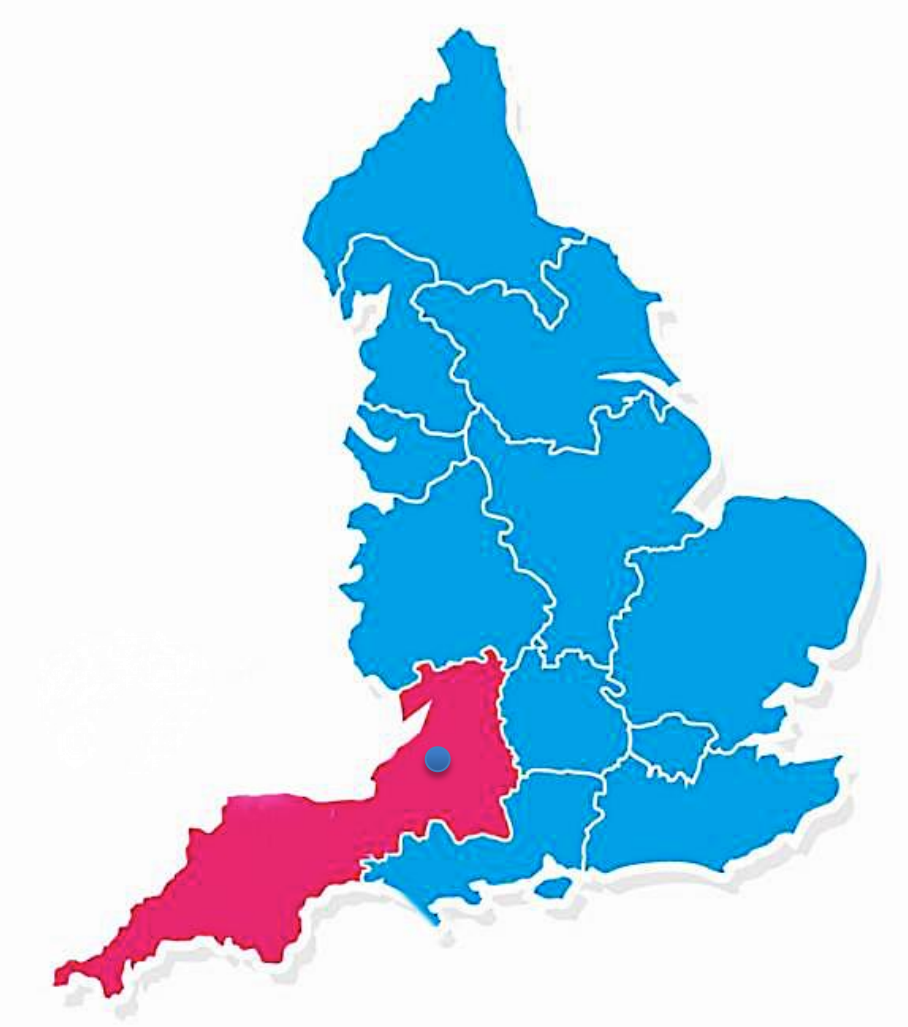
South West Clinical Senate

Emergency General Surgery – A review of trusts in the South West



Royal United Hospital Bath NHS Foundation Trust

22nd November 2016

Contents

Introduction

The spotlight on waiting times has meant an increasing focus on elective care. The four hour target has been the driver for emergency work to reduce waiting times in A&E, particularly during the winter. The pressure around meeting these targets has used resources and made it difficult for Emergency General Surgery (EGS) to maintain the continual improvement necessary in today's environment. The majority of trusts staff their EGS service with surgeons, who already have a sub-specialisation and are involved in the EGS service via a rotational rota. This often means EGS can lack the ownership necessary to find the commitment and resources in order to develop. As a service, EGS represents the largest group of surgical admissions in UK hospitals and accounts for a high number of complications, resulting in long periods of care and a high number of fatalities. It is nationally recognised that there is a considerable variability in outcomes between trusts. Whilst services between trusts will differ, there is clearly an opportunity for outcomes to be improved through sharing ways of working throughout the region. By learning from neighbouring trusts, processes can be improved, leading to an increase in quality and associated improvement in patient safety.

