The Royal Wolverhampton NHS Trust

OP102 v3.0
Non-Elective Surgery Policy

Contents

1.0 Policy Statement

The Trust provides non-elective care in all the major surgical specialties except neurosurgery. This policy directs the Trust's approach to optimize clinical effectiveness and patient safety in line with national publications. The key points are that non-elective care of surgical patients must be consultant-led and be prioritized according to risk-stratification, displacing elective activity if necessary.

1.1 The aim of this policy is to create formal processes for the provision of non-elective care in surgical specialities.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy (OP 109) must be considered and addressed. In the case of any inconsistency, the Conflicts of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

Critical Care: any level of care greater than ward care (level 0); level 1 is enhanced ward care, level 2 is the High Dependency Unit (HDU) and level 3 is the Intensive Care Unit (ICU).

Higher-risk patient: one with an expected mortality of greater than or equal to 5%.

Non-elective care: the management of patients who have a need for urgent or emergency investigation and treatment. These patients may be admitted through the emergency portals, or they may develop acute surgical diseases during hospitalization for other indications, or they may develop serious complications from elective or emergency surgery.

Responsible Consultant: the consultant who has overall responsibility for the patient. This may be the admitting consultant or one who has formally taken over the inpatient care of the patient. During periods of leave, the care of inpatients must be transferred to a covering consultant. During out-of-hours periods, the on-call consultant will have final responsibility for all patients within that specialty unless other specific arrangements have been made.

Surgical Registrar: a non-consultant surgical doctor with MRCS (or an equivalent qualification) who is a Specialist Trainee (ST3 and above) or a specialty doctor or senior clinical fellow of equivalent experience.

3.0 Accountabilities

3.1 The Divisional Medical Director for surgical services must disseminate this policy to all relevant parties.

3.2 Clinical Directors in the surgical and anaesthetic specialties must disseminate this policy to all medical staff and senior nurses in their directorates and ensure they comply with its contents where relevant to their duties.

3.3 Matron for Critical Care Services Directorate must disseminate this to all theatre staff and ensure that they comply with its contents where relevant to their duties.

3.4 All consultants and junior medical staff in the surgical and anaesthetic specialties must comply with the contents of this policy where relevant to their duties.

3.5 All theatre staff must comply with the contents of this policy where relevant to their duties.

4.0 Policy Detail

4.1 Key Principles

4.1.1 Services for non-elective surgical patients must be consultant-led.

4.1.2 All surgical (including gynaecology) patients admitted to the Trust must be under the direct daily supervision of a consultant surgeon.

4.1.3 The timings of investigation and treatment of non-elective surgical patients must be determined by clinical need, which includes taking priority ahead of elective patients if necessary.

4.1.4 There must be early senior clinical review (surgical registrar or consultant) of all non- elective patients to improve diagnostic accuracy. A clear management plan must be devised and recorded in the notes.

4.1.5 Non-elective operations should not be done at night unless a delay will prejudice the outcome of treatment (see 4.4.3).

4.1.6 Consultants must be actively involved in the diagnostic, surgical, anaesthetic and Critical Care elements of the management of higher-risk patients.

4.1.7 Critically ill patients must have prompt assessment and resuscitation by the surgical registrar. There must be rapid access to appropriate imaging with early formal reporting of diagnostic tests and rapid access to Critical Care support. All critically ill and higher risk patients must be discussed with the Responsible Consultant surgeon.

4.1.8 All patients for whom immediate surgery is being considered must be discussed with the Responsible Consultant.

4.1.9 Higher-risk patients must be discussed with the Responsible Consultant and reviewed by the consultant within four hours if the management plan is unclear and the patient is not responding as expected regardless of the time of day.

4.2 Risk Stratification

4.2.1 All patients who may require major non-elective surgery (e.g. laparotomy) must have an estimate made of their risk of post-operative mortality using a recognized methodology (e.g. P-POSSUM or the National Emergency

Laparotomy Audit (NELA) risk model for general surgery patients). This must be recorded in the patient's notes.

4.2.2 Frailty is an independent risk factor for post-operative mortality risk and so must be assessed by the clinical team.

4.2.3 Risk prediction models must be used in conjunction with clinical judgement: the majority of patients undergoing emergency laparotomy, for example, fall within the higher-risk category.

4.2.4 The result of the estimated mortality risk must be offered to the patient: if he or she wants to know their estimated mortality risk, it should be written on the consent form.

