Subject: **The reconfiguration of complex elective inpatient gastrointestinal surgery at Maidstone and Tunbridge Wells Trust**

To: **HOSC**

From: **Dr Amanjit Singh Jhund, Director of Strategy, Planning and Partnerships, Maidstone and Tunbridge Wells NHS Trust and Mr Adam Wickings, Deputy Managing Director West Kent CCG**

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Purpose: **To outline the case for the reconfiguration of complex elective inpatient gastrointestinal surgery, from the Maidstone Hospital site to the Tunbridge Wells Hospital site, at MTW**

Introduction:

Maidstone and Tunbridge Wells Trust (MTW) Trust provides a wide range of general and specialist surgical services with two centres of expertise in surgery, one at Tunbridge Wells Hospital at Pembury (TWH) and one at Maidstone Hospital (MH). Both sites provide surgical outpatient consultations, endoscopy services, daycase and 23 hour stay elective surgical procedures. However, inpatient complex surgery is split, with around 5,700 patients admitted as a surgical emergency per year directed to TWH and around 600 patients per year for complex elective gastrointestinal surgery directed to MH.

This split coincided with the opening of the TWH in 2011, and the rationale at the time was to co-locate complex elective cancer surgery, including complex upper and lower GI surgery, with the cancer centre at MH. In 2013 a shared regional decision was taken that MTW would no longer provide the complex upper GI cancer surgery service.
In 2019, an internal strategic clinical service review of the surgery services at MTW identified a number of challenges and safety concerns with the current service configuration. The service review concluded it was a priority that a plan be developed to address the challenges.

1. **Why do services need to be reconfigured?**

The Challenges:

Gaps in the continuity of care for the surgical patient

In the current surgical configuration, patients requiring complex gastrointestinal (GI) surgery can face multiple handovers between surgical teams. The emergency surgical consultants are based at TWH and the specialist upper and lower GI surgeons attend TWH to undertake a block of on-call but then return to MH for to carry out their elective activity. Because of their elective commitments at MH, the upper and lower GI surgeons cannot have ongoing involvement with the patients they treated as an emergency at TWH. Patients who have had planned surgery at MH whose condition deteriorates may experience delays to their treatment awaiting emergency transfer to TWH. Patients who require emergency readmission for post op complication following planned surgery at MH are re-admitted to TWH. Both of these groups of patients, the deteriorating patient and the emergency re-admission are high risk groups. They fall under the care of the on-call teams at TWH, not under the consultant's team who operated on them in the first instance. This can cause significant issues with the continuity of care and puts significant pressure on the emergency

surgical teams. The relatively high number of handovers between surgical teams leads to frustrating repetition, additional risk, clinical delay and unnecessary increased length of stay in hospital.

Fragmented systems of working that mean the service faces additional challenges with recruitment, with training and barriers to multidisciplinary working

For all specialist staff, increasing demand, decline in numbers entering the professions and an existing shortfall create a challenge for the service. Opportunities to recruit to gaps are lost as the current fragmented service configuration is not attractive to potential recruits. Lost opportunities to recruit do not help the surgery service that has a very high spend on locum and agency staff. To put this in context, in 2018 -19 the service spent £2.8M on locum/agency medical staff and £2M on bank/ agency nurses.

The surgery service at MTW provides training for the next generation of specialists. Trainee doctors receive core and specialist training at MTW but recently the trainees have raised issues with their experience to the Kent, Surrey and Sussex region of Health Education England. Many of these issues are related to the challenges of the cross site configuration and specifically, the view that the emergency block of the rotation is for service provision rather than offering training opportunities.

Many units in England take what is regarded as a highly beneficial multidisciplinary approach to the care of patients with gastroenterological conditions. They do this by forming a Digestive Diseases Unit (DDU). A DDU is a combined medical and surgical ward where patients with gastrointestinal conditions are looked after. Surgeons and physicians work together to provide in house multidisciplinary care for all patients. This enables the team to provide higher quality care for patients with conditions requiring Colorectal Surgery, Gallstones, Hepatology, Inflammatory Bowel Disease (IBD), Lower GI (medical), Oncology with established diagnosis and Upper GI conditions including Dyspepsia. MTW does not have a DDU as the current fragmented surgical service lacks the scale and concentration of expertise required to set one up.

2. The solution

The surgical senior clinical management team, together with colleagues from other disciplines, undertook a structured option appraisal on a set of options to establish a preferred way forward. The options they explored were:

ID	Title	Option Description
1	Status Quo	Leave emergency general surgery at TW with the current cover provision.
2	Status quo plus	Leave emergency general surgery at TW but increase the consultant workforce covering the site.
3	Concentrate inpatient service at TW	Leave emergency general surgery at TW and transfer planned **cancer,** major and intermediate colo-rectal procedures (+/-UGI) from MS to TW.
4	Emergency and elective surgery at both sites.	Provide Emergency general surgery and elective cancer and major surgery at both sites.
5	Move Emergency surgery to Maidstone	Change the provision of emergency surgery from TW to MS with only planned minor surgery and day cases at TW.
6	Workforce based solution	Further review of surgical consultant workforce

7	Split patient pathway	"Northumbria model" Patients to move from TWH to MS when stable either for surgery or rehab

The clinical group assessed the options against 16 criteria. The criteria were:

- Patient pathway- Continuity of care
- Patient pathway – The number of cross hospital site patient transfers
- Patient pathway – Patient's initial emergency access
- Workforce – Ability to cover service commitments
- Workforce – Recruitment and retention
- Workforce – Training and supervision
- Strategic – Opportunities to develop the surgical service
- Strategic – Opportunities to further research and innovation
- Operational – Impact on A&E and A&E access standard
- Operational – Addresses the blocks to efficient day/ short stay surgery processes
- Operational – Achievability assessment including time taken until option operational
- Operational – Option supports whole hospital winter resilience
- Operational – Option provides for continuing adequate surgical support for the Trauma Centre
- Operational – Option can be supported by Theatres
- Operational – Option can be supported by Critical Care and Theatres
- Operational – Option can be supported by Imaging

Each of the options was scored by the clinical group on weighted criteria.
The highest scoring option was option 3: 'Leave emergency general surgery at TW and transfer planned cancer, major and intermediate colo-rectal procedures (+/-UGI) from MS to TW'
The solution would affect around 600 patients a year, who live across our region who would have had their surgery at MH but will in future have their surgery at TWH. The 5,700 emergency surgical patients a year at TWH are unaffected other than in future there will be a greater surgical presence at TWH to care for them.
The 56,000 surgical outpatient consultations a year and the 9,000 patients admitted for day case or endoscopy a year will be unaffected by the change.

The Trust then consulted west Kent CCG about the proposed approach and received the CCG's endorsement.

<u>The urgent clinical need for change and benefits of the proposed solution</u>

Clinicians have identified an urgent clinical need for change and identified the following benefits associated with the proposed solution:

Improved continuity of clinical personnel
Currently, clinical continuity is exceptionally poor with too many handovers, at times a lack of clarity of the line of responsibility for some patients and delays to progressing care of the sickest patients. The importance of this continuity and clear governance cannot be overstated.
The Royal College of Surgeons standards[1] state: 'Effective continuity of care is vital in protecting patient safety. It is the duty of every surgeon to convey high quality and appropriate clinical information to oncoming healthcare professionals to allow for the safe transfer of responsibility for patients…whenever possible, ensure that there is a clear line of responsibility for the patient's care at any one time…. when transferring care to an oncoming

[1] The Royal College of Surgeons. Good Surgical Practice Royal College of Surgeons

team, ensure that team members have access to all necessary clinical information about the patient.'
In the past, local surgical services have been deemed unsafe and have been closed by the Royal College of Surgery as a result of issues leading on from sub-standard governance and poor continuity of care.

Co-location of complex elective with emergency surgery will; simplify governance, reduce the number of handovers and avoid unnecessary changes of the team in charge of patient's care and simplify governance. These are issues which our clinicians recognise impact upon the quality of care.
Co-location of complex elective with emergency surgery will allow continuity of involvement and most effective use of our Clinical Nurse Specialist Team, giving patients best access to specialist nursing care

Continuity of Clinical Information
When patients have been discharged from Maidstone and suffer a postoperative complication they usually re-present to TWH and there have been problems with quality and continuity of clinical information. For the most complex care clinical information is vital. The paper records travel with the patient to Maidstone for elective surgery and are not immediately available to clinicians at TWH in the event of any early need for reassessment.

Complex Care
Patients requiring the most complex care and/or with multiple conditions are not getting the quality of service that clinicians know is possible. It is often challenging because of the configuration of services to undertake combined diagnostic and therapeutic procedures leading to a need for patients to have 2 separate anaesthetics and potential for pathway delay in some cancer treatments. The availability of theatre team skilled in emergency and complex routine surgery also has synergistic improvement on the quality of benign surgery

Excellent Perioperative Management
Dedicated surgical high dependency facilities can provide the best care available for the perioperative patient. Without the critical mass of cases allowing centralisation of specialist staff such a facility is unachievable. TWH will become a much stronger centre for perioperative surgical management with some centralisation of complex surgical workload. Enhanced operational efficiency associated with a consolidated unit which will reduce incidence of cancellation for patients and reduce delays for both emergency and urgent surgery.

Transfers for clinical reasons.
Too many patients currently have delays to their treatment pending transfer across hospital sites. The proposal is expected to lead to a reduction in the requirement and the delay caused by patient transfers from Maidstone to TWH and vice versa.

Other identified service benefits with include:

- Improved sustainability of the surgical service including improving compliance with developing seven day service requirements
- Improved training experience for surgical trainees
- Reduced reliance on the use of locum doctors. The reconfigured service will provide the emergency service workforce with more support and make the surgical work pattern considerably more attractive for hard to recruit and retain specialist clinical staff.
- Consolidation will provide an opportunity to develop a digestive diseases unit with medical gastroenterology co located with GI surgery

Patient involvement in the proposed changes
Given the urgent clinical case for change the proposed solution has been designed with clinicians rather than patients. While there has been no formal consultation process patient and staff representatives have been engaged and consulted informally. This informal consultation included discussions with patients presenting through the PALS (Patient Advice and Liaison Service) and complaints services with problems with the current service as well as with Trust Patient representatives and former staff members. Although there has been no formal co design process, in planning the Digestive Diseases Unit at Tunbridge Wells patients are being engaged in it's design and will be involved from the start. Both patients and the families of patients that have experienced problems with care have already been asked to be involved in the co-design process.

Given the urgent clinical case for change, the patient engagement undertaken and the numbers of patients affected, we recommend that HOSC agree that this is not a significant change and that we should proceed with the planned change to clinical services without formal public consultation.

The identified risks associated with the solution
The project group has identified the following risks, for which mitigation is planned associated with the preferred solution.

- A risk of increasing the bed pressure at TWH leading to a risk of cancellation of complex cancer elective patients. Mitigation plans include a new escalation policy to ensure the beds identified for cancer patients are 'ring fenced' and not used for escalation. A number of service changes and improvements to patient flow are planned across the Trust. A senior operational 'gateway decision' will be made prior to 'go live' that the planned changes have made the required and sustainable bed capacity available.
- A risk of overloading the TWH critical care capacity was considered and investment in enhanced post-operative surgical recovery, six additional enhanced care beds together with measures designed to speed the flow of patients are planned that mitigate the risk.
- A risk of inadequate surgical cover for the Maidstone site has been mitigated by ensuring there would still be a consultant surgeon on call for the site and an RMO covering the site.
- A risk that operating theatre capacity could be compromised was identified so the project group worked with the critical care and theatres teams to produce a full review of theatre schedules that has mitigated the risk
- A risk that surgical nurses may be lost to the Trust was identified. Subsequently, senior nurse engagement with the nursing teams has clarified and mitigated the risk.
- A risk was identified that appropriate consultation on medical job plans could take some months. The service identified temporary mitigations were available should the process be delayed.

Patient numbers

Patients visiting surgical services at MTW for general surgery, gynae oncology and breast surgery	TWH		Maidstone	
	Current	Future	Current	Future
Emergency surgical inpatient admissions	5700	5700	100	100
Day case admissions (includes patients for endoscopy)	4300	4300	4600	4600

Patients visiting surgical services at MTW for general surgery, gynae oncology and breast surgery	TWH		Maidstone	
	Current	Future	Current	Future
Outpatients for general surgery	24000	24000	32000	32000
In patient (ordinary) elective admissions for general surgery 'non-complex'	100	100	600	600
In patient (ordinary) elective admissions for complex general surgery LGI procedures	0	400	400	0
In patient (ordinary) elective admissions for complex general surgery UGI procedures	0	200	200	0

The proposed plan
The table above demonstrated that the planned change would mean different site of care for 600 patients per year (400 inpatient elective LGI plus 200 inpatient elective UGI,) Ten beds are required for these 600 patients. The proposed plan is therefore that in March 2020, following the easing of the pressures associated with winter, medical patient outliers in surgical beds will have eased and the surgical service will be in a position to accommodate the extra 10 beds in their current bed stock.

To assist the management of the patients there will be:

- An investment in an enhanced post-operative surgical recovery area of two beds staffed by intensive care trained nurses at TWH. These beds will meet the needs of the higher dependency care these patients require immediately post operatively.
- Six enhanced care beds will be introduced on Ward 32 to manage the pressure on the TWH ITU/HDU, improve flow and ensure that the complex post-op patients receive a higher level of monitoring.
- A streamlined operating theatre schedule has been developed and will be introduced to coincide with the reconfiguration. The Critical Care team who manage the operating theatres are using the opportunity to rationalise the whole operating theatre schedule to increase productivity and balance capacity across multiple specialties through the week.
- A senior surgeon and a resident medical officer will be rostered to provide emergency surgical cover for the MH site.
- Streamlined embedding of the complex GI inpatient surgeries at TWH
- Change to the on-call structure and rotas allowing the consultant surgeon workforce to remain responsible for both their emergency and elective inpatients.
- The longer term development of a DDU for multidisciplinary care of patients with gastrointestinal conditions

The plans for the reconfiguration are developing and input from stakeholders is sought. Approval and input from stakeholders is sought to enable detailed planning to progress. Due to Winter Pressures the earliest that the service could be ready for a ‘go live’ date is March 2020. The Trust anticipates no change in overall patient flow to the Trust and no impact on neighbouring Trusts.