Worcestershire Acute Hospitals NHS Trust

# Transfer of Elective Gynaecology Surgery to Alexandra Hospital and Kidderminster Treatment Centre Updated Standard Operating Procedure (SOP) Clinical Management of Patients

| | | |
|---|---|---|
| **Key Document code:** | WAHT-TP-027 | |
| **Key Documents Owner:** | Miss Alex Blackwell | Consultant Obstetrician and Gynaecologist |
| **Approved by:** | Gynaecology Governance Committee | |
| **Date of Approval:** | 11th March 2022 | |
| **Date of review:**<br>**This is the most current version and should be used until a revised document is in place** | 11th March 2025 | |

## Key Amendments

| Date | Amendment | Approved by |
|---|---|---|
| 11th June 2021 | New document created | Gynaecology Governance Committee |
| 21st September 2021 | Bleep numbers updated | Alexandra Blackwell |
| 11th March 2022 | Document updated to include details of consultant post op ward rounds at AHR and KTC | Alex Blackwell |

## Aim and scope of Standard Operating Procedure

This procedure describes the Trust-wide arrangements for the clinical management of patients, including complications, following elective gynaecology surgery at Alexandra Hospital and Kidderminster Treatment Centre.

### Abbreviations

| | |
|---|---|
| AHR | Alexandra Hospital Redditch |
| WRH | Worcester Royal Hospital |
| SBH | Spire Southbank hospital |
| KTC | Kidderminster Treatment Centre |
| BMI | BMI Droitwich Spa Private Hospital |

The Covid-19 pandemic limited significantly the delivery of elective gynaecology surgery in WRH. Arrangements were made in collaboration with the independent sector (BMI and SBH), which enabled WAHNHST consultants to deliver some gynaecology surgical procedures in a carefully selected group of patients. This collaboration with BMI and SBH has now ended.

In order to continue to offer a full range of surgery in gynaecology we have developed a plan to deliver an increased surgical service in the AHR and KTC. Elective major gynaecology surgery has not been performed in KTC and AHR for a number of years. Therefore, there is the need to establish protocols to ensure the safety of these patients. There are steps in this transition which will have to be strictly followed in order to minimise the risk of and optimise the management of postoperative complications that may result in repatriation of patients to WRH site. These include:

Patient selection
Operative standards
Postoperative care and Escalation

This SOP will also address the management of patients who, following gynaecological surgery at AHR or KTC, develop significant complications which require further surgical intervention, and/or do not progress as expected and need supportive treatment or specialist input not available at present at AHR or KTC.

It will include:

Identification of sick patient
Transfer protocol
Audit and Monitoring of outcomes

## Patient selection

1) The Theatre Users Safety Committee has established detailed patient selection criteria for surgery at KTC and AHR. While based on previous case selection, the complexity of medical and anaesthetic co-morbidities has been increased as well as the complexity of the surgery offered.
2) All cases to be performed at AHR and KTC will be selected in line with these admission criteria with reference to any MDT recommendation but it is ultimately the decision of the operating gynaecology surgeon and the consultant anaesthetist who may decide to advise surgery only at the WRH site if clinically appropriate. Case selection is paramount and it is expected that there will be still a significant number of “high risk” cases that will need to be operated on in the WRH site.
3) Initially, cases with the lowest risk of intra-operative or post-operative complications will be selected. This will allow a safe start of elective intermediate and major gynaecological surgery at AHR and KTC. Once systemic confidence increases we will then be able to maximise the utilisation of theatre lists.
4) Cases will be scheduled for theatre according to their clinical priority as defined by RCOG and with reference to the Trust selection criteria. Attention will also be paid to the postoperative care delivery at the site of surgery acknowledging that the operating team will not usually be able to attend the patient for postoperative review.

