Front door surgeons:

the rise of consultant-delivered acute surgical care

BACKGROUND

Over the past decade there has been a rapid and dramatic increase in the number of patients presenting to acute care services. This includes a >30% increase in the number of emergency admissions to hospitals.¹

This has created an unsustainable rise in pressure on both acute medical and acute surgical services. It can be explained by a multitude of factors, including an increasingly older and comorbid population, a shortage of GP appointments, and higher patient expectations. There also appears to be a lack of public understanding about the provision and role of urgent and out-of-hours services.

Many acute medical services (notably stroke and cardiology) have stepped up to this challenge to provide safe, rapidly accessible, and high-quality multidisciplinary units to address two of the biggest causes of mortality in the UK: stroke and myocardial infarction. However, acute general surgery still lags behind its medical counterparts.

CONSULTANT-DELIVERED, RATHER THAN CONSULTANT-LED, SERVICE

The traditional NHS model for acute admissions has followed a 'consultant-led' or 'consultant-based' service. In this model, although patients were admitted under a named consultant, the majority of daily patient care and interaction was delivered by junior members of the team, with a variable degree of consultant supervision and input. For surgical specialties, emergency services were not prioritised and so elective commitments ran side by side with emergency on-call because trusts feared losing out financially by abolishing their profitable elective services. In this model, the duty consultant may not have personally reviewed the patients admitted acutely under their care until 24 hours later, and thereafter in many cases will have had no further contact with them. The consultant would typically be kept informed of their patient's status by their juniors while they carried on with elective work.

However, there is now good evidence pointing to significant benefits for both trusts and patients by prioritising the emergency workload and cancelling elective work for the entire period a consultant surgeon is on-call.

Box 1. Definition of 'consultant-delivered' care²

Consultant-delivered care includes 'ready availability [of a consultant] for direct patient care responsibility', which may not necessarily mean 24 hours a day consultant presence.

Freeing up the on-call consultant allows them to adopt a more 'hands-on' approach to acutely referred patients, delivering high-value input early on in the patient's pathway within secondary care. This enables key decisions to be made not only regarding further investigations and management, but also, crucially, whether this requires the patient needing to be formally admitted, or whether they may be managed as an out-patient. This 'consultant-delivered' model of care (Box 1) was the subject of a comprehensive review published by the Academy of Medical Royal Colleges.

There is good evidence that this consultant-delivered approach can help trusts to reduce emergency admissions, easing pressure on in-patient beds and allowing more efficient use of trust resources.³⁻⁵ Patient outcome data indicate that this approach also has significant benefits to patients, who are better satisfied by seeing a senior, decision-making member of the team rather than being routinely admitted to the ward to await senior review up to 24 hours later (Box 2).

In this way, the benefits of consultant-delivered care can be administered at the front line, or 'front door' of the hospital, avoiding the routine admission and cutting down on in-patient bed occupancy.

SURGICAL AMBULATORY CARE UNITS

Some innovative trusts have taken the concept of consultant-delivered care even

further forward in the acute surgical setting by introducing 'emergency surgery ambulatory care' (ESAC) units.⁶ Similar models of care have long existed in the acute medical setting, for example, in the treatment of venous thromboembolism. Such units aim to safely and effectively treat as many patients as possible as out-patients, rather than routinely admitting every patient for in-patient care. In general, this approach is eminently suitable, for example, for patients referred acutely with suspected gallstone-related symptoms, an increasingly common acute general surgical referral. In one system, GPs may refer patients to a daily ESAC 'hot clinic' where the use of standardised care pathways with immediate on-site availability of biliary ultrasound can identify patients with symptomatic gallstone disease. Patients requiring cholecystectomy may then be listed for surgery and prioritised on the waiting list accordingly. Patients requiring more urgent cholecystectomy (for example, following an episode of acute gallstone pancreatitis, where the recommendation for gall bladder removal is within 2 weeks) may be operated on sooner on dedicated ESAC theatre lists, separate from the main emergency theatres reserved for in-patient procedures. Patients with minimal symptoms are listed in the standard manner on the elective waiting list. Patients not fulfilling ambulatory care criteria (for example, those with cholangitis or severe acute cholecystitis requiring intravenous antibiotics and fluids) are admitted as part of the general surgical take.

One ESAC unit in which this system has been successfully piloted is that set up by Bath Royal United Hospital. It makes for impressive reading, with a 25% reduction in the daily number of acute surgical patients admitted and with estimated reduction in patient bed stays of 130 per month. At £300

Box 2. Evidence for consultant-delivered care

- Numerous expert reviews in a wide range of medical and surgical subspecialties (including surgery, medicine, anaesthetics, trauma, and obstetrics) have concluded that delay in consultant input results in a higher patient morbidity and mortality rate.
- The widely quoted higher patient mortality rate at weekends has been at least in part attributed by medical experts to a lack of consultant input at this time.³
- The 2006 New Zealand national junior doctors' strike inadvertently provided a natural experiment where consultants were forced to act on the front line. In contrast to expectations, data indicate that patient care actually improved over the strike period, with faster patient processing and reduced length of stay.⁴
- Studies that incorporate early involvement of consultants result in better patient outcomes, more efficient use of beds, and a reduced length of hospital stay.⁵

“... surgical ambulatory care units [allow a] more integrated approach to the care of acute surgical patients, allowing GPs rapid access to the opinion of a consultant surgeon.”

per bed per night, this alone amounts to annual savings of approximately £500 000. With a typical consultant salary at £75 000, it is clearly cost-effective to employ one or more consultant emergency surgeons to set up such a service.

