Royal Free London
NHS Foundation Trust

Enhanced Integrated Postoperative Care (EPIC) Unit

Standard Operating Policy

November 2022

positively welcoming actively respectful clearly communicating visibly reassuring

Validation Grid	
Version	1.0
Title	Enhanced Perioperative Integrated Care (EPIC) Unit Standard Operational Policy
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Lead Business Unit	Anaesthetics, Theatres & ICU
Target audience	All users of EPIC unit – medical, nursing & operational
Commissioning body (e.g. Directorate/CPG)	Directorate
Stakeholders consulted	ICU Consultants ICU Matrons + Band 7s Anaesthetics Consultants Theatre Matrons Clinical service leads of surgical specialties including: HPB (Prof Joerg Pollok), Colorectal (Mr Derek Boyle), Vascular (Prof Fiona Myint)
Clinical Practice / Advanced Practice	Clinical Practice
Associated Policies / Documents	See ICU policies
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Key words	PACU, SHDU, ICU, Critical Care, High Dependency, Enhanced Care, Complex Surgical Patient

Version control				
Version	**Date**	**Author**	**Status**	**Comment**
1.0	July 2022	Dr Craig Lyness	New policy	

Contents

Royal Free London equality & diversity statement

"The Royal Free London NHS Foundation Trust is committed to creating a positive culture of respect for all individuals, including job applicants, employees, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability (including HIV status), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. It is also intended to use the Human Rights Act 1998 to treat fairly and value equality of opportunity regardless of socio-economic status, domestic circumstances, employment status, political affiliation or trade union membership, and to promote positive practice and value the diversity of all individuals and communities.

This document forms part of the Trusts commitment, you are responsible for ensuring that the Trust's policies, procedures and obligation in respect of promoting equality and diversity are adhered to in relation to both staff and service delivery."

1. Abstract

This operational policy refers to the newly established Enhanced Postoperative Integrated Care (EPIC) Unit on the 3rd floor with 20 beds. The policy and all aspects of the unit will need continuous review and updating as needed.

2. Aim & scope

The primary purpose of the EPIC unit is to provide a dedicated 24/7 facility for immediate postoperative care for adult patients undergoing surgery or interventional radiological procedures at the Royal Free Hospital.

The overriding objective is to improve the structure and facilitate the processes essential to provide the best-quality, evidence-based postoperative care. By substantially increasing the capacity for delivering enhanced care to both planned and unplanned major surgical postoperative patients, the unit will relieve the pressure on the existing SHDU/ICU resource and provide optimal immediate postoperative care for the increasingly frail and comorbid surgical cohort currently managed in the general ward environment.

The unit will not be specialty-specific and patients from all surgical specialties will be considered for admission. The aim is for a flexible area with multiple levels of postoperative care in zoned cohorts with predicted length of stay from <24 hours to maximum 72 hours, ranging from level 1/1.5 (enhanced) to level 2/3 care. Zones include a level 2 capable post-anesthesia care unit (PACU) for stays less than 24 hours and a level 2/3 (HDU/ICU) postoperative care unit for stays of up to 72 hours. The relative proportion of patients receiving different levels of postoperative care will be flexible, as determined by the case mix undergoing surgery.

This facility is a consultant-led nurse-delivered unit with standardised perioperative care pathways to provide protocolised care including: admission and discharge criteria; escalation and de-escalation strategies; subspecialty enhanced recovery after surgery (ERAS) programmes; pain management pathways and other specific perioperative medicine treatment algorithms. Care is provided on a ‘closed unit’ model evidenced to provide optimum patient care.

The fundamental aim is to provide close monitoring and limited periods of both cardiovascular and respiratory support in the immediate postoperative phase. Mechanical ventilation can be provided in the Level 3 zone but only for patients with predicted early extubation and length of stay less than 72 hours. Patients with predicted length of mechanical ventilation or haemodynamic support of more than 72 hours, need for renal replacement therapy or specific advanced monitoring modalities, e.g. pulmonary artery catheters, should be transferred directly to ICU4 immediately postoperatively.

Levels of postoperative care & expected length of stay

Adherence to postoperative length of stay guidelines within the unit is critical to maintain patient flow and minimise cancellations or delay to surgery due to bed availability.

PACU: 24hrs

- Postoperative day 1 morning consultant review prior to ward discharge

Surgical HDU/ICU: 24-72hrs

- Patients undergoing complex major surgery requiring basic/advanced respiratory support or basic cardiovascular support within a timeframe to facilitate discharge within 48hrs.

- Twice daily consultant review prior to timely ward discharge.
- Patients still requiring level 2/3 care at 72hrs will require escalation to ICU NIC (2400) or ICU Matron/ICU EPIC Consultant, for transfer to ICU4 for ongoing support if appropriate.
- Patients with predicted postoperative length of stay greater than 72hrs should be managed postoperatively in ICU4. This should include patients predicted to be intubated for more than 24hrs postoperatively.

3. Definitions

Glossary

Closed unit	Patients are admitted to the ICU and responsibility for their treatment is transferred to the Consultant Intensivist until they are ready for discharge
CSP MDT	Complex Surgical Patient Multidisciplinary Team meeting
EPIC	Enhanced Postoperative Integrated Care
ICU(4)	Intensive Care Unit (4th Floor)
PACU	Post Anaesthesia Care Unit
SHDU	Surgical High Dependency Unit

Levels of Care

Level 0	Patients whose needs can be met through normal ward care in an acute hospital
Level 1	Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from the Critical Care team
Enhanced Care (Level 1.5)	An intermediate level of care where a higher level of observation, monitoring and interventions can be provided than on a general ward but not requiring high dependency care/organ support.
Level 2	Patients requiring more detailed observation or intervention including support for a failing organ system or postoperative care, and those stepping down from higher levels of care.
Level 3	Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least 2 organs systems. This level includes all complex patients requiring support for multi organ failure.

4. Staff

There will be hybrid model for both medical (anaesthetic/ICU) and nursing (recovery/surgical/ICU) staffing. The unit will be staffed 24/7 at business as usual (BAU), although the bed footprint and staffing required at the weekend will be expected to be reduced due to relative reduction in planned surgical activity. The PACU zone will operate at full capacity, for elective and emergency admissions (staffed for 8 beds), Monday to Friday and reduced capacity (staffed for 2 beds) for emergency surgery and limited weekend (WLI) elective activity, from Saturday afternoon to Monday morning.

Nursing competencies must be appropriate for the allocated zone, with the minimum training requirement for PACU, SHDU & ICU nursing staff being the enhanced care & HDU & ICU

courses respectively. Level 1/1.5 enhanced care patients being the 'National Competency Framework for registered practitioners: Level 1 and Enhanced Care Areas', developed by the National Outreach Forum (NOrF) and Critical Care Networks - National Nurse Leads (CC3N). PACU zone nursing will require a mix of nursing competencies to reflect the patient case mix and ensure nursing for level 2 PACU patients is delivered by HDU level competent nurses. EPIC Level 2/3 zone nursing allocation will be based on competencies required for patient case mix in this zone and determined by the senior nurse in charge. Flexibility within this staffing model to flex down to accommodate case mix of patients with regard to level of care will be required but within the CC3N competency framework. Nursing staff within enhanced care training should be provided within additional training opportunities to acquire additional levels of competency to allow more flexibility with staffing the unit in the future.

For medical staffing, a dedicated consultant anaesthetist will oversee PACU zone patients with a dedicated consultant intensivist (FICM accredited) for EPIC level 2/3 care patients. The daytime consultant to patient ratio for each zone will therefore meet FICM guidance and not normally exceed 1:12. ICU clinical fellows will be based in the EPIC level 2/3 zone with anaesthetics / perioperative medicine (POM) fellows in the PACU zone. Staffing at night will be provided by 1 ICU fellow and 1 POM fellow for the EPIC level 2/3 and PACU respectively with oversight from non-resident on call EPIC ICU & anaesthetics consultants respectively.

All patients must have an identified surgical consultant on admission.

Total bed capacity for the entire unit is for 20 patients, with the relative proportion of PACU and SHDU/ICU patients varying depending on surgical activity. However, PACU zone patients will be accommodated in the bedspaces 1-8 (8 beds) and the SHDU/ICU (Level 2/3) zone patients in bedspaces 9-20 (12 beds). There will be flexibility within this bed footprint especially with regards to side room provision for infection control measures, with up to 4 side rooms (bedspaces 9-12) available in the SHDU/ICU for patients in all care levels. If PACU patients require a side room, bedspaces 9-10 should be used as first preference. SHDU patients can be then be accommodated in the PACU zone as a direct 'swap'

The entire EPIC unit and the bed spaces within will have full ICU level capabilities as per HBN 04-02 guidance. Although the standard operating procedure of the unit will be as is described in this document, in exceptional circumstances this function may change, whereby the unit will have the ability to function as a full level 3 ICU facility.

5. Admission

- All planned surgery will be booked through the existing on-line ICU booking system and discussed at the weekly Complex Surgical Patient (CSP) Perioperative MDT meeting (Friday, 2pm), where appropriate level of care will be allocated.
- Additions to the booking list on the day of surgery and all emergency admissions will be at the discretion of the on-call PACU or ICU Consultant and senior nurse responsible for EPIC unit bed management
- For unplanned admissions, PACU referrals should be discussed with PACU Consultant and then ICU NIC (2400) informed, if accepted. ICU/SHDU referrals should be discussed with ICU Consultant on-call (not EPIC Consultant) and ICU NIC (2400). If referring team is unsure about appropriate level of care, the PACU and on-call ICU Consultant will discuss directly to allocate level of care.
- Admissions will be from theatres or IRCU only (i.e. not from the ward)

Admission criteria

Strict pre-determined admission criteria will be used from risk stratification and patient selection based on surgical factors, perioperative risk factors or identification of specific potential postoperative complications requiring additional monitoring or level of nursing care.

1. Pre-determined surgical procedures will be triaged to specific level of postoperative care (PACU, SHDU/ICU, ICU4) for each surgical subspecialty (see Appendix) with potential to increase level of care based on medical co-morbidities or additive surgical risk
2. Objective surgical risk assessment should be performed at preassessment (e.g. SORT, NELA risk, CPET, Nottingham hip fracture score) to guide choice of postoperative care level as required eg:
    a. ICU4 recommended for predicted 30-day mortality >10%
    b. SHDU/ICU care recommended for predicted 30-day mortality 5-10%
    c. PACU recommended for predicted 30-day mortality 2-5%
3. Additional risk assessment paradigms may be considered in Preassessment / CSP Perioperative MDT include:
    a. Risk of postoperative pulmonary complications (ARISCAT)
    b. Frailty (Rockwood score) & risk of postoperative cognitive deficit (POCD)

The CSP Perioperative MDT will review all referred higher risk patients that meet these criteria to determine appropriate level of postoperative care prior to scheduled surgery. The template for minimum level of postoperative care for common major / complex major surgery is followed in LOC allocation in the CSP MDT and is shown in Appendix .

Emergency patients undergoing unplanned surgery should be risk assessed and postoperative destination tailored to perioperative risk and predicted postoperative length of stay e.g. emergency laparotomy with predicted 30-day mortality (NELA) risk >10% consider ICU4, 5-10% consider SHDU/ICU whereas 2-5% consider PACU. Similar paradigms may be beneficial in assessing patients undergoing emergency vascular peripheral bypass surgery. Appropriate postoperative care level destination should then be discussed with PACU/ICU consultants on EPIC unit and zone determined using relevant infection control guidelines for that patient (low/medium/high risk, need for isolation etc)

6. Components of care delivery for specific EPIC unit zones

The following monitoring modalities, levels of organ support or therapies are the maximum provided for each EPIC zone. Patients requiring higher levels of monitoring, organ support or specific additional therapies should be referred to higher level care i.e. EPIC level 2/3 or ICU 4. Furthermore, patients requiring this level of care beyond the timeframe expected for the EPIC zone need to be referred to higher level zone for continuation of appropriate level care.