4.2.4 All higher-risk surgical patients undergoing surgery must be assessed preoperatively by the consultant surgeon and discussed with the Critical Care consultant to seek post-operative admission to Critical Care; some patients may benefit from preoperative admission there.

4.2.5 The patient's mortality risk must be reassessed at the end of surgery, and Critical Care admission must be sought if the risk is ≥5%.

4.3 Medical Staff

4.3.1 The on-call team in specialties with a high emergency workload (General Surgery and Orthopaedics and Trauma) must be free from elective commitments throughout the period of on-call and may need a "mop-up" session free from elective duties at the end of that period according to the needs of the directorate.

4.3.2 The Emergency General Surgery team must comprise a consultant, a registrar, an SHO or equivalent and a Foundation Year 1 doctor.

4.3.3 A named consultant must be available at all times for telephone advice and be able to attend his or her base hospital within 30 minutes at all times.

4.3.4 A consultant surgeon and consultant anaesthetist must be present for any operation with a predicted mortality of ≥5% unless they have satisfied themselves that the junior doctors have adequate experience, competence and manpower to undertake the procedure.

4.3.5 A consultant surgeon and consultant anaesthetist must supervise directly any operation with a predicted mortality of ≥10%.

4.3.6 A consultant surgeon should be present for all unscheduled returns to theatre unless they have satisfied themselves that the junior surgeons have adequate experience, competence and manpower to undertake the procedure.

4.3.7 A consultant surgeon must be present in theatre for all operations on both

children and adults who present with rare conditions.

4.3.8 Surgeons must make arrangements for their private patients to be cared for by someone else when they are on call for emergencies.

4.3.9 Perioperative anaesthetic care should be led by a consultant anaesthetist unless they have satisfied themselves that the junior anaesthetists have adequate experience, competence and manpower to undertake the procedure.

4.3.10 All patients needing emergency anaesthesia must be seen by an anaesthetist pre-operatively. Preoperative assessment and emergency anaesthesia in ASA≥3 patients and higher-risk patients should be provided by consultants but can be delegated to a supervised, clinically competent trainee of sufficient seniority.

4.4 Emergency Theatres

4.4.1 At all times there must be adequate access to appropriately-staffed, dedicated emergency theatres.

4.4.2 There must be a dedicated orthopaedic theatre. There must be rapid access to theatre for urgent and complex problems such as open fractures and those with neurovascular compromise.

4.4.3 Theatre prioritization is vital (see also the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Classification).

- Immediate surgery is needed for acute airway compromise, ongoing haemorrhage, endoscopic or surgical removal of an ingested battery impacted in the oesophagus, fracture with major neurovascular deficit, compartment syndrome etc.
- Urgent surgery in patients with a completely ischaemic limb or testicular torsion should be done within four hours of the onset of pain where possible.
- Urgent surgery (within hours of the decision to operate) is needed to treat peritonitis due to a perforated viscus, critical organ ischaemia, a compound fracture, perforating eye injuries etc.
- Sepsis source control surgery must be done within a tight timescale:
    1. Septic shock: within 3 hours;
    2. Severe sepsis (organ dysfunction without shock): within 6 hours;
    3. Sepsis without organ dysfunction: within 18 hours, optimally avoiding 2200 – 0700;
    4. Infected source without sepsis: next available day-time 0700 – 2200 list.
- Oesophageal foreign bodies (other than batteries) should be removed within 24 hours, but sharp, oesophageal foreign bodies should be removed within 6 hours.
- For other patients needing non-elective surgery, the operations should be done during day-time operating sessions if possible. If they are done at night, the reasons for doing so must be documented.

4.4.4 If the emergency theatre is busy and a patient needs an operation before it will be free, an elective theatre list must be stopped to accommodate the emergency: when that need arises, the first list to finish whatever operation is on table will be the one to stop for the emergency. This decision will be taken by the surgical and anaesthetic consultants, and will be conveyed urgently to the Theatre Coordinator who will arrange for the next available theatre to be used.

4.4.5 The WHO Surgical Safety Checklist must be used for all cases (OP 100).

4.4.6 A staffed post-anaesthetic recovery area for the emergency theatres must be available 24 hours a day all week long and have the facility for airways care, mechanical ventilation and ongoing management of the patient.