In 2011 a joint working group between the Royal College of Surgeons (RCS) and the Department of Health (DH) was set-up and produced a number of guidelines on perioperative care of general and vascular surgery. This provided guidance on standards of care and key issues, which in the opinion of the specialist group, could be implemented within two years and produce an appreciable difference in outcomes. These standards of care were incorporated within the RCS guideline document, Emergency Surgery: Standards for unscheduled care, which is primarily aimed at commissioners, planner and providers of emergency care. The uptake of these standards has been slow. Some regional providers, most notably, The Strategic Health Authority in London, commissioned a London health audit in 2012 to understand the performance of London hospitals for emergency general surgery and acute medicine.

In 2014 the South West Clinical Senate presented a number of key recommendations on how EGS services could be configured in the South West in order to provide sustainable and comprehensive, high quality emergency care, which is based on national standards. Using the 2011 RCS standards for Emergency Surgery, the SW Clinical Senate has commissioned a review of emergency general surgery in the region. Using a mixed method approach, the work aims to review 14 South West trusts in order to provide an overview of performance in the South West. By highlighting areas of improvement and providing recommendations on improving aspects of perioperative care, the aim will be to raise standards of care for emergency general surgery patients.

Background to the review

A clinical expert panel was formed and a set of standards produced for EGS in the South West. The standards were primarily based around three existing sources: RCS 2011 Standards for Unscheduled Surgical Care, London Health Audit (2012) standards for EGS and the recent (2016) NHS England 7 day standards.

Following a pilot review in April 2016 the review was conducted throughout the South West at fourteen Acute Trusts in order to understand the current status of South West hospitals with reference to the EGS standards. Details of the key dates for this hospital can be found in Appendix 1.

The methodology for the review followed a similar pattern to London's Health Audit but with the exclusion of acute medicine.

The review consisted of two main stages:

Stage 1 Hospital self-assessment of compliance with EGS clinical standards.
Stage 2 An external assessment against the EGS clinical standards by an independent review team

Further details on each stage are included in Appendix 2.

In the self-assessment, hospitals were asked to provide evidence into the standards they felt they were meeting, as well as detailing any plans into standards that were currently not being met. Six weeks later, trusts underwent an external review to determine which standards were currently being met. Where there was a firm plan in place for meeting a currently unmet standard, this is outlined in the assessment write-up below. This report details the findings and conclusions from the review.

Royal United Hospital Bath NHS Foundation Trust

Tel: (01225) 428331

Royal United Hospitals Bath
NHS Foundation Trust
Combe Park
Bath BA1 3NG

Website: http://www.ruh.nhs.uk/

The Royal United Hospitals Bath NHS Foundation Trust provides acute treatment and care for a catchment population of around 500,000 people in Bath, and the surrounding towns and villages in North East Somerset and Western Wiltshire.

The Trust provides 772 beds and employs around 4,800 staff, some of who also provide outpatient, diagnostic and same day case surgery services at local community hospitals in Bath & North East Somerset, Somerset and Wiltshire.

Summary of findings

Table 1 provides a summary of the performance against the commissioning standard. The following Table 2 provides the standards with commentary from the review process. As shown in table 1 the green, red and amber colours demonstrate whether a standard was met, not met, or partially met.

Table 1: Summary of compliance with the Emergency General Surgery standards

No.	Standard	Week	Weekend
1	*Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds such that patients are generally seen within 14hrs from arrival. There is evidence of continuity of care ……..(cont)*	Met	Met
2	*Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.*	Met	Met
3	*All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.*	Met	Met
4	*All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week, either on site or through a formalised network with an agreed SLA (Service Line Agreement). Critical patients - within 1 hour if IR on site, within 3 hours if networked, Non-critical patients - 12 hours. Interventional facilities are safe for emergency patients.*	Partially Met	Partially Met
5	*Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.*	Partially Met	Partially Met
6	*A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialities throughout the emergency pathway.*	Met	Met
7	*All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (ST3/SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.*	Met	Met
8	*Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7*	Met	Met
9	*All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. ……..(cont)*	Met	Met
10	*All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented*	Met	Met
11	*The majority of emergency general surgery to be done on planned emergency lists on the day that surgery was originally planned. The date, time and decision makers should be documented clearly in the patient's notes and any delays to emergency surgery and reasons why recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre*	Met	Met
12	*Handovers must be led by a competent senior decision maker (ST3/SpR & above) and take place at a designated time and place, twice a day. These arrangements to be in place for handover of patients at each change of responsible consultant/surgical team/shift or block of*	Met	Met

	on-call days where it should be consultant led. Changes in treatment plans to be communicated to nursing staff and therapy staff ……..(cont)		
13	*Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. The service has participated in national audits (e.g., NELA, EPOCH - list those known) ……..(cont)*	Met	Met
14	*Hospitals admitting emergency patients have access to comprehensive (Upper/Lower) 24 hour endoscopy service, that has a formal consultant rota 24 hours a day, seven days a week covering GI bleeding.*	Met	Met
15	*Training is delivered in a supportive environment with appropriate, graded, consultant supervision.*	Partially Met	Partially Met
16	*Sepsis bundle/pathway in emergency care.*	Met	Met
17	*There is a policy for review of all Emergency general surgery patients by a consultant, every day, 7 days a week, whilst they remain under the care of the emergency team.*	Partially Met	Partially Met
18	*Emergency surgical services delivered via a network (e.g. vascular surgery, IR, Plastics,/Burns and Paediatrics.) have arrangements in place for image transfer, telemedicine, and agreed protocols for ambulance bypass/transfer and a formal SLA. Standards for the transfer of critically ill patients are adhered to and regularly audited.*	Partially Met	Partially Met
19	*For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and ……..(cont)*	Met	Met
20	*As a minimum, a speciality trainee (ST3/SpR or above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status), is available at all times within 30 minutes and is able to escalate concerns to a consultant. Juniors qualifications - i.e., experience level of team.*	Met	Met
21	*Do you have clear protocols for senior speciality review of all general surgical in-patients to include GI surgery (Colorectal, Upper GI, Hepato-billary), Vascular, Breast & Urology) every day, seven days a week.*	Not Met Met	Not Met Met
22	*Do you have clear protocols, including a standard for timing, for senior medical speciality review by a physician of emergency general surgical admissions?*	Not Met	Not Met

Table 2: Summary and commentary of compliance with the Emergency General Surgery standards

No.	Standard	Commentary and Conclusions	Week	Weekend
1	***Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds such that patients are generally seen within 14hrs from arrival. There is evidence of continuity of care either through multiple day working or specific patterns of working that allow continuity of care. When on-take, a consultant and the on call team are to be completely freed from other clinical duties or elective commitments. Surgeon with private practice commitments makes arrangements for their private patients to be cared for by another surgeon/team, when they are on call for emergency admissions.***	In general, the team felt that this standard was met. There were clearly 2 consultant led ward rounds happening at 8.00am and then again around 4.00 – 5.00pm. The only issue raised was this meant that some patients admitted late in the afternoon/early evening, may have to wait more than 14 hours before being seen by a consultant. All of the team were free from all elective activities during the on call session. There were some concerns raised about the issues around continuity of care because of the single day on call rota that is currently worked in Bath. We understand there is due to be the appointment of a further colorectal post in the near future, which will allow provision of a consultant colorectal surgeon of the week and should alleviate some of the concerns related to the more complex colorectal cases and continuity of care.	**Met**	**Met**
2	***Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.***	This standard was clearly met. There is a well-established escalation policy, and in addition to this, the scoring of the NEWS marking is audited on a regular basis. There is a good culture within the hospital with both nursing and junior staff happy to escalate problems to consultant as required.	**Met**	**Met**

3	***All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.***	This standard was clearly met. There was very good access to radiology 24/7, including plain x-rays, ultrasound, CT and even MRI scanning. Pathology was also available 24/7. The radiologists are on call overnight as well as outsourcing to TMC who provide the more run of the mill, out of hours work. Urgent reporting is done within 12 hours, and emergency reporting was done real time by the on call radiologist or through TMC.	**Met**	**Met**
4	***All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week, either on site or through a formalised network with an agreed SLA (Service Line Agreement). Critical patients - within 1 hour if IR on site, within 3 hours if networked, Non-critical patients - 12 hours. Interventional facilities are safe for emergency patients.***	The team felt this standard was partially met (although the upper end of partially met) The hospital currently runs a 1 in 6 nephrostomy/intra-abdominal drainage interventional radiology service, and on 3 out of those 6 slots there will be a vascular interventional radiologist on call. Unfortunately, at present for the other 3 slots, there is no clear arrangement for any vascular based GI work such as GI embolization or managing a GI bleed. At present this is on a rather ad-hoc basis with NBT due to the lack of a formal SLA which is currently being negotiated.	**Partially Met**	**Partially Met**
5	***Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.***	The team felt this standard was partially met, primarily due to concerns about the single day on-call rota currently being run. At present, the on-call consultant for the day is responsible for patients up until 4.00 pm in the afternoon. Any patient admitted after that time is then the responsibility of the consultant coming onto the next day. Overnight, those patients admitted after 4.00 pm are looked after by that day's on-call consultant, but the ongoing responsibility falls to the consultant on the next day. There was a concern expressed by the team that there was opportunity for patients to fall between the two on-call services. In particular, their job plans were	**Partially Met**	**Partially Met**

		variable; some have a clear ward round for the day after on-call planned and some did not. As a consequence, the consultants tended to try and juggle commitments in order to try and see patients from the day before. The planned appointment of a new colorectal surgeon should provide a consultant of the week within colorectal which should address some of these issues. In general, the patients are managed on the Surgical Assessment Unit, although this unit currently gets medical outliers, which can have a profound effect on the functioning of the SAU and on the ESAC (Emergency Surgery Ambulatory Care). It was noted that when the medical bed occupancy was greater than 40% with medical outliers, there was a severe impact on the ability to manage the emergency general surgical take.		
6	***A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialities throughout the emergency pathway.***	There was a unitary document in place and it is used consistently, although not all sections are completely filled out by the junior teams, in particular, those relating to sepsis and physiological scoring, although these do appear to have been done elsewhere.	**Met**	**Met**
7	***All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (ST3/SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.***	This standard was clearly met and is probably better than in any other hospital within the South West. There is a clear well organised emergency general surgery ambulatory care process run through the ESAC unit. This was commenced in May 2013, and takes referrals from GP, the Emergency Department, and the Surgical team itself. It has got dedicated ultrasound and rapid access to CT and MRI scanning. There is rapid access to 4 Priority Day surgery lists for managing ambulatory cases including	**Met**	**Met**

		laparoscopy, abscess drainage, laparoscopic appendectomies and perianal cases. The service has clear pathways dedicated to day case work, and has a clear area as well as a dedicated hot clinic. Bath have a well thought out emergency ambulatory care service with 3 emergency surgical nurse practitioners, as well as a dedicated laparoscopic cholecystectomy pathway. As part of the development of the ambulatory care pathway in Bath, they have a clear agreement with the local commissioning groups around the tariffs for this pathway which make it both cost effective for the Trust as a whole, as well as providing ideal care for patients. It should be noted that Bath is the only hospital we have come across that has a clear system for recording all emergency referrals (called ARAMIS) allowing them to note all GP emergency department referrals, including phone calls and in-house referrals.		
8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	This standard was met. The only issue raised was that after 5.00pm, the CEPOD and trauma theatres become one and the same. However, in view of the fact that there is a 10 hour trauma list, as well as a ½ day hip fracture list available each day, there is very little emergency orthopaedic surgery that impacts on the CEPOD list much after 6.00pm. Both the clinical staff and the theatre teams noted that the only orthopaedic cases that tended to interfere with the CEPOD list were open fractures, or	**Met**	**Met**

		fractures involving children.		
9	***All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care.*** ***All patients with a predicted mortality of >5% (SORT or P-Possum), should be discussed with an intensive care consultant preoperatively. A consultant surgeon and consultant anaesthetist must be present for the operation except in specific circumstances where adequate experience and the appropriate workforce is otherwise assured.*** ***Risk of death at end of surgery reassessed to determine location for post-op care.***	The team felt this standard was well met. There was clear evidence that patients are assessed physiologically with P-POSSUM scoring before surgery, and in addition, with the future introduction of the "Landing Card post laparotomy", should also be a scoring P-POSSUM after surgery. The majority of high risk patients are being placed in critical care following surgery, and there is over 80% attendance of consultant surgeon in theatre, but more recently, there has been a falloff in the presence of consultant anaesthetists, in emergency laparotomy.	**Met**	**Met**
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	The review team felt this standard was met in the majority of cases. All surgical cases processed through the ESAC pathway were seen by a consultant, listed for theatre, and usually operated on by that consultant, hence they were the direct decision maker. On the notes review, the majority of the laparotomies were discussed with the consultant, or the decision to operate was made by the consultant.	**Met**	**Met**
11	***The majority of emergency general surgery to be done on planned emergency lists on the day that surgery was originally planned. The date, time and decision makers should be documented clearly in the patient's notes and any delays to emergency surgery and reasons why recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre***	Based on the discussion with the clinical team and on the notes review, the review team felt that this standard was met in that the majority of operations were taking place on the day of surgery on the planned CEPOD list. In general, the decision makers were documented in the notes. A few check lists were done and routinely audited, although they	**Met**	**Met**

		are not recorded in the notes. The completion and accuracy is routinely audited.		
12	***Handovers must be led by a competent senior decision maker (ST3/SpR & above) and take place at a designated time and place, twice a day. These arrangements to be in place for handover of patients at each change of responsible consultant/surgical team/shift or block of on-call days where it should be consultant led. Changes in treatment plans to be communicated to nursing staff and therapy staff as soon as possible if they are not involved in the handover discussions. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.***	The team felt that this standard was met in that there were two handovers each day at 8.00 am and 8.00 pm. Each handover was consultant led, and the second handover, whilst being registrar led, was fed/driven by the second consultant ward round of the day. The F1 handover was very organised with specific printed sheets containing all the appropriate information. This was done electronically and archived on their 'Aramis' system.	**Met**	**Met**
13	***Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. The service has participated in national audits (e.g., NELA, EPOCH - list those known)*** ***Do you audit:*** ***a. Outcomes - death, LOS, return to theatre, readmissions*** ***b. Risk assessment prior to surgery*** ***c. Risk assessment post-surgery*** ***d. Time to CT/US from request*** ***e. Time from decision to theatre*** ***f. Proportion of patients having gall bladder out on admission*** ***g. Proportion of patients having gall bladder out on admission for pancreatitis***	The team felt this standard was met fairly thoroughly. As part of the development of the emergency ambulatory care service in Bath, they have had a considerable review of the aspects of their emergency general surgical pathway. There is regular review of patient experience collective data, although not clearly separated from ED and the Medical Assessment Unit. They are actively involved in the majority of national audits relating to emergency general surgery including NELA, EPOCH, the emergency laparotomy collaborative, and the recent Chole-quick. There is a clear audited pathway for the management of biliary colic and gallstone disease with associated pancreatitis and a dedicated nurse practitioner to streamline the management of these patients in an effective and efficient way.	**Met**	**Met**
14	***Hospitals admitting emergency patients have access to comprehensive (Upper/Lower) 24 hour endoscopy service, that has a formal consultant rota 24 hours a day, seven days a week covering GI bleeding.***	This standard was clearly met. There is a 24/7 GI bleed rota run by the gastroenterology team and any other urgent endoscopy can be arranged by discussion between consultants. We note the absence of the option of flexible	**Met**	**Met**

		sigmoidoscopy for decompression of sigmoid volvulus by the on-call endoscopy team.		
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	There was difficulty in marrying up the results from the last GMC survey on general surgery with comments from trainees in the focus group. From speaking to the trainees, they were very positive about their learning, and found all the consultants to be very supportive. The Emergency Nurse practitioner's provided support to the F1's with the clerking, bleeding and cannulating. However, the survey reported a number of measures below the national mean average, with 2016 having significant decreases in almost all measures compared to previous years. As such this standard is partially met.	**Partially Met**	**Partially Met**
16	***Sepsis bundle/pathway in emergency care.***	This standard appeared to be clearly met, and in fact Bath hospital was amongst the highest levels of patients who scored a positive sepsis screen with getting antibiotics within one hour at 84%. In quarter 2, 2016 results, the sepsis data suggested 80% of admissions were screened.	**Met**	**Met**
17	***There is a policy for review of all Emergency general surgery patients by a consultant, every day, 7 days a week, whilst they remain under the care of the emergency team.***	This standard was partially met. In absolute terms, as the standard is worded, the emergency patients of that day are seen each day by the on-call consultants 7 days a week. However, as evidenced by discussion with the medical staff, and by review of the notes, patients that were admitted the day before do not necessarily get seen the next day in a coherent and consistent way. As a consequence, there was concern that the absence of a job planned ward round for the preceding day's on-call consultant left a potential gap for the review of emergency patients.	**Partially Met**	**Partially Met**

18	***Emergency surgical services delivered via a network (e.g. vascular surgery, IR, Plastics,/Burns and Paediatrics.) have arrangements in place for image transfer, telemedicine, and agreed protocols for ambulance bypass/transfer and a formal SLA. Standards for the transfer of critically ill patients are adhered to and regularly audited.***	In general this standard was partially met. There was a clear networked arrangement for vascular surgery to be transferred to North Bristol along with vascular interventional radiology. However, there was not a complete interventional radiology rota arranged with North Bristol, and hence some of the GI aspects of embolization and GI bleeds are not currently covered. They are currently part of a trauma network, which means that major trauma cases bypass Bath and go straight to North Bristol. There was no evidence of any clear policies for transfer of critically ill patients and the networked arrangement for children was slightly unclear. The anaesthetists certainly had a specific policy around anaesthetising children for surgery, and also had an on-call rota for paediatric anaesthesia. The surgeons were able to provide some paediatric surgery at emergency level. All children under the age of 5 requiring possible intra-abdominal surgery get transferred to Bristol.	**Partially Met**	**Partially Met**
19	***For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and competence to handle the emergency surgical care of children, including those with life-threatening conditions who cannot be transferred or who cannot wait until a designated surgeon or anaesthetist is available.***	The review team felt that this standard was met. However, unlike all other Trusts in the South West, the paediatric emergency general surgical cases were admitted under the surgical team, other than the paediatric team and the latter were invited in view as required. As a consequence of this, all fluid balance, drug dosages etc. were managed by the emergency general surgical team rather than the paediatric team. It was noted during this discussion that it was rare for them to see many patients below the age of 8, which does raise the question of whether there is a specific age level at which cases were referred onto the Children's hospital. Subsequent	**Met**	**Met**

		feedback clarified that All children under the age of 5 requiring possible intra-abdominal surgery get transferred to Bristol children's hospital.		
20	***As a minimum, a speciality trainee (ST3/SpR or above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status), is available at all times within 30 minutes and is able to escalate concerns to a consultant. Juniors qualifications - i.e., experience level of team.***	This standard was clearly met.	**Met**	**Met**
21	***Do you have clear protocols for senior speciality review of all general surgical in-patients to include GI surgery (Colorectal, Upper GI, Hepato-billary), Vascular, Breast & Urology) every day, seven days a week.***	This standard has been divided into 2 sections. The first relates to whether all patients are seen by a consultant, and the second as to whether they are all seen by the registrar. With respect to the former, the review team felt that this standard was not met based on some discussions with the Bath team and on review of the notes.	**Not Met**	**Not Met**
		However with respect to the latter, all patients are seen each day by a registrar including over the weekend.	**Met**	**Met**
22	***Do you have clear protocols, including a standard for timing, for senior medical speciality review by a physician of emergency general surgical admissions?***	This was not met as with all other trusts in the South West.	**Not Met**	**Not Met**

Recommendations

Bath is ahead of all the Trusts in the South West in terms of its ambulatory care provision. However, the set-up is clearly not impervious to other pressures on the hospital and it was clear that the SAU struggled to function at times due to medical outliers. This was demonstrated in delayed/prolonged ward rounds and patient reviews (including hot clinic reviews), delayed Emergency Theatre starts, increased length of stay (LOS) and delayed transfers from the Emergency Department (ED).

Furthermore, whilst the ambulatory care is formalised, there are aspects of the consultant job plans less so, and the single day on-call rota did not lend itself to providing the best continuity of care.

Bath are one of only 3 Trusts in the South West running a ‘single day on call’ consultant rota, which the review team felt impaired continuity of care with the incoming consultant operating on cases from the previous day with limited involvement in the prior care. Ongoing care of non-operated cases was also raised with the outgoing consultant occupied with normal elective work the following day.

There is currently no provision of any out of hours EGS interventional radiology rota at Bath, no network service and no clear pathway to refer onto another provider. Arrangements are currently ad hoc, based on goodwill from the existing interventional radiologists locally and in Bristol. We would recommend this is looked into and a formal arrangement for IR is put in place to ensure there is no delay in urgent and emergency cases.

These recommendations form part of the six final recommendations proposed following the EGS review of all Trusts in the South West:

1. The provision of a protected Surgical Assessment Unit (SAU).
2. The provision of 24/7 CEPOD or Emergency Theatre.
3. A 'South West' standardised, rolling audit of EGS.

4. The appointment of an EGS lead and an Emergency Nurse lead in each Trust.
5. Delivery of 2 consultant led ward rounds per day of EGS patients.
6. Development of a fully integrated ambulatory EGS service.

Further information on the findings from the EGS review can be found at: http://www.swsenate.org.uk/

Appendix 1 – Key information relevant to the hospital review

Emergency General Surgery

Notification of review: 28/6/16
Self-assessment submission date: 8/11/16
Review visit date: 22/11/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Meg Finch-Jones (Surgeon) Paul Mackey (Surgeon) Kandaswamy Krishna (Surgeon) Deborah Harman (Theatre sister) Karen Rayson (Theatre sister) Corinne Edwards (Commissioner) Liz Varian (Clinical Nurse Manager) Michelle Smith (RCS Regional Co-ordinator).

Emergency General Surgery Programme team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Ellie Devine (South West Clinical Senate Manager).

Appendix 2 – The review process

A set of 22 Emergency general surgery standards were taken from three main sources: RCS (2011) Emergency Surgery: Standards for Unscheduled Surgical Care, London Health Audit (2012) Quality and safety programme, NHS Services, Seven Days a Week Forum (2013). These were reviewed and adapted by an expert panel to be used as the commissioning standards to assess all South West acute trusts that deliver an emergency general surgery service.

Hospital self-assessment

The purpose of this stage was for the hospital to self-assess the current status of each of the 22 standards as either met or not met. To support the self-assessment, documentary evidence was supplied by the hospital. Where a standard was assessed as not met, the hospital had the opportunity to detail any current plans that would enable compliance with the standard or to offer further detail on any current challenges faced by the hospital in meeting any of the standards.

The hospital was given six weeks to complete the self-assessment stage. The hospital was supplied with standard pro formas to complete.

Review of evidence

The evidence submitted by the hospital was reviewed by members of the review team (members detailed above). Any initial points of clarification relating to the adult emergency standards were sent back to the hospital team. The review of evidence ensured that the review team was able to identify key lines of enquiry for the review visit day. Prior to the visit the hospital was informed of the key lines of enquiry and asked to address these as part of their presentation.

Review visit

The purpose of the review visit was to understand how the hospital had implemented the adult emergency standards and to discuss and clarify outstanding challenges to implementation and the plans and timeframes in place to address them. The day had four key components which all contributed to the overall assessment of whether a standard was being met. The 4 components were:

1. Presentation by the trust executives on how the hospital was meeting the standards
2. Hospital walk round that included discussions with all levels of seniority and staff professions, including medical, nursing and therapies
3. A focus group with doctors in training and members of nursing and therapy staff
4. A short review of patient notes

To ensure consistency of reviews, the programmes clinical lead and Project manager were present on every review.