## Operative Standards

1) Gynaecology consultants are comfortable with the delivery of care across all Trust sites but several consultants have not performed major gynaecology surgery at KTC or AHR. The operating consultant will be supported as requested and there will sometimes be a requirement for 2 consultant gynaecologists to operate together. (It is worth highlighting that all colorectal major cases will have 2 consultants operating together while colorectal surgery is embedded at AHR.) The need for 2 consultants will be at the discretion of the main operating surgeon. Where possible, it may be suitable for a case to be performed by solo consultant with middle grade doctor assistance but additional senior presence will allow extra support to theatre staff in getting familiar with this type of surgery.
2) Additional operating time will be needed to allow surgical teams to become familiar with operations, equipment and staff.
3) Middle Grade attendance will be encouraged in order to allow training opportunities, and will be at the discretion of operating surgeons.

## Postoperative Care, Escalation and on call consultant availability

1) Care will be taken by the operating team to ensure the postoperative care instructions are relayed clearly to the ward staff by writing in the post operative instructions on the operation note and all medication and fluids must be prescribed – including VTE prophylaxis - before leaving the site.
2) The operating consultant and anaesthetist will review each patient at the end of the list before leaving the site.
3) Before leaving the hospital site the operating team will ensure that the Gynae on call team are aware of the patients from their operating list and the on call team will ensure the patient details have been added to the Gynae Handover sheet held at WRH and updated twice daily by the Gynae on call team.
4) In addition, a Microsoft Teams Chat (to be managed by the Women and Children's Division Operations Team) will include all consultants, MG and junior doctors and will be used as the main facility to handover and communicate information about each post operative gynaecology patient at the Alexandra and Kidderminster sites.
5) When the operating team have left, the evening, overnight and daytime ward cover of these patients will be provided by the established urology/general surgery FY/CT at the AHR and by the established RMO at KTC.
6) It is expected that post op Gynae surgical patients will be reviewed daily by the ward urology / general surgical FY/CT at AHR and RMO at KTC. A daily postoperative consultant gynaecology ward round will be scheduled at 8am on Weds / Thurs and Fri at AHR and Tues / Weds / Thurs at KTC. The details can be found on Medirota https://worcsacuteobs.medirota.com and access details can be obtained from the Gynae Admin Team on Ext 39444.
7) Outside of the time of the theatre list or the formal ward round any clinical concerns should be escalated immediately to the on call Gynaecology Team at WRH.
8) In the event of clinical deterioration of a postoperative patient, the junior doctor or RMO should contact the on call gynaecology team at WRH. On call gynaecology registrar bleep 654 or on call gynaecology consultant bleep 474 (8-6) or contactable through switchboard out of hours. The on call gynaecology team will likely contact the operating surgeon however to minimise delay in the first instance the ward team are advised to contact the on call Gynae team at WRH who are readily available to advise.

9) Postoperative nursing care support is available 24 hours a day from the Emergency Gynaecology Assessment Unit (EGAU) Ext 30425.
10) Several documents relating to Gynaecological care are available at http://www.treatmentpathways.worcsacute.nhs.uk/womens/gynaeoverview/gynaecology-key-documents/ Specifically there are patient information leaflets and a departmental guideline about bladder care after gynaecological surgery.
11) Bladder care after gynaecological surgery is different to urology surgery and patients with bladder emptying difficulties should be managed with close attention to the Gynaecology guideline. Support is readily available through the on call medical team or the EGAU Ext 30425.
12) Before discharge, all patients must receive the patient information leaflet 'Advice following Gynae Surgery' which contains the telephone number for the Emergency Gynaecology Assessment Unit (01905 761489) which is the first point of call for complications in the immediate postoperative period.

Despite the above planning, there is an expected but low risk of patients developing complications following their elective surgery. There is presently no facility for out of hours gynaecology emergency surgery at AHR or KTC and as such any patient needing return to theatre out of hours will need postoperative transfer to WRH.

## Identification of sick patient

1) Gynaecology patients who have undergone elective gynaecological surgery may need urgent post transfer to WRH if their surgery has been more complicated than anticipated; if they are at high risk of postoperative complications or need supportive treatment not available at AHR or KTC(i.e. more than once daily or weekend gynaecology consultant input) or if they are likely to require emergency surgery (i.e. bleeding concern).
2)

These patients will be identified either by the operating consultant and/or junior team providing postoperative care at KTC or AHR .

It is expected that the first port of call for any concerns with gynaecology patients will be the FY1 or FY2 covering the ward at AHR or the RMO at KTC. The second port of call will be the gynaecology registrar on call at WRH Bleep 654 and they may escalate concerns to the gynaecology consultant on call at WRH Bleep 474 or via switchboard out of hours. It is of course acceptable for the nursing staff caring for the patient on the post op ward to make a jump call to the gynaecology on call registrar or on call consultant if needed. The operating consultant (who is not on call) may not be available out of hours and to minimise delay the on call gynaecology team should be the first point of contact in the event of clinical deterioration.

Following assessment of the case, if a transfer of the patient is required the following protocol will be followed.

## Transfer Protocol

The transfer of patients from the Alexandra Hospital Redditch or Kidderminster Treatment Centre to Worcester Royal Hospital would be appropriate in two distinct circumstances:-

1) Transfer of the sick patient
2) Transfer of the patient who fails to thrive post op for example due to postoperative complications

### 1) Transfer of the sick patient

If a patient in need of transfer has been identified by the nursing staff; the junior tier; the RMO or the on call gynaecology registrar then the gynaecology consultant on call at WRH must be involved. It is likely that the on call gynaecology consultant will review the patient on arrival at WRH but earlier review at AHR or KTC may be possible depending on the location of the on call consultant and other clinical pressures. The need for theatre should not be a requirement for patient transfer (although patient transfer will be required if there is a need to return to theatre). If they are unwell, they will be sent in a WMAS Bliue light ambulance across to WRH.

If any patient needs to go back to theatre at WRH, the on call gynaecology consultant will be present.

ICU involvement may be sought if transferring a critically ill or unstable patient between Alex and WRH.

### 2) Transfer of the patient who fails to thrive post op

Elective gynaecology patients would be expected to have a post-operative length of stay of 1-3 days maximum, 3-5 days if midline surgery. We expect patients to follow a traditional post-operative course, as dictated by Enhanced Recovery After Surgery (ERAS). Should a patient deviate from the normal post-operative course, the nursing staff, the junior tier or the RMO should contact the on call gynaecology registrar (bleep 654) or the gynaecology consultant on call (bleep 474) at WRH. It may be possible to arrange assessment of the postoperative patient on the post op ward depending on gynaecology service provision and staffing levels but it may be necessary for such patients to be transferred to WRH for senior review. Priority of transfer should be equivalent to the above mentioned requirements of critically unwell patients.

## Audit and review of SOP

Adequate monitoring of the activity and special focus on patients complications and logistic difficulties encountered will be essential to safely start and increase elective major gynaecology surgery at AHR and KTC. This will include:

### Contemporaneous Audit and presentation at Gynaecology Governance

1) A contemporaneous database to be kept by Gynae Governance whereby incidents will be closely monitored including:
    a. Returns to theatre
    b. Transfers to WRH

c. Other post-operative complications
d. Any theatre incidents
e. Ward incidents
f. Concerns from any member of team
g. Complaints

**6 Month Review**

1) The 6 month review will consider
    a. Patient outcomes (length of stay),
    b. Transfers,
    c. Morbidity and mortality data
    d. Consultant opinion regarding suitability of the arrangements for post op care including ward rounds and out of hours cover.

2) It is our understanding and expectation that our outcomes and overall experience should be similar to postoperative care at WRH.

## Break Clause – Immediate stop to proceedings

Should we identify a patient safety concern, the Gynae Directorate reserve the right to put an immediate halt to elective gynaecological surgery at AHR or KTC should we as a group feel the need to do so.

## Other sites

This SOP could also be applied to cover the care of NHS patients operated on as NHS patients at private provider institutes such as BMI Droitwich and SBH by NHS gynaecology consultants from WAHNHST within their NHS role. This SOP would not include private patients at other hospitals or NHS patients receiving care from a gynaecology consultant working outside their NHS contract.

## References

1. Case Selection Criteria for surgery at KTC and AHR – requested from Theatre Users Safety Committee April 2021
2. Restoration and Recovery: Priorities for Obstetrics and Gynaecology. A prioritisation Framework for care in response to COVID 19. RCOG May 2020.
3. Standard Operating Procedure for the transfer of elective colorectal surgery to Alexandra Hospital - clinical management of patients. P Sivathondan April 2021.