4.5 Patient Management

4.5.1 Low risk patients must, as an absolute minimum, be discussed with the Responsible Consultant within 12 hours of admission and must be seen by the consultant within 14 hours of arrival at the hospital.

4.5.2 A patient with a deteriorating NEWS 2 score must be seen by a surgical registrar or, if the surgical registrar is detained elsewhere, by the ICU or anaesthetic registrar according to a local tiered escalation policy (Prevention and Management of the Deteriorating Patient CP61 and Vitalpac Policy and Procedure OP88).

4.5.3 Patients must be screened and monitored for sepsis with NEWS 2 or PEWS scores and must receive prompt treatment (the ***Sepsis Six***) if the score rises to five or more and there is evidence of infection or the patient is at high risk of infection. Appropriate antimicrobials (selected from the Trust Antimicrobial Guidelines or after discussion with a consultant microbiologist) must be given within one hour of diagnosis – they must not be delayed for the taking of blood cultures.

4.5.4 While patients are awaiting emergency surgery, they must be monitored in an environment with appropriate support and surgical review, ideally on a dedicated Surgical Emergency Ward.

4.5.5 There must be daily ward rounds of non-elective patients by a consultant including at weekends and Bank Holidays.

4.6 Diagnostics

4.6.1 There must be 24-hour access to CT, plain films and ultrasound, and they must be available within 30 minutes of request for urgent and emergency non-elective patients. If the immediate outcome depends on imaging results, a definitive report must be available within 1 hour. Requests for imaging of this urgency should be made by surgical consultants or registrars to radiology consultants or registrars (or registrar equivalents).

4.6.2 If CT scanning is to be performed in patients with multiple injuries, routine use of 'top to toe' scanning is recommended in the adult trauma patient if no indication for immediate intervention exists.

4.7 Critical Care

4.7.1 If Critical Care facilities are not available for emergency surgery, there must be agreed protocols for transfer.

4.7.2 If the patient requires transfer to another facility for emergency surgery, the Critical Care team should support the transfer in line with agreed transfer protocols.

4.7.3 Specialist surgery that is likely to need Critical Care support should not be done if there is no bed available unless the patient's life is endangered by delaying surgery or by transfer prior to surgery.

4.8 Emergency Paediatric Surgery

4.8.1 Not all surgeons and anaesthetists who participate in on-call rotas have specific skills for treating paediatric patients. The Critical Care Services Directorate offers general anaesthesia for children over the age of five of ASA I or II (see Guidelines for Paediatric Anaesthesia & Surgery at Royal Wolverhampton NHS Trust on the intranet).

4.8.2 Some anaesthetists can anaesthetize younger or less fit children – all cases need to be discussed with the on-call consultant anaesthetist. If a child requires non-elective anaesthetic or surgical intervention that lies beyond the professional competence of the available staff, transfer to a specialist Paediatric Unit must be sought. Occasionally, urgent surgical intervention is needed to preserve life, limb or critical organ function before the child can be transferred elsewhere or before a specialist paediatric surgeon and, or anaesthetist can attend. Under these circumstances, the Trust will support fully a non-paediatric anaesthetist or surgeon undertaking emergency anaesthesia and surgery; the consultants in both specialties must be in theatre for such cases.

4.9 Emergency Vascular Anaesthesia

Occasions may arise when a patient with a vascular emergency is unfit for transfer to the Black Country Vascular Surgery hub. If there is no available specialist vascular Anaesthetist for the operation, the Trust will support fully a non-vascular anaesthetist undertaking emergency anaesthesia.

4.10 Relatives & Supporters

4.10.1 Patients and supporters must have access to a member of ward staff to get information about the patient provided the patient gives their consent.

4.10.2 Information should be given to patients and supporters at each stage of the care pathway; these communications must be Consultant-led.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	

6.0 Equality Impact Assessment (where assessed in the policy does not need to be repeated for the procedure)

Authors are required to complete an Equality Impact Assessment via the following linkhttp://intranet/departments/equality_and_diversity/equality_analysis/equality_an alysis_proformas.aspx andissues identified from the assessment must be included here with a summary of redress action.

7.0 Maintenance

This policy will be reviewed three-yearly by the Divisional Medical Director for surgical services.