PACU

- Invasive blood pressure & CVP monitoring
- Non-invasive cardiac output monitoring (eg Edwards ClearSight)
- Single vasopressor/inotrope support to a maximum of 0.2 mcg/kg/min noradrenaline
- High Flow Nasal Oxygen to a maximum of FiO_2 0.4 / 50lpm flow.
- Anti-arrhythmia infusion (IV amiodarone)
- Anticoagulant infusions (IV heparin)
- Anti-hypertensive infusions (IV GTN/labetalol)
- Infusions for analgesia & patient-controlled analgesia (IV opioids/ketamine/lidocaine)
- Epidural infusions
- Peripheral nerve catheter, wound infiltration catheter and amputation stump catheter local anaesthetic infusions

SHDU/ICU

- Invasive blood pressure & CVP monitoring
- Non-invasive & invasive cardiac output monitoring (Flotrac EV1000), not pulmonary artery catheters
- Single vasopressor/inotrope support to a maximum of 0.2 mcg/kg/min noradrenaline or 5 mcg/kg/min dobutamine.
- High Flow Nasal Oxygen to a maximum of FiO2 0.40 / 50lpm flow
- Non-invasive ventilation eg CPAP/BiPAP
- Anti-arrhythmia infusion (IV amiodarone)
- Anticoagulant infusions (IV heparin)
- Thrombolysis infusions
- Anti-hypertensive infusions (IV GTN/labetalol)
- Infusions for analgesia & patient-controlled analgesia (IV opioids/ketamine/lidocaine)
- Epidural infusions
- Peripheral nerve catheter, wound infiltration catheter and amputation stump catheter local anaesthetic infusions
- Cerebrospinal fluid (CSF) drainage systems & LiquoGuard monitoring for complex aortic surgical patients

7. Escalation & de-escalation protocol

Triggers for referral of a surgical patient to **higher** level care i.e. SHDU/ICU or ICU4 rather than PACU/SHDU respectively:

- Patients in whom there has been unforeseen intraoperative deterioration or complications should be discussed with the on-call Consultant to determine whether they should be referred to higher level care e.g. SHDU/ICU or ICU4. This includes patients with unexpected intraoperative or ongoing hemodynamically instability or intraoperative or ongoing haemorrhage (e.g. >1 litre blood loss)

- Patient is thought to require greater than 72 hours of level 2 support (or patients expected to remain intubated for greater than 24 hours) should be referred to ICU4
- Patients with likely requirement for renal replacement therapy should be referred to ICU4
- Noradrenaline requirement of greater than 0.2 mcg/kg/min or dobutamine requirement greater than 5 mcg/kg/min should be referred to ICU4
- Patients requiring two or more two vasoactive infusions (e.g. noradrenaline and dobutamine) should be referred or ICU4
- Patients requiring isolation for infection control measures (e.g. MRSA, VRE, ESBL, CPO) should be referred to SHDU/ICU or ICU4 for side room accommodation.
- ICU4 'upgrades' should be discussed directly with ICU Consultant on-call (not EPIC Consultant) and ICU NIC (2400)

Triggers for referral of a surgical patient to **lower** level care i.e. PACU/SHDU rather than SHDU/ICU or ward rather than PACU/SDU/ICU:

- Patients in whom the scale of the surgery has changed intra-operatively e.g. inoperable pancreatic resection (Whipples converted to palliative bypass) should be discussed with the on-call Consultant to determine whether they should be referred to lower level care e.g. ward, PACU or SHDU.
- Suitability for 'downgrading' level of care must be discussed with EPIC ICU and PACU Consultants, together with NIC and, if necessary, surgical bed manager.
- Downgrading level of care should be based on clinical criteria rather than due to bed occupancy.
- PACU 'downgrades' should be discussed directly with PACU Consultant on call and ICI NIC (2400).

8. Daily operation of unit

- Identified PACU (Anaesthesia) & Level 2/3 (ICU) Consultant (FICM accredited) with associated clinical fellows +/- foundation year doctors
- Twice daily ward rounds by both PACU & ICU Consultants
- All patients must have a dedicated primary team and named surgical consultant. Patients should be reviewed at least once daily by a surgical consultant and contact details provided for contacting the surgical team at any time. Care is provided on a 'closed unit' model evidenced to provide optimum patient care, except for the prescription of immunosuppression in renal transplant patients.
- Multi-disciplinary board meeting at 9.15am weekdays (10.30am weekends) attended by both PACU/Anaesthesia and ICU teams, NIC and visiting teams e.g. pain management team to review admissions (including estimated time of arrival), discharges, any escalation/de-escalation of level of care required, pain management review or identify other issues, especially pertaining to timely discharge.
- Dedicated nurse in charge and nurses assigned to patients based on level of care, competency and skill mix
- Nurse patient ratios variable according to EPIC zone i.e. level of care and postoperative phase: Level 3 1:1, Level 2 1:2
- Unstable patients or patients requiring additional organ support or higher nursing input at the discretion of the senior nurse in charge.
- MDT input will be provided from pharmacy, physiotherapy and pain management team
- Daily microbiology ward round
- Audit of practice using normal ICU processes and procedures

Admission and discharge process

- On admission there will be a full bedside handover of the patient from the anaesthetic team to the appropriate zone EPIC medical and nursing teams.
- Patient should have admission documentation completed by Anaesthetics/POM or ICU fellow and entered into EPR Critical Care View.
- Nursing staff should undertake admission care bundle (see separate guide) including admission blood investigations (ICU panel), ECG
- The Anaesthetics/POM & ICU fellows and NIC overnight will review all patients and identify those fit for discharge before 8am.
- Any issues regarding unavailability of PACU/SHDU/ICU beds for elective cases must be communicated to clinical matrons for ICU and theatres and theatre coordinator before 8am.
- If patients are deemed fit for discharge, as indicated on the ICU SitRep, ward beds will be requested at the 8.30am bed meeting. PACU discharges should be prioritized due to requirement to maintain flow. due to and have an allocated ward bed, then that bed will be available for a surgical patient.
- Confirmation of suitability for ward discharge will be confirmed before 9.15am at the MDT board meeting (attended by EPIC nurse in charge and both PACU and SHDU/ICU medical teams).
- Following confirmation of suitability for ward discharge, removal of invasive lines (CVC then arterial) should be prioritized by nursing staff and frequency of observations modified to ward level (usually 4-hourly).
- Prompt ward discharge within allocated time frame is essential to maintain flow of admissions into EPIC unit. Any delay to timely discharge must be escalated to nurse in charge for further escalation.
- Patients ideally should not be discharged to ward within 4hours of discontinuation of vasopressor support
- There should be no discharges between 20.00 and 07.00 unless under exceptional circumstances.
- Transfers from EPIC unit to ICU4 must have full medical (Consultant), nursing and therapies handover

Surgical reviews

- Identified surgical consultant for each patient
- Daily review by surgical team (Consultant or SpR/SCF) as a minimum, including weekends.
- Surgical team must read EPIC daily review and handover surgical plan to EPIC doctor on relevant unit. If doctor not available, then surgical team to update via bleep/phone
- Documentation of surgical reviews on EPR must be completed at the time of visit and not retrospectively.
- Surgical team must not prescribe medications while patient is on EPIC unit (with the exception of immunosuppression for transplant patients) but discuss any suggested changes with the relevant EPIC team.
- For PACU patients with delayed discharges to ward (fit for discharge but no ward bed available), surgical teams should be first point of contact, with support from PACU fellow.

9. Documentation

- All patients will be admitted using the Critical Care Admission clerking note on EPR.
- Handover worklists are available on the Critical Care Worklist function on EPR.

- The night staff (medical and nursing) should complete the Critical Care Discharge documentation on EPR.
- Daily PACU and ICU ward rounds plus entries from surgical teams must be clearly documented on EPR.
- PACU & ICU fellows must ensure accurate and safe electronic prescribing on EPR with appropriate use of either PACU or Critical Care Prescribing Plans an cross-checking postoperative prescriptions initiated by theatre teams, including analgesia regimens e.g PCAs or regional anaesthesia prescriptions e.g wound infiltration or stump catheters
- Senior PACU/SHDU nurses will enter CCMDS patient data after midnight. .
- Senior nursing staff must ensure patient discharged on CCMDS and patient transferred to relevant ward area on Cerner.

10. Infection Prevention & Control

This will be led by the Trust Infection Prevention & Control team. EPIC unit staff will abide with Trust policies and patients will be treated in accordance with this.

There are currently three pathways for patients to be admitted to EPIC unit:

1. **Elective/planned surgery patients coming from DSU/ SAA via theatres (on non-respiratory pathway)** - can be admitted to EPIC open bay (if no infection alert flagged e.g. MRSA/VRE) ie EPIC beds 1-8 or 14-20
2. **Elective/planned surgery patients coming from surgical ward via theatres (on non-respiratory pathway)** can be admitted to EPIC open bay as above (if no infection alert flagged e.g. MRSA/VRE)
3. **Emergency surgery patients coming from ward/ED (on non-respiratory pathway)** - admitted initially from ED, must come via theatre on appropriate pathway and not direct to the EPIC unit. Admission to EPIC unit is dependent on confirmation patient is not on respiratory pathway.

Patients on respiratory pathway (e.g Covid positive) must not be admitted to EPIC unit.

Please note that all immunocompromised renal transplant patients should be admitted to EPIC side rooms (beds 9-12)

Patients with infection alerts should be admitted to the following areas:

- **EPIC unit side rooms**: CPO/C-difficile/VRE (with diarrhoea) - may be admitted to EPIC side rooms (beds 9-13) if meet admission criteria
- **ICU4 side rooms <u>must</u>** be used for patients:
    - Surgical patients requiring respiratory isolation (respiratory pathway)
    - Post-operative liver transplant patients
    - EPIC side room not available

The EPIC unit admission infection screen is the same as ICU for all EPIC patients

- Covid PCR
- MRSA (Nose and perineum)
- VRE – Rectum
- CPO

11. Medical patients in EPIC unit

In exceptional circumstances, medical patients in ICU4, or requiring admission to ICU4, will be accommodated in EPIC unit. This negatively impacts the ability of the unit to maintain flow for surgical admissions and provide necessary side room capacity.

Decision to admit medical patients into EPIC unit must be discussed with ICU Matron and Consultant, only if ICU4 capacity has been exceeded, including side room capacity. However, if a medical patient is accommodated in EPIC unit, it should be reviewed daily to relocate to another more suitable ICU4 area. Delayed transfer to the appropriate ICU4 area or failure to accommodate a postoperative surgical admission due to medical in-lier should be escalated to ICU Matron and Clinical Service Leads.

12. Major/complex major surgery minimum postoperative level of care template

Subspecialty	Operation	Min postoperative care level
Colorectal	Panproctocolectomy & ileostomy (open/laparoscopic)	PACU (24hr)
	Right hemicolectomy (open/laparoscopic)	PACU (24hr)
	Abdominoperineal (AP) resection (open/laparoscopic)	PACU (24hr)
	Anterior resection (open/laparoscopic)	PACU (24hr)
	Left hemicolectomy (open/laparoscopic)	PACU (24hr)
	Hartmann's procedure	PACU (24hr)
	Ileo-caecal resection	PACU (24hr)
	Sigmoid colectomy	PACU (24hr)
Vascular	Carotid endarterectomy	PACU (24hr)
	Endovascular repair of thoracic aortic aneurysm (TEVAR)	SHDU (72hr)
	Fenestrated endovascular abdominal aortic aneurysm repair (FEVAR)	SHDU (72hr)
	Open infrarenal abdominal aortic aneurysm repair	SHDU (72hr)
	Endovascular infrarenal abdominal aortic aneurysm repair (EVAR)* (*high risk medical)	PACU (24hr)
	Explant of endovascular aortic graft	ICU4 (>72hr)
	Aorto-iliac/femoral or ilio-femoral bypass	SHDU (72hr)
	Aorto-bifemoral bypass	SHDU (72hr)
	Axillo-uni/bifemoral bypass*	PACU (24hr)
	Femoro-popliteal bypass*	PACU (24hr)
	Femoro-distal bypass*	PACU (24hr)
HPB	Wedge resection	PACU (24hr)
	Segmental resection	PACU (24hr)
	Left lateral hepatectomy	PACU (24hr)
	Left hemihepatectomy	SHDU (72hr)
	Right hemihepatectomy	SHDU (72hr)
	Central hepatectomy	ICU3 (72hr)
	Right extended hemihepatectomy	ICU3 (72hr)
	Left extended hemihepatectomy	ICU3 (72hr)
	Orthotopic liver transplantation	ICU4/LCCU(>72hr)
	Open cholecystectomy	PACU (24hr)
	Distal pancreatectomy +/- splenectomy (open/laparoscopic)	PACU (24hr)
	Pancreatoduodenectomy (Whipple's procedure)	SHDU (72hr)
	Total pancreatectomy	SHDU (72hr)
	Splenectomy	PACU (24hr)
	Gallbladder fossa resection	PACU (24hr)
	Biliary reconstruction	SHDU (72hr)
	Frey's procedure	PACU (24hr)
Sarcoma & Upper GI	Excision of retroperitoneal sarcoma	PACU (24hr)
	Sleeve gastrectomy	PACU (24hr)
	Partial gastrectomy	PACU (24hr)
Renal & Endocrine	Open nephrectomy	PACU (24hr)
	Open nephrectomy + IVC tumour thrombectomy	SHDU (72hr)
	Cadaveric renal transplant	PACU (24hr)
	Live related/unrelated renal transplant	PACU (24hr)
	Dual kidney transplant	PACU (24hr)
	Robotic/open adrenalectomy (non-secretory)	PACU (24hr)
	Robotic/open adrenalectomy (secretory)	SHDU (72hr)
Plastics	Abdominal wall reconstruction	PACU (24hr)

Equipment required	
Procedure	**Rationale**

14. Audit/Monitoring

Element to be audited/ monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared

15. References

Appendix 1: Royal Free London NHS Foundation Trust Equality and Human Rights Analysis

Name of the policy / function / service development being assessed		
Briefly describe its aims and objectives:		
Division and department		
Details of the person responsible for the EHRA	**Name:** **Job Title:** **Contact Details:**	
What are the main aims and objectives of the policy/ document/ project/ programme?		
Does the document include the equality statement?	**Yes** ☐ **No** ☐ **If no, do not proceed with Equality Analysis until complete**	

5. Engagement and involvement **Who have you consulted with as part of this EA? E.g. Staff Networks, Trades Unions, patients, carers, families, advocacy groups, staff etc.**

6.	a) Impact **Is the policy, project or programme likely to have a differential impact on any of the protected characteristics? If so, is this impact likely to be positive or negative?** **Consider:** How does the policy, project or programme help us meet our public sector duty of: • Eliminating Unlawful discrimination • Advancing Equality of Opportunity • Promoting good relations between groups Does the policy exclude individuals with a protected characteristic e.g. females, older people etc? What does existing evidence show? E.g. consultation from different groups, demographic data, questionnaires, equality monitoring data, analysis of complaints etc. For internal policies, projects, or programmes, you need consider impacts on staff from all protected characteristics. For policies, projects and programmes based on services, you should consider others affected by the proposals such as those accessing the service, taking into consideration the nine protected characteristics and human rights. Please use, the factsheet, the top tips and things to think about when conducting an equality analysis	b) Mitigation **Can any potential negative impact be justified? If not, how will you mitigate, reduce or remove any negative impacts?** Think about reasonable adjustments Consider positive action Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints.
Equality Group:	**Impact:**	**Mitigation:**
Age		
Carers / People with caring responsibilities		
Disability		

Race / Ethnicity		
Gender		
Gender Reassignment		
Marriage & Civil Partnership		
Pregnancy & Maternity		
Religion & Belief		
Sexual Orientation		
General Comments across all equality strands		

If the policy, project or programme changes the way that we deliver our services, please complete section 7 - Human Rights duties assessment. You do not need to complete this section if the policy or document is internal-facing, e.g. a People policy – you can skip to section 8 – Action Planning.

7.	**a) Human Rights duties compliance** **Is the policy, document, project or service likely to have human rights implications If so, is this impact likely to be positive or negative? Use the FREDA (Fairness, Respect, Equality, Dignity and Autonomy) principles when considering the following:** - The impact **on respecting people's human rights** could our actions directly affect people's rights. For example, by compromising their privacy - **The impact on protecting people's human rights** e.g. changes which impact on how we protect the human rights of people using services, - **The impact on fulfilling people's human rights,** this relates to helping people exercise their human rights themselves, for example through the provision of information about rights or promotion of advocacy - **If the proposals could affect rights to privacy, a data protection impact assessment should be undertaken – please complete the template:** **Data protection Impact Assessment**	**b) Mitigation** **Consider:** **How will any potential positive impact on human rights be maximised?** This helps us to meet our duty to fulfil human rights. Consider the FREDA principles as the basis to enhance a person-centred approach when considering: **How will any potential negative impact on human rights be mitigated?** Note that there are differences in our duties depending on the rights concerned and whether the impact relates to respecting, protecting or fulfilling human rights. For example, the duty to respect the right to freedom from inhuman or degrading treatment is absolute. However, respecting rights to privacy can be restricted if this is lawful, for a legitimate aim and proportionate.
Freedom from inhumane or degrading treatment		This document does not change the way that we deliver our services; it is a staff clinical practice guideline/ policy based on national best practice The guideline is written to promote equality, privacy, dignity and respect in line with the trusts world class care values, and to….
Right to liberty – exceptions include Deprivation of Liberty Safeguards		
Right to respect for family and private life, (includes autonomy issues in care and treatment)		
Other rights, e.g. right to life, right not to be discriminated against in connection with other rights		

8. Action Planning – this should be completed whenever a differential equality impact or human rights impact has been identified			
Action	**Action Owner**	**Timescales**	**Date completed**

9. EA – internal assurance	**If your Analysis relates to staff along with policy, project or programme document should be sent to: Yemesi Osibote, Head of Workforce, Staff Experience Yemisi.osibote@nhs.net**
	All other Equality Analysis along with policy, project or programme document should be sent to: Kulvinder Hira, Equality and Diversity Manager (Patients and Carers) Kulvinder.hira1@nhs.net

10. Sign off and publish	**Governing committee**	See Validation Grid
	Date of approval	See Validation Grid
	Date of publish	See Validation Grid
	Date of review (if relevant)	See Validation Grid

Note that after sign off, EAs will be published on Freenet or internet so should be written with that in mind, for example in relation to person identifiable information.