met by ESTC

Typical patients who will be seen and assessed in the ambulatory clinic include those with:

- abscesses
- minor post-operative wound issues
- right upper quadrant pain
- right iliac fossa pain
- fit patients with left iliac fossa pain
- painful herniae
- painful jaundice
- low volume rectal bleeding.

Having a daily ESTC clinic provides the opportunity to monitor the evolution of acute abdominal pain in an ambulatory way rather than with admission until there is diagnostic clarity. This is obviously supported by

- Rapid access to radiology.
- Protocols for the treatment of acute diverticulitis
- Acute biliary presentations requiring immediate admission are:
- Cholangitis
- Severe cholecystitis requiring intravenous antibiotics and inpatient monitoring
- Acute pancreatitis
- Biliary presentations which can be managed on an ambulatory basis include
- Well patients with 'surgical jaundice'

- Mild cholecystitis requiring oral antibiotics
- Acute biliary colic

It is anticipated that an acute biliary pathway over the winter utilising upper GI WRH lists and/or a surge CEPOD facility will be utilized for the management of this group of patients.

All contemporaneous patient records will be submitted for scanning after the patient pathway is complete using Trust systems.
On-going reviews may require records to be held in a secure facility. The concept of a virtual ward for patients
discharged and awaiting elective or urgent surgery will be developed.

5. Data Collection

A prospectively collected electronic database of patients will be collected to allow audit of activity, outcomes etc. A patient satisfaction questionnaire/friends and family test should be offered.
Information regarding PALS and complaints should be freely available

6. Discharge Information

The patient database has been developed to allow easy and immediate production of a clinic letter. This will be copied to the secretary for filing in Bluespier and eZ notes, the patient (who will take a printed copy with them) and the GP.

Patients will receive specific advice about their diagnosis and the anticipated natural history. They should be informed about symptoms and signs which may cause alarm, and the details of how to seek help in and out of hours.

We will develop an ANP-led next day follow-up telephone consultation for all patients who have been discharged.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Monitoring of patients attending the ambulatory clinic will be via the trust IT systems and departmental database. Numbers of patient admissions and avoided admissions will be kept and a dashboard with KPIs will be maintained.	The consultant surgeons will monitor compliance with the policy	Checks will be undertaken monthly in the first instance and then quarterly	Consultant surgical leads will undertake the check	The results of audits will be presented to the Divisional Surgical Board	Monthly initially and then quarterly.

7. Policy Review

The policy will be reviewed in April 2018 at the end of the Winter period. This service has initially been agreed and funded to reduce pressures in ED over the winter period. In Q3/4 the service will be evaluated and a full business case will be developed to enable the service to continue into 18/19.

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the Policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the Policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	NA	
6.	**What alternatives are there to achieving the Policy/guidance without the impact?**	NA	
7.	**Can we reduce the impact by taking different action?**	NA	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	Receptionist / HCA required and not currently funded (seeking slippage from winter funds and FBC for ongoing service is being developed)
4.	Does the implementation of this document release any manpower costs through a change in practice	Yes, consultant on-call costs will reduce
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	Not material
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval