Surgical Ambulatory Care:
The Huddersfield Experience

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Calderdale and Huddersfield NHS Foundation Trust

Surgical AEC Cohort 1 Launch Event, London
Tuesday 28th March, 2017

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A bit about us…

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A bit about us…

- 10 consultants
  - 6 Colorectal
  - 4 Upper GI / Bariatric
- All on full acute rota
- 150-180 emergency laparotomies per year
- 25-29 acute admissions per day
- Accredited colorectal cancer and NHS bariatric units
- Trainees from Yorkshire and the Humber Deanery

A bit about us…

We’re quite like everyone else!

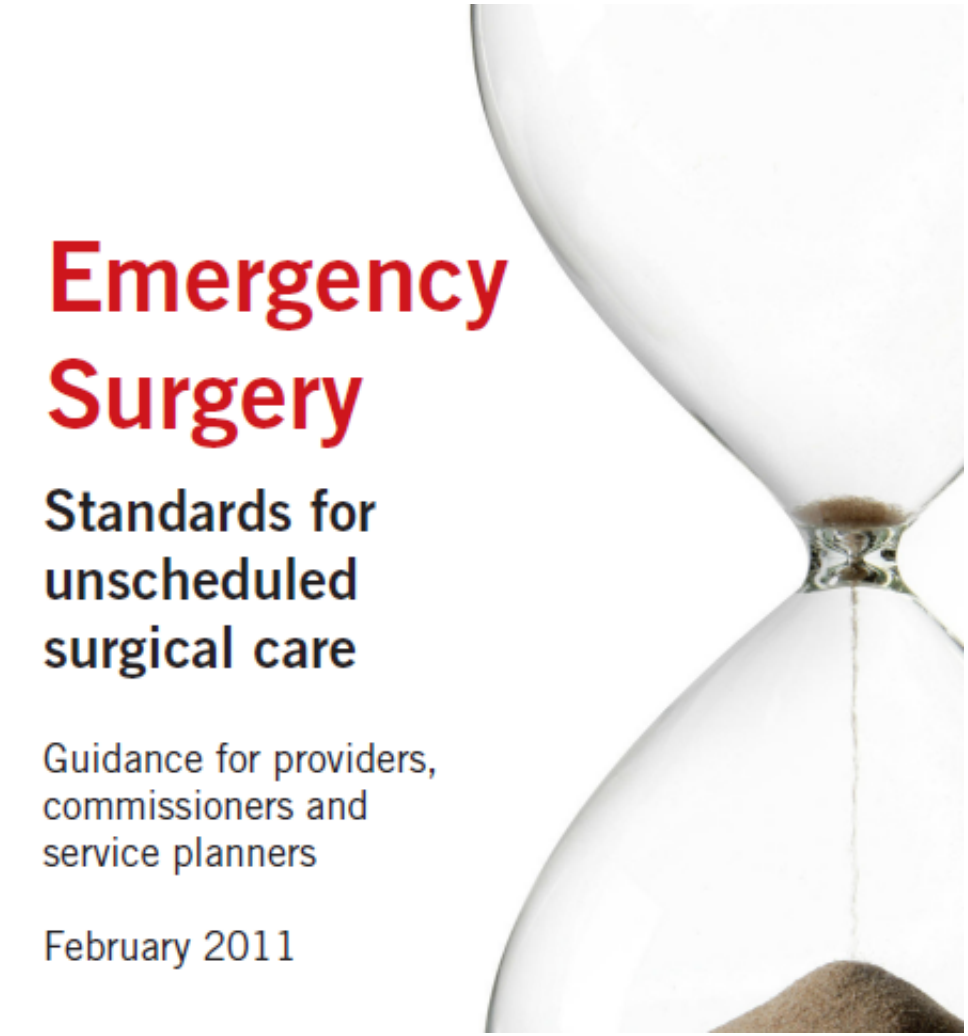
Aims of today

- To describe:
  - The way we were
  - Our Mission Statement
  - Why we changed
  - How we changed
  - The way we are now
  - What we've learnt and what we can teach
  - **What's next**

Why change?

- We never have enough beds
- Elective patients were being cancelled
- The emergency rota was becoming harder and harder to do
- Not all decisions were being made by the consultant
- Things were ‘parked’ till the morning
- We were ‘OK’ – no worse than our neighbours but no better

Why change?



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Our Surgical AEC Unit – what we didn't have

- More consultants
- More money
- More space
- More juniors

Our Surgical AEC Unit – what we had

Surgical Admissions Unit – Level 4, Ward 9

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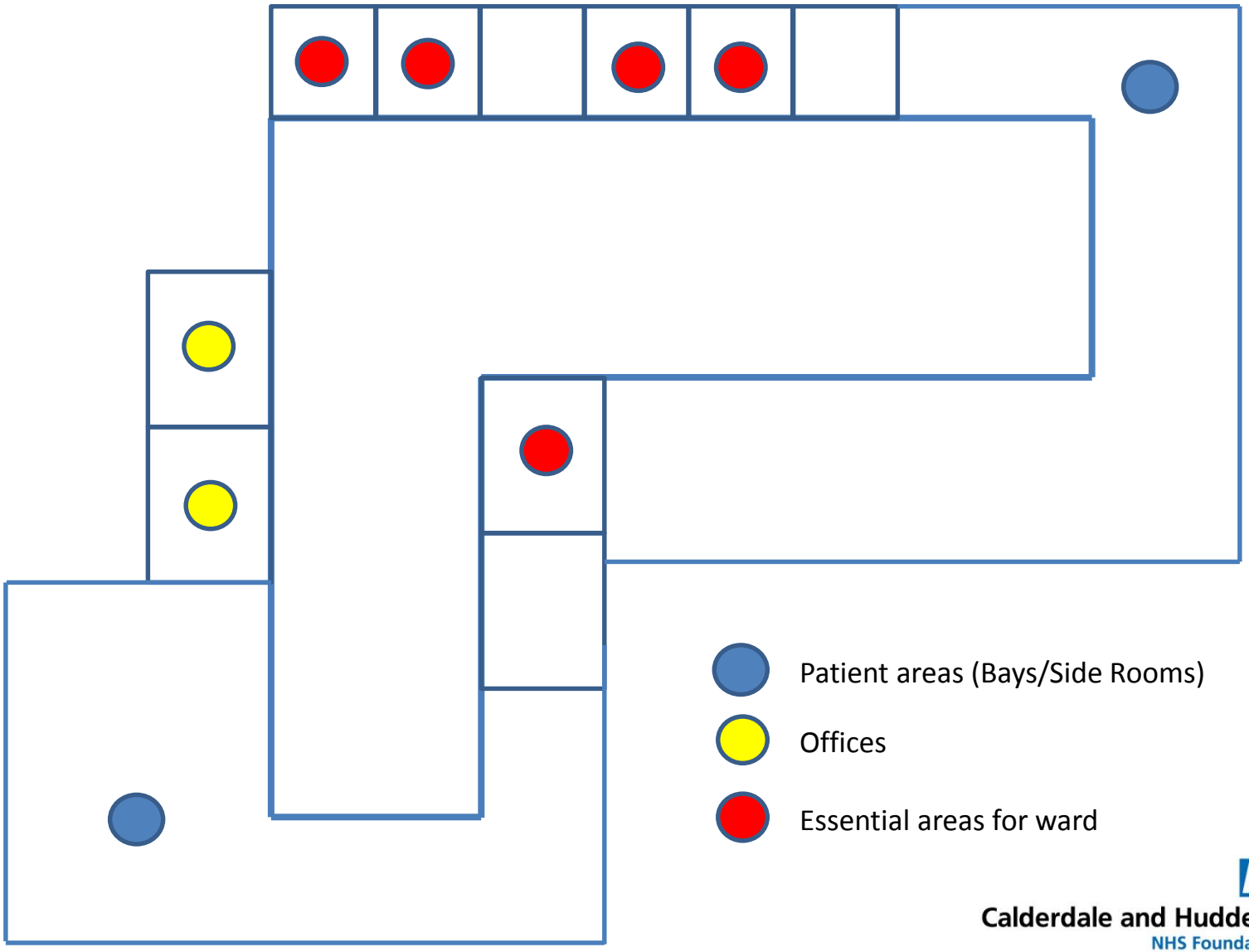

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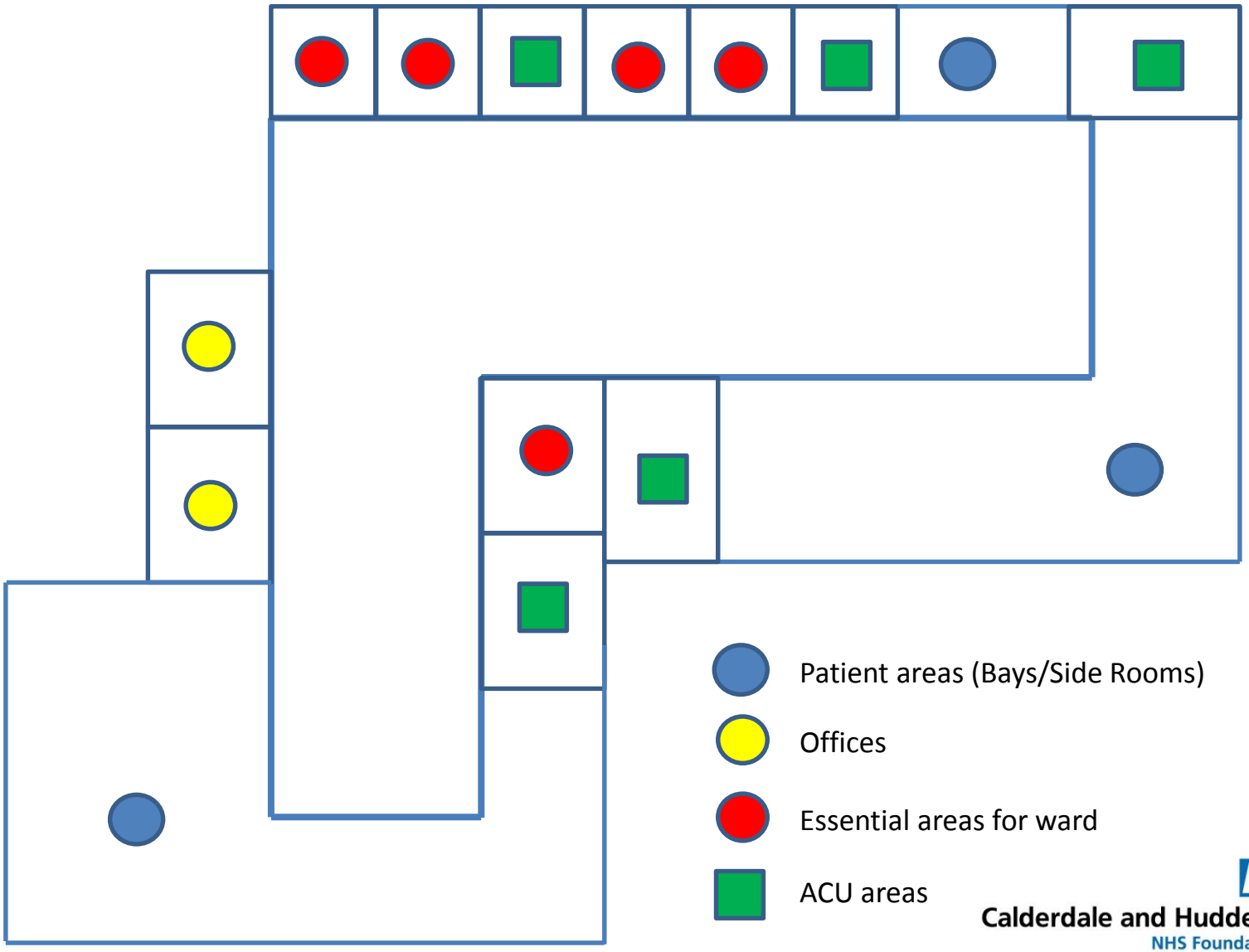
Surgical Admissions Unit – Level 4, Ward 9



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Surgical Admissions Unit – Level 4, Ward 9

- **We lost**:
  - 4 beds
  - 2 storage areas
- **We gained**
  - Ambulatory treatment area
  - 3 assessment rooms
  - Waiting area

Surgical Admissions Unit – Level 4, Ward 9

- **We changed**:
  - Registrar rotas
    - Separate on-call and CEPOD registrars
    - SAU clinic
    - Ambulatory assessment area
    - Referral protocols (GP and A+E)
  - Nursing responsibilities
    - Development roles
    - Empowered nurses (Bleep 331)
  - Links with other departments
    - Radiology / Theatres / Anaesthetists

The way we were

Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun
1	48 hours on call		CEPOD	Elective	Elective		
2	Elective	Elective	Elective	Elective	Elective		
3	Elective	Elective	Elective	Elective	Elective		
4	Elective	Elective	Elective	Elective	72 hours on call		
5	CEPOD	Elective	48 hours on call		CEPOD		
6	Elective	Elective	Elective	Elective	Elective		
7	Elective	Elective	Elective	Elective	Elective		
8	Elective	Elective	Elective	Elective	Elective		
9	Elective	Elective	Elective	Elective	Elective		
10	Elective	Elective	Elective	Elective	Elective		

How we changed – our 'Mission Statement'

- **Minimum standards**
  - Two complete consultant ward rounds **of all acute patients** every day (8AM, 6-7PM)
  - 8PM consultant-to-consultant **face-to-face** handover of all acute patients (day and night junior teams present)
  - Patients with NEWS > 5 within the department discussed
  - 8AM and 8PM CEPOD theatre planning meeting
  - Difficult patients reviewed together (UGI/LGI split)

How we changed – our 'Mission Statement'

- **Minimum standards**
  - Consultant present at **all laparotomies**
  - Investigations ordered when you need them
  - All patients risk assessed
  - HDU/ITU for any predicted mortality >5/10%
  - Surgery performed when needed through the night
  - Aim to satisfy minimum standards for sepsis (source control)

The way we are now

Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun
1	Day	Day	Day	CEPOD	Night	Night	Night
2	Night	Night	Night	Night	Rest		
3	Rest	Rest	Rest	Elective	Elective		
4	Elective	Elective	Elective	Elective	Elective		
5	Elective	Elective	Elective	Elective	Elective		
6	Elective	Elective	Elective	Day	Day	Day	Day
7	CEPOD	Post Take	Elective	Elective	Elective		
8	Elective	Elective	Elective	Elective	Elective		
9	Elective	Elective	Elective	Elective	Elective		
10	Elective	Elective	Elective	Elective	Elective		

Results (all admissions)

	Before rota change	After rota change	P
Consultant review <12 hours	22%	76%	**0.001**
Time till consultant review (hours) [Median, IQR]	18.7 (12.7-23.5)	7.2 (4.2-11.5)	**<0.001**
Length of stay (hours) [Median, IQR]	55 (23.1-110)	42.1 (19-96.4)	**0.037**
Length of stay < 1 day	25%	31%	**0.048**
Re-admissions	18%	19%	**0.671**

Results

	Before rota change	After rota change	P
Time to see consultant (hours, median, IQR)	**18.25 (8.4 – 78.4)**	**5.3 (2 – 10.6)**	**<0.001**
Time from decision to operate to surgery (hours, median, IQR)	4.4 (1.7 – 18.6)	2.8 (1.7 – 7.7)	**0.048**
Length of stay (days, median, IQR)	17 (9 – 29)	13 (7 – 21)	**0.036**
Days on ITU (days, median, IQR)	0 (0-2)	0 (0-1)	NS
Days on HDU (days, median IQR)	0 (0-0)	0 (0-0)	NS

Results

	Before rota change	After rota change	P
Grade of decision maker	96%	97%	NS
Consultant Surgeon in theatre	76%	91%	**0.005**
Consultant anaesthetist in theatre	83%	76%	NS
HDU/ITU post-op	41%	31%	0.068

Results

	2013/2014 (Pre rota change)	2015/2016 (Post rota change)
Predicted mortality >5%	55%	54%
Return to theatre	3%	3%
Unplanned move to HDU/ITU	7%	<1%
Post-operative 30 day death	12%	6.4% **(P<0.001)**
Observed:Expected Mortality Ratio (SMR)	0.78	0.51 **(P<0.001)**
National average (NELA)	15%	11%

Results – unplanned effects

- Increase in acute laparoscopic cholecystectomy rate
- ‘Change in culture’
  - Abscesses and appendixes are getting done sooner
- Greater proportion of CEPOD theatre time used
- Greater consultant ‘presence’ drives things along
- **8 patients a day seen in SAU Clinic**
- **56% patients seen in ambulatory area**

Results – the patient experience

- Engagement with Friends and Family scores (>90%)
- Engagement with complaints
- Reduction in complaints

Complaint (domain of complaint)	Before rota change (% of complaints)	After rota change (% of complaints)
Treatment/procedure	34%	16%
Communication	28%	22%
Ongoing review	20%	6%

What next?

- Getting paid properly
  - Commissioners yet to agree a formal tariff for ambulatory patients
    - Are they ‘clinic attendances’ or ‘admissions’?
- Trying to ensure the ambulatory area isn’t made into beds
- More equipment / people
  - USS, Phlebotomist

Take home messages

- Start small
- You'll never get agreement from everyone – don't even try!
- Don't overstate your potential benefits
- Put your area where your staff are
- 'Senior review driven' is better than 'pathway/protocol driven'
- Ask yourself not 'Can we afford to change?' but rather 'Can we afford not to change?'

Thank you

thebmjawards
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