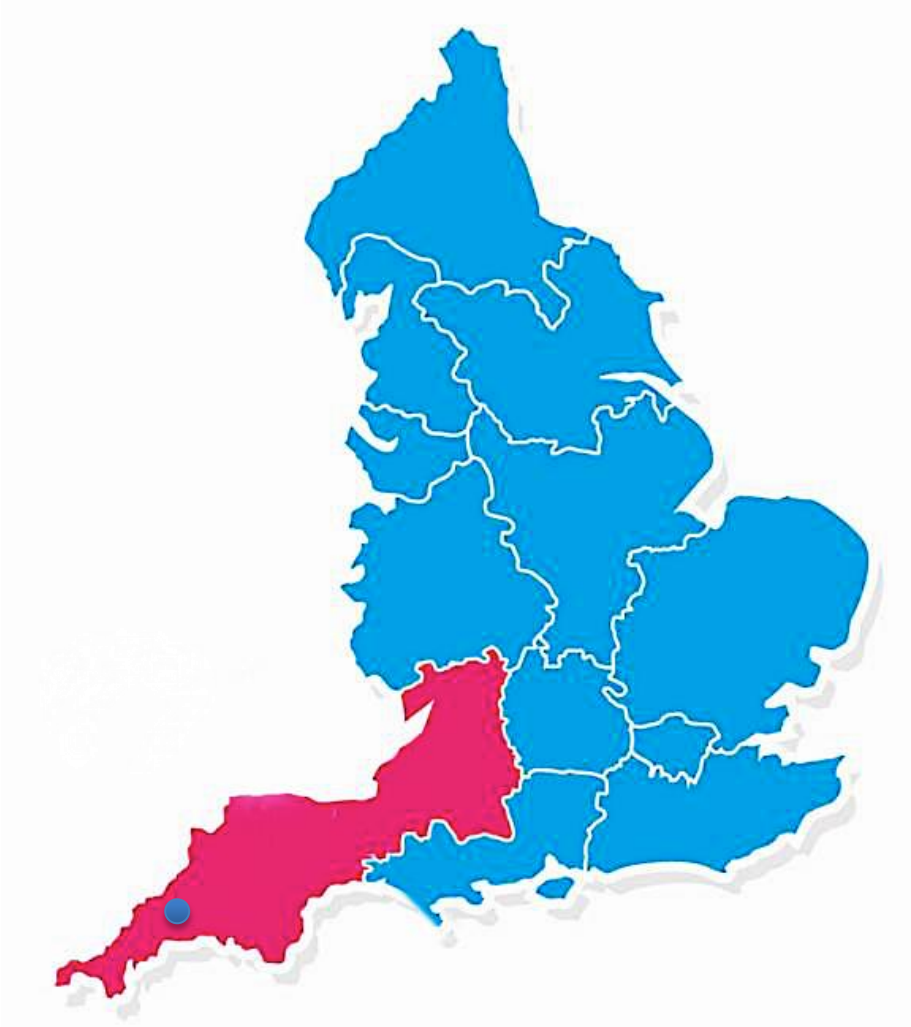
South West Clinical Senate

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



Royal Cornwall Hospitals Trust

25th October 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.

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The Royal Cornwall Hospitals NHS Trust employs approximately 5,000 staff who provide acute care for a population of more than 450,000, a figure that can be doubled by holidaymakers during the busiest times of the year. Population demographics show an aging population with a projection that 25% of the population will be over 65 by 2020.

Acute General Surgery is delivered by 12 consultants, 7 Colorectal and 5 Upper GI. The hospital provides sub-specialist services across GI including Bariatric, Pelvic floor, Extralevator AP surgery and Pouch surgery for IBD. The on call follows the common “week on service” model with a second consultant delivering morning operating 5 days a week and separate night cover Monday, Wednesday and Friday nights.

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.*	Met	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.*	Met	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.*	Partially Met	Partially 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)*	Partially Met	Partially 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 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 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.*	**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**	**Not 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?*	**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.***	The review team felt that this standard was met although there were certain caveats. There are two consultant led ward rounds each day of the week which are job planned. Based on feedback from the junior staff, these ward rounds do happen. However, the review team were unable to find evidence of these ward rounds in the patient's notes, suggesting documentation is not always complete. The review team did raise concerns that there seemed to be a tendency for the second consultant ward round to happen quite late in the afternoon, around about 4.00 to 5.00 pm and there was the potential for patients to be admitted to have waited more than 14 hours before being reviewed by a consultant. This was borne out by the NELA data, which showed that only 61% of patients were seen within 14 hours of arrival. It was noted from the Truro team that the consultants were job planned to be on site until 7.00 pm, hence this ward round could be moved back a little bit later to more effectively meet this standard. At present, it is believed that the ward round is done earlier in order to fit in with the junior staff shift pattern. It was noted that there was good continuity of care with a	Met	Met

		4/3 shift pattern of working for consultants, and that the consultants are free of all elective activity when they are on call.		
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 in that there is a clear escalation policy. On discussions with both the nursing staff and junior staff, there was a clear willingness to escalate problems up the chain of command as far as the consultant if this was necessary.	**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 team felt that this standard was met with the provision of 24/7 X-ray and CT. The standard was not necessarily available 24/7, but most of the emergency surgeons felt the radiologists would be willing to accept a CT scan, and they did not find that their care of patients was particularly influenced by the lack of 24/7 ultrasound. It was noted that if appropriately skilled radiologists were happy to undertake ultrasound, then it could be accessed out of hours. Note the Trust is part of the PROC (Peninsula Radiology On Call) for reporting.	**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 only does the hospital offer full hybrid theatres offering full interventional facilities, they do have an on-call interventional radiology service comprising of 6 interventional radiologists. There is a full interventional radiology service provided on site 24/7 without the need to link into the Plymouth service.	**Met**	**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 met. The rotas are constructed to maximise continuity of care for all emergency general surgical patients, and the working week is split into a 4/3 arrangement. Patients remain under the care of the admitting consultant when they are	**Met**	**Met**

		moved off the assessment unit, and transfer between speciality teams is normally done as a consultant to consultant discussion. The emergency general surgical patients are managed in an acute surgical environment, although these are very slightly separated by a short length of corridor. Assessment area for triage and ambulatory care are also slightly separate from the ward where the acute patients are admitted.		
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.***	The review team felt that this standard was partially met in that the hospital had a core based emergency unitary document which is being used in most of the patient notes. However, there was no space or opportunity for use by allied health professionals or nurses. It is not a single source of information for emergency admitted patients.	**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.***	The review group felt that this standard was partially met. There is a dedicated area (St Mawes lounge) which works as a triage area. Patients can be brought there the next day for treatment. However the review team were slightly concerned in that this appeared to be managed predominantly by the junior staff and depended on how each consultant actually used these facilities. In addition, the junior staff noted that patients could sometimes wait unnecessarily long periods for senior review. The review group felt that the infrastructure was there to run a good ambulatory care service. The arrangements were not formalised and processes were not being accurately measured.	**Partially Met**	**Partially Met**

8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	This standard was clearly met. There was an available CEPOD theatre 24/7 for emergency surgical work. This CEPOD theatre is separate from orthopaedics and trauma, but it is shared with all other surgical specialities.	**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.*** ***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 review group felt that this standard was partially met. There were good numbers; 85% patients having both the consultant surgeon and anaesthetist present in theatre for high risk cases. However, patient flow and bed pressures made it difficult for patients to access critical care, and the NELA data reported only 62% of high risk patients getting into a critical care bed. Furthermore, the review team struggled to find P-POSSUM scoring recorded in the patient notes. Comments from the staff suggested calculations were done during the operation, which was felt to be counterproductive to managing patients preoperatively or planning for destination post-surgery.	**Partially Met**	**Partially Met**
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	This standard was felt to be partially met. In about half of the patient notes we reviewed, the operations were recorded as having been discussed with the consultant. On talking with the staff, it was the impression of the review team that the majority of operations were actually being discussed with the consultants, but this was not always clearly documented. On the plus side, the electronic CEPOD booking theatre system does log the time at which the patient is booked. It will, of course, fail to pick up if there is any significant delay between decision made to go to theatre, and booking.	**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***	This standard was met in that most operations did seem to be done on the day they were planned with occasional operations being pushed to the following day. The WHO surgical checklists were consistently done, and stored in the patient's notes, and the staff we spoke to felt that the process of list and safety briefing were done appropriately with full engagement from the team.	**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.***	The review team felt this standard was met. Handovers were taking place twice a day in a clearly designated area. The evening handover was often registrar led, and was "driven" by the second consultant ward round from earlier that afternoon/evening. On the changeover between the 4/3 split of the consultant's on-call, there was a consultant to consultant handover of all patients on the surgical assessment unit and who needed ongoing care. The nurses felt they were engaged in the handover process, and they were currently working on a system whereby both the nursing and medical handover notes could be seen by each party (they are currently recorded on a separate excel spreadsheet).	**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***	The review team felt this standard was partially met. As with most organisations, Truro was actively engaged in completion of the NELA database high risk patients. However, they were lacking in distinct patient experience data related to emergency general surgery. There are generic friends and family data available, but nothing specific. There was limited availability of in-house audits in review of emergency general surgical patients, although some data from the colorectal M&M meeting was presented. There was also some interesting data on	**Partially Met**	**Partially Met**

	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***	length of stay demonstrating a reduced length of stay following a change in rota working. However this data was over 9 years old and there did not appear to be any ongoing audit, process or outcomes. NB. We did see some recent acute Length of stay data and readmission rates following review, which demonstrated good performance on these two outcome measures.		
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 endoscopy service provided by the gastroenterology team.	**Met**	**Met**
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	The review team had difficulty in scoring this one as the focus group contained only F1's and no surgical registrars. The F1 doctors we interviewed felt supported, and a recent change in shift patterns had been made to address the low par GMC results in 2016. The trainees interviewed did indicate that they felt there was a good level of cover and based on their positive description of the service, coupled with lower GMC results, we have given this standard a partially met outcome.	**Partially Met**	**Partially Met**
16	***Sepsis bundle/pathway in emergency care.***	We felt this standard was met in that there is a new pro-forma with sepsis boxes on the front which the juniors are encouraged to fill out. There is an escalation policy to the registrar which is good for patients. We saw a recent audit of their sepsis. Whilst there had been a drop in patients receiving full sepsis 6, and a drop in overall screening, there had been improvement in time to antibiotics, with over 80% of patients with severe sepsis now receiving AB's within one hour.	**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.***	The review team felt that this standard was partially met. It is clear that all patients on the surgical assessment unit are reviewed daily by a consultant 7 days a week. However the review of patients once they had moved off the surgical assessment unit became slightly more ad-hoc and informal. They would be seen by a registrar on a daily basis, but only very sick patients who stayed, or a patient of note, would be guaranteed a visit by a consultant.	**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.***	This standard is partially met. Vascular interventional radiology is provided in-house, and Truro is part of the major trauma network with a bypass or ambulance divert to Plymouth. Sick children under the age of 1 year are transferred to the Bristol Children's Hospital, although there was no formal transfer document provided for this. There was no evidence of a policy for transfer of critically ill patients, and as with most other Trusts in the region, there was a lack of evidence of a clear clinical pathway or SLA for any of the other surgical speciality transfers such as neurosurgery, cardiac surgery, thoracic surgery, plastic surgery etc.	**Partially Met**	**Partially Met**
19	We felt this standard was met in that all children are admitted under the care of the paediatricians and hence their ongoing hydration, drug dosages and pain relief are managed by the paediatric team. There is a clear policy of transfer of all sick patients under the age of 1 year to the Bristol Children's hospital (although the documentation is lacking).	We felt this standard was met in that all children are admitted under the care of the paediatricians and hence their ongoing hydration, drug dosages and pain relief are managed by the paediatric team. Children are prioritised and have a priority operating slot at 9.00am. There is a clear policy of transfer for all sick patients under the age of 1 year to the Bristol Children's hospital (although the documentation is lacking).	**Met**	**Met**
20	***As a minimum, a speciality trainee (ST3/SpR & above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status),***	This standard was clearly met.	**Met**	**Met**

	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.			
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. The first assessment of the Trust fails in that not all patients are reviewed by a consultant either 5 or 7 days a week. However, all inpatients do get a review by an SPR or above, 5 days and 7 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?***	This standard was not met, as for most of the other Trusts in the South West.	**Not Met**	**Not Met**

Recommendations

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. In the current Cornwall set-up, the ambulatory care was managed predominantly by the junior staff and depended on how each consultant actually used these facilities. In addition, the junior staff noted that patients could sometimes wait unnecessarily long periods for senior review. As such, we would recommend that the ambulatory care service is formalised in its arrangements to be senior led with consistent timings for senior review and for bringing back patients.

Improvements in the delivery of EGS care will require ongoing audit and review, in particular there is a need for the systematic 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. During the review it was noted by staff that review of patients transferred out of the SAU could be slightly ad-hoc, and we would recommend review of all the EGS patients during the ward round.
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: 30/08/16
Self-assessment submission date: 11/10/16
Review visit date: 25/10/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Mark Vipond (Surgeon) John Spearman (Surgeon) Sally Matravers (Assoc. Dir. Nursing) Catherine Allen (Sister) Karen Kay (Commissioner)

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.