Such surgical ambulatory clinics can have significant advantages for elective waiting lists, too. Patients who have their operations on the dedicated ESAC theatre lists will avoid being added onto the traditional elective waiting list, resulting in a reduction in waiting times. Similarly, avoiding in-patient admissions also vacates beds that can subsequently be used to house elective waiting-list patients. In this way, freeing up beds reduces the likelihood of elective procedures being cancelled on the day due to a lack of beds.

However, despite the apparent benefits, there are potential drawbacks. A high-quality ambulatory care service may take several years to fully develop and may incur significant initial capital costs (including equipment and staffing). The introduction of ambulatory care also requires coordination with other specialties, especially radiology, and the ongoing training of support staff such as dedicated nurse practitioners. It may be argued that trainee doctors in such a system may feel they are missing out on independent clinical decision making. In order to reduce the negative impact on trainees, trusts may consider allowing foundation doctors to formally rotate through such ambulatory care units, providing an ideal opportunity to develop acute medical and surgical knowledge and skills. Emphasising to juniors the principles of ambulatory care treatment as the default action for all referrals from primary care should be encouraged and it would allow juniors closer liaison and contact with primary care colleagues. Any new system or model of care needs to be promoted within primary care with education and liaison with primary care practitioners to allow understanding of the new system and how to use it effectively.

INTEGRATED CARE

In a recent British Medical Association study, GPs have been described as ‘the architects

of new care models’.⁷ Such models, many of which are currently being trialled at vanguard sites throughout England, focus on attempting to break down boundaries between general practice, community services, and hospital and social care. The importance of improving relationships and dissolving boundaries between primary and secondary care services has similarly been highlighted recently in the Royal College of General Practitioners’ ‘vision for general practice’.⁸ One of the key aims of the emergency surgical ambulatory care units has been to facilitate this more integrated approach to the care of acute surgical patients, allowing GPs rapid access to the opinion of a consultant surgeon. A model where GPs and specialists work together as part of the multidisciplinary team, without the divide between primary and secondary care, with ready access to highly knowledgeable specialists who can see patients at first point of contact, will not only improve health outcomes and patient experiences but also will be more cost-effective with reduced health inequalities and enhanced job satisfaction.

CONCLUSION

A significant increase in pressure on acute services over the past decade has forced a re-think as to how we deliver high-quality and cost-effective urgent patient care. A system based on consultant-delivered care, rather than consultant-led care, offers significant advantages to both trusts and patients alike. Medical subspecialties still lead the way in the reorganisation of acute services but the development of newer emergency surgical ambulatory care pathways provides clear benefits to both patients and trusts. It is also likely that there are significant cost-efficiency savings to be made by implementing such changes, which will no doubt be valuable contributions to reducing the NHS funding gap over the coming years.

Caroline Rance,

GP registrar, Wessex Deanery, Bournemouth.

Sarah K Richards,

Acute Care Consultant Surgeon, Bath Royal United Hospital NHS Foundation Trust, Bath.

ADDRESS FOR CORRESPONDENCE

Caroline Rance

Alma Medical Centre, 31 Alma Road, Winton, Bournemouth, Dorset, BH9 1BP, UK.

E-mail: caroline.rance@doctors.org.uk

Alun E Jones,

Acute Care Consultant Surgeon, Bath Royal United Hospital NHS Foundation Trust, Bath.

Provenance

Freely submitted; externally peer reviewed.

DOI: 10.3399/bjgp16X684889

REFERENCES

1. NHS England Urgent and Emergency Care Review Team. *Transforming urgent and emergency care services in England: update on the Urgent and Emergency Care Review*. NHS England. 2014. <http://www.nhs.uk/NHSEngland/keogh-review/Documents/uecreviewupdate.FV.pdf> (accessed 6 Apr 2016).
2. Academy of Medical Royal Colleges. *The benefits of consultant-delivered care*. London: AoMRC, 2012. http://www.aomrc.org.uk/doc_download/9450-the-benefits-of-consultant-delivered-care (accessed 6 Apr 2016).
3. Cooper H, Findlay G, Goodwin APL, et al. *Caring to the end? A review of the care of patients who died in hospital within four days of admission*. London: National Confidential Enquiry into Patient Outcome and Death, 2009. http://www.ncepod.org.uk/2009report2/Downloads/DAH_report.pdf (accessed 6 Apr 2016).
4. Robison G, McCann K, Freeman P, Beasley R. The New Zealand national doctors’ strike; implications for the provision of acute medical services. *Clin Med [London]* 2008; **8**(3): 272–275.
5. NHS England. *High quality care for all, now and for future generations: transforming urgent and emergency care services in England*. 2013. <http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf> (accessed 6 Apr 2016).
6. Tierney GM, Tou S, Hender J, Lund JL. Pilot study of a new paradigm in the management of surgical emergencies using emergency surgery ambulatory care. *Ann R Coll Surg Engl* 2014; **96**(Suppl): 198–201.
7. British Medical Association’s General Practitioners Committee for local medical committees. *General practice and integration: becoming architects of new care models in England*. 2015. <http://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/negotiating%20for%20the%20profession/general%20practitioners/general%20practice%20and%20integration%20apr%202015.pdf> (accessed 6 Apr 2016).
8. Royal College of General Practitioners. *The 2022 GP. A vision for general practice in the future NHS*. London: RCGP, 2013. <http://www.rcgp.org.uk/campaign-home/-/media/files/policy/a-z-policy/the-2022-gp-a-vision-for-general-practice-in-the-future-nhs.ashx> (accessed 31 Mar 2016).