8.0 Communication and Training

This policy will be made available on the intranet and copies will be sent to the Clinical Directors of relevant directorates (to disseminate to their medical and nursing colleagues) and to the Matron for the Critical Care Services Directorate to disseminate to theatre staff.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee / Group
Patient outcomes	Surgical Specialty CD's, Medical Examiners and Mortality Reviewers	Mortality Reviews, Morbidity Audits and Exception Reporting (e.g. RCA's)	Monthly	Directorate and Divisional Governance Mortality Review Group
National Emergency Laparotomy Audit (NELA)	Local NELA reporter	Prospective data collection	Annual	Divisional and General Surgery Directorate Governance COG
Seven Day Services Audit	Seven Day Services Lead	Notes audit for consultants seeing patients	Quarterly	QSAG

10.0 References

The Royal College of Surgeons of England and the Department of Health. *Standards for Unscheduled Surgical Care.* London: Royal College of Surgeons of England: 2011.

The Royal College of Surgeons of England and the Department of Health. *The Higher Risk General Surgical Patient: Towards Improved Care for a Forgotten Group*. London: Royal College of Surgeons of England: 2011.

National Confidential Enquiry into Perioperative Deaths. *Knowing the Risk: A Review of the Perioperative Care of Surgical Patients.* London: NCEPOD: 2011.

The Royal College of Surgeons of England. *The High-risk General Surgical Patient: Raising the Standard.* London: Royal College of Surgeons of England: 2011.

NELA Project Team. *Third Patient Report of the National Emergency Laparotomy Audit (NELA) December 2015 to November 2016*. London: Royal College of Anaesthetists.

National Emergency Laparotomy Audit. NELA Risk Calculator. http://data.nela.org.uk/riskcalculator.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Classification of

Intervention. https://www.ncepod.org.uk/classification.html.

Document Control

Reference Number and Policy name: **OP102 – Non – Elective Surgery Policy**	**Version:** **Version 3.0** **April 2023**		**Status: Final**	**Author:** **Mr John Murphy** **Director Sponsor:** **Chief Medical Officer - BM**
Version / Amendment History	Version	Date	Author	Reason
	1.0	July 2013	Mr I Badger	Response to national guidelines
	2.0	May 2016	Mr I Badger	Full review includes only minor update re emergency admission seen by consultant within 14 hours arrival to comply with seven day services initiative.
	2.1	Jan 2018	Mr I Badger	Amendment so that it is compulsory that a consultant surgeon is present in theatre for any operation in an adult or a child presenting with a rare condition.
	2.2	June 2019	Mr I Badger	Full review incorporates national guidance from the Royal College of Surgeons of England and National Emergency Laparotomy Audit data.
	2.3	Nov. 2022	Divisional Medical Director, Division 1	Extension applied
	3.0	April 2023	Divisional Medical Director, Division 1	Full review
Intended Recipients: Surgical Specialties, Critical Care, Anaesthetics, Cardiology and Radiology				
Consultation Group / Role Titles and Date: Individual Directorates				

Name and date of Trust level committee where reviewed	Trust Policy Group – April 2023
Name and date of final approval committee	Trust Management Committee – April 2023
Date of Policy issue	May 2023
Review Date and Frequency [standard review frequency is 3 yearly unless otherwise indicated]	April 2026 (every 3 years)
Training and Dissemination: Divisional Medical Director	
To be read in conjunction with: *Prevention and Management of the Deteriorating Patient CP61* and *Vitalpac Policy and Procedure OP88*	
Initial Equality Impact Assessment [all policies]: **Completed Yes** **Full Equality Impact assessment [as required]:** **Completed No** If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114.	
Contact for Review	Divisional Director Surgical Division
Implementation plan / arrangements [Name implementation lead]	Dissemination to appropriate directorates by Mr Ian Badger
Monitoring arrangements and Committee	Division 1 Governance Committee
Document summary / key issues covered: **This policy formalizes the arrangements for the delivery of non-elective care in the surgical specialties at Royal Wolverhampton NHS Trust in line with 2011 recommendations from the Royal College of Surgeons, the Department of Health and National CEPOD.**	

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and policy version v3.0	**Policy Title OP102 – Non – Elective Surgery Policy**	
Reviewing Group Policy Committee		**Date reviewed:**
Implementation lead: Mr John Muprhy		

Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.	Not applicable	
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form	Not applicable	
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed	Not applicable	
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?	E-mail to all relevant CD's	Divisional Medical director
Financial cost implementation Consider Business case development	Not applicable	
Other specific Policy issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation		