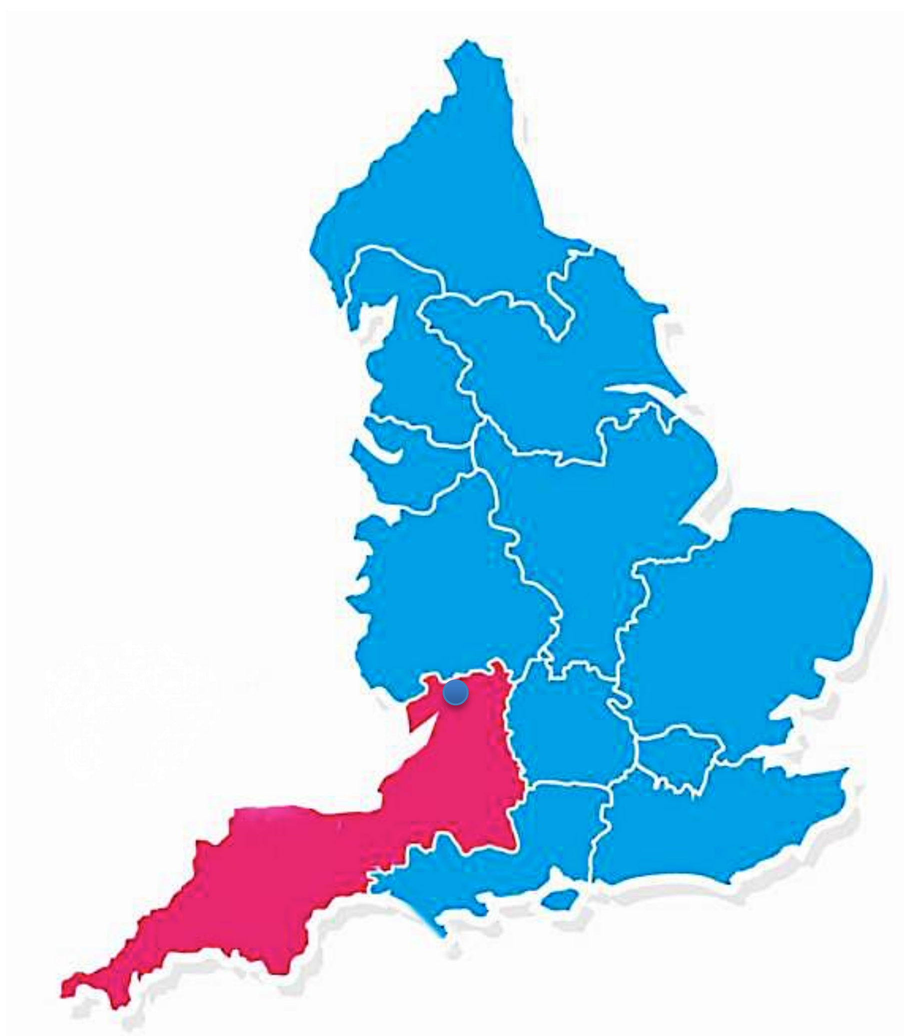
South West Clinical Senate

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



Cheltenham General Hospital (Gloucestershire Hospitals NHS Foundation Trust)

26h July 2016

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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.

Gloucestershire Royal Hospital NHS Foundation Trust

Tel: 03004 222 222

Cheltenham General Hospital
Sandford Road,
Cheltenham,
Gloucestershire,
GL53 7AN

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

Gloucestershire trust employs approximately 7400 staff who provide acute care for a population of more than 612,000. Cheltenham hospital has 359 beds (125 across surgical specialties). The trust was formed in 2002 with the merger of

Gloucestershire Royal and East Gloucestershire NHS Trusts and runs both Cheltenham General and Gloucestershire Royal Hospitals.

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)*	Partially Met	Partially 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.*	Not Met	Not 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.*	Partially Met	Partially 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.*	Not Met	Not Met
8	*Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7*	Not Met	Not 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)*	Not Met	Not Met
10	*All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented*	Partially Met	Partially 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*	Met	Met

	reasons why recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre		
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 ……..(cont)*	**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) ……..(cont)*	**Partially Met**	**Partially 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.*	**Met**	**Met**
16	*Sepsis bundle/pathway in emergency care.*	**Partially Met**	**Partially 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.*	**Met**	**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)*	**Na**	**Na**
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.*	**Met** **Met**	**Met** **Met**
22	*Do you have clear protocols, including a standard for timing, for senior medical (physician) speciality review 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.***	This standard was partially met. There is a consultant led ward round once a day, which is done in the morning but a second handover/ward round, is informal, often without a consultant. There was evidence of continuity in that the consultants do four day blocks over the weekdays with three over the weekend; hence, each ward round in the morning allows review of all of the emergency patients. Patients remain under the care of the admitting consultant but day to day care is handed over to the new consultant. All juniors and consultants are completely free from all other clinical commitments during their on-call period including private practice.	Partially Met	Partially 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.***	The review group felt this standard was clearly met. The information derived from the focus groups and walkaround suggested junior staff were not frightened to speak to consultants or escalate issues.	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.***	The Review Group felt this standard was met. Plain X-ray and CT is provided 24/7. Ultrasound is available 6 days a week, which can cause patients admitted on a Friday to wait until the Sunday for treatment. Emergency imaging is reported real time and out of hours cross sectional scanning is provided by a commercial company, Medica, who regularly audit the provision of their scanning.	**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.***	Despite having all of the facilities, there was no provision for IR 24/7 and no formalised network, hence this standard was not met and is acknowledged by the Cheltenham group. They have no provision of any interventional radiology rota, 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 between Cheltenham and Gloucester, although there are concerns that some of them feel more confident in some aspects of interventional radiology than others. There is no formal vascular or interventional radiology network for Cheltenham General hospital or for the county of Gloucester.	**Not Met**	**Not 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 review group felt that this standard was partially met. On the one hand the rotas are constructed to maximise continuity of care. There is excellent hand-over between the incoming and outgoing teams. There are clear policies for handover and transfer of care to other surgical teams. However, there is a lack of a consistent acute surgical environment for the admission of these patients. A good number of them go to the acute surgical ward – Prescott Ward, but there are numerous outliers, which lead to a rather spread-out and disparate take.	**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.***	This standard is partially met. There is a single unitary document for emergency admissions through Cheltenham general hospital in the form of the ED department emergency admission document. This appeared to be used quite thoroughly in Cheltenham general hospital with more complete recorded information by medical staff. Any further documentation beyond this was then moved to standardised medical continuation sheets. There was however a lack of recording of all information by all health care professionals in this single document. It was also noted that there was an excellent admission checklist for surgical emergency patients in Cheltenham general hospital, although this did not link automatically with the ED department document. As we understand it, there are plans to further develop the surgical admissions document into a more complete form.	**Partially Met**	**Partially 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.*	Unfortunately, with the lack of a hot clinic, daycase pathway and dedicated area it is very difficult to provide ambulatory care. Therefore this standard is not met.	**Not Met**	**Not Met**
8	*Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7*	The review team felt this standard was not met as there is not a full availability of a CEPOD theatre list 24/7. At present the theatre only becomes available between 1 and 2 o'clock in the afternoon, runs through the afternoon, and at 6 – 7 o'clock in the evening becomes a combined list with the trauma service, which can again limit access to theatre. The staff also noted that despite the planned starts of 1 – 2 o'clock in the afternoon, there were numerous occasions where this was delayed, sometimes as late as 3	**Not Met**	**Not Met**

		– 3.30pm.		
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.***	Both junior doctor and nurse focus groups indicated good consultant surgeon presence in theatres both in and out of hours. This standard is heavily weighted towards the NELA data for consultant and anaesthetist presence in theatre when risk of death >5%. The latest figures show that this happens in 70% of cases. As such, this standard is scored as not met.	**Not Met**	**Not Met**
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	Generally the information we collected on the day indicated that all operations are discussed with the consultant surgeon. However the documentation was not clear on this. Whilst some of the patient notes were filled out well, focus groups did indicate that sometimes there was a disconnect in communication, hence this standard is partially met.	**Partially Met**	**Partially 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***	The junior doctors focus group did indicate that WHO checklists were usually carried out, although we did not see any audit data to demonstrate this. Majority of cases were being done on the planned date of surgery but often late at night and sometimes a few were rolled on because of no morning CEPOD list. The lack of 24hr CEPOD was on the risk register. With Urology and Vascular getting busy at Cheltenham, this has added to the pressure and meant more surgery has happened at night.	**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 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.*	This standard was met. Certainly there was good evidence that the handover between the incoming and outgoing consultant teams on the Monday and Friday worked extremely well and were very thorough. During the on-call blocks, the morning handover was with a consultant present whilst the evening handover was often lead by the SpR. It was noted by some of the ward staff that there was a lack of communication as to the plans for patients due to a lack of documentation in the notes. On a positive note, Cheltenham keeps a historical record of the on-call and handover sheets which are saved and uploaded daily onto the hospital server.	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 review group felt that this standard was partially met. The Trust is actively involved in both the NELA and EPOCH national audits and demonstrated excellent practice in a weekly M&M review of all emergency admissions, as well as a 2 monthly emergency surgery governance meeting. However, there was limited evidence of in-house audits in the self-assessment and no clear evidence of in-house audit within the last 5 years. In addition, whilst the Trust recorded (like all Trusts) family and friends patient experience, there was no specific patient experience related to emergency surgical patients.	Partially Met	Partially 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.*	The review group felt this standard was met with respect to the emergency bleed service available in Cheltenham Hospital.	Met	Met
15	*Training is delivered in a supportive environment with appropriate, graded, consultant supervision.*	New staff reported very positively on their training experience in Cheltenham. They felt well supported with a high level of consultant involvement, certainly in theatre.	Met	Met

		They did note that the lack of a 24 hour CEPOD theatre does impact on the training time available to them. In addition, the GMC result showed below average results for the regional teaching of general surgery.		
16	***Sepsis bundle/pathway in emergency care.***	The review group felt this standard was partially met. Whilst there were excellent figures for screening for sepsis, unfortunately only 49% of patients actually received their prescribed antibiotics within an hour. There was some discussion as to whether the screening was clearly done in the ED department, but the antibiotics were not necessarily prescribed in the emergency department. If there was a delay between moving the patient from the department to the ward, this could lead to the antibiotics not being given within the appropriate time.	**Partially Met**	**Partially 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.***	The review group felt this standard was met. All emergency general surgical patients are reviewed by a consultant every day for 7 days a week during the course of the morning ward round.	**Met**	**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.***	This standard was partially met in that they have a clear network service for the provision of vascular surgery, urology and paediatric surgery. Vascular network is provided through Gloucester, Cheltenham and Swindon. Network in urology is provided through Gloucester, Cheltenham and Hereford. All paediatric patients go to Gloucester. They felt that they would transfer cardiac, thoracic and plastics cases to Bristol, however there were no clear clinical pathways or SLA demonstrated. Finally, there is a lack of network interventional radiology provision or a clear pathway to another provider.	**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 group felt this standard was not applicable, as paediatric emergency general surgery is undertaken in Gloucester, so patients are all transferred there from the emergency department	Na	Na
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.*	The review group felt 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.*	We report two outcomes for this standard according to whether the review is undertaken by a consultant or SpR. Both outcomes are met, as there were protocols for review of all emergency general surgical patients, and all general surgical inpatients by the on call consultant. In addition, there is a daily vascular and urology ward round 7 days a week.	Met Met	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 standard was not met. They do have a dedicated gastroenterologist on Prescott ward that was able to provide a medical review to patients from a GI perspective and a physician of the day for general chest pain although Rheumatology review was more difficult to get. It was less clear how easy it would be to get a physician review for other medical specialities. There were generally good middle grades available, as well as an accessible outreach team which operates almost 24/7.	Not Met	Not Met

Recommendations

There was no doubt from our review of all Trusts in the South West that a Surgical **Assessment** Unit where the majority of the EGS take patients are located and which provided a hub for the on-call surgical team was considered invaluable to both senior and junior medical staff. In some Trusts, this was sometimes called, and indeed used, as a Surgical **Admission** Unit. Patients on an assessment unit are triaged prior to admission to ensure they are moved onto the appropriate pathway. (Note: this has implications for patient expectation, Length of Stay and how clinical data is coded to be used later in audit). A functioning SAU was recognised as a key requirement to maintaining an efficient and effective EGS service. When integrated with EGS ambulatory care and co-located close to the Emergency Theatre, the SAU provides a 'hub' to focus delivery of EGS care in a more efficient way.
At Cheltenham there is a lack of a consistent acute surgical environment for the admission of these patients. A good number of them go to the acute surgical ward – Prescott Ward, but there are numerous outliers, which lead to a rather spread-out and disparate take. This results in the review of patients being delayed as the on-call ward rounds become what is colloquially known as 'safari ward rounds'.

It was clear throughout the South West Emergency review that all Trusts recognised the value of ambulatory EGS care where appropriate, but most had struggled to deliver this effectively. The exception was Bath which had significantly developed its service to focus on ambulatory care with a resultant impact on admissions, bed occupancy and an ongoing improvement in the delivery of acute gall bladder surgery. As such it serves as an example and model for EGS ambulatory care.

There were certain issues related to the delivery of a high quality ambulatory EGS care service, which came out during the discussions in Bath and other Trusts. Firstly, there was a need for senior decision makers within the ambulatory care part of the service. Junior or nurse led decision making did not appear to deliver the same benefits. There was a need to link this service with day surgery list access (and with staff to run these lists) separate to the CEPOD list. Failure to do this resulted in delays to the 'day cases' with a potential risk of admission.

Without availability of a 24/7 CEPOD theatre at Cheletenham, there was at times a delay in managing EGS patients. This frequently led to delayed surgery and an extended LOS, as cases were rolled over to the next day, or operated on late into the night, which is proven to have poorer outcomes. Consideration should be given to whether one theatre is enough depending on EGS volume, and whether this conflicts with other services, creating significant or frequently occurring delays in surgery for EGS patients. There should be adequate anaesthetic cover to support the CEPOD list and emergency obstetrics separately, and that all EGS cases should be run through the CEPOD process, even if the procedure is to be performed elsewhere - such as in radiology or endoscopy.

There is currently no provision of any out of hours interventional radiology rota at Cheltenham, 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 between Gloucester and Cheltenham, although there are concerns that some of them feel more confident in some aspects of interventional radiology than for others. 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.

Improvements in the delivery of EGS care will require ongoing audit and review, in particular there is a need for the collection of outcome data, audit of processes and of patient experience. The review group felt this could only be delivered with a dedicated lead for EGS, appropriately resourced with time and support. In view of the key role that nursing staff play in EGS the report also recommends a lead EGS nurse be appointed.

Finally, there is currently one consultant ward round that happens in the morning with a second ward round which is ad-hoc and run by the middle grade staff. There is an opportunity in the current consultant job plans for the consultant to run two consultant rounds enabling all patients to be seen within 14hours of arrival. 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: 12/7/16
Self-assessment submission date: 16/8/16
Review visit date: 30/8/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Paul Mackey (Surgeon) Nic Mathieu (Matron) Tracy Day (SAU Junior Sister) Karen Rayson (Theatre sister) Annemarie Vicary (Commisioner) Kay Houghton (Commisioner).

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.