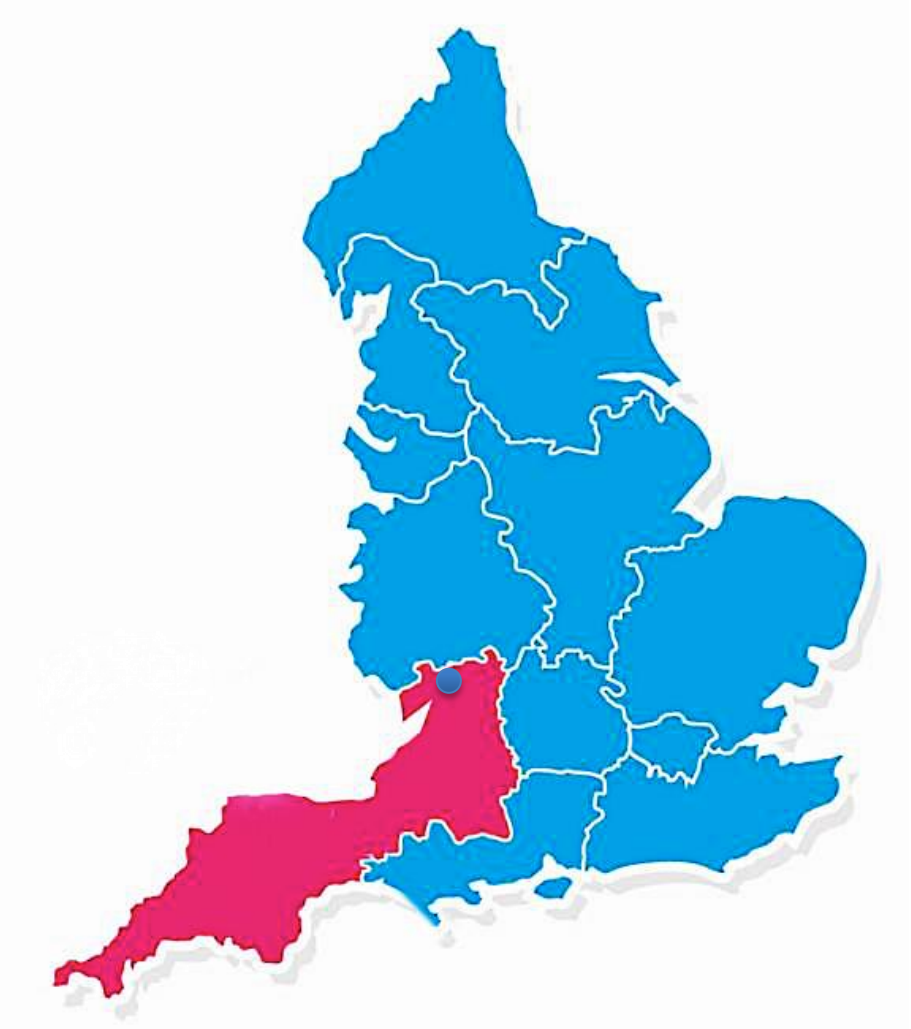
South West Clinical Senate

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



Gloucestershire Royal Hospital NHS Foundation Trust

26h July 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.

Gloucestershire Royal Hospital NHS Foundation Trust

Tel: 0300 422 2222

Gloucestershire Royal Hospital
Great Western Road
Gloucester
GL1 3NN

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

Gloucestershire trust employs approximately 7400 staff who provide acute care for a population of more than 612,000. The hospital has 683 beds. 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*	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*	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)*	**Partially Met**	**Partially 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.*	**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.*	**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)*	**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 (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 in that there is a single consultant led ward round each day of the week in the morning, but the second ward round tends to happen at a variable time in the evening, dependent upon the availability of the registrars and is led by the junior team. However, there is good continuity of care through working patterns with the consultants taking emergency work for 7 days, and working 24 hours over each day of the weekend. Then working from 8 until 5 on each of the week days with one of their colleagues covering the take of emergency patients overnight. All on-call consultants are freed from their elective commitments including private practice. We discussed the provision of two consultant led ward rounds each day, and the Gloucester team felt this would require a complete re-job planning for the on call general surgical team. They have factored this in as aspiration into their proposal of a strategic merger of all acute surgery being delivered at one site for the county of Gloucester.	**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 was met, and that there was clear documentation for nursing escalation. On review of the notes we were also able to see a medical escalation planned. On talking with both the nursing staff and junior staff, there was a clear willingness to escalate problems up the chain as far as the consultant, should this be necessary. We felt the standard was met, although we could not find a clear documented policy on escalation to the consultant within one hour, had there been a failure from all other parts of the escalation plan.	**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.***	We felt this standard was met. Plain x-ray, CT scanning & Pathology services are available 24 hours a day, 7 days a week. Ultrasound is not available 24/7, as is the case in most hospitals, and most emergency general surgical teams do not feel that this is necessary. However, ultrasound is available on weekdays from 9.00 to 21.00 and at weekends from 8.30 until 17.30. This service is outsourced to by Medica-Nighthawk, who provide a very satisfactory service with ready access to CT scanning and plain x-rays, as well as a quick turnaround of reporting. The Gloucester team felt that all urgent reporting was easily achieved within the 12 hour window.	**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.***	This standard is clearly not met, which is acknowledged by the Gloucester 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	**Not Met**	**Not Met**

		Gloucester and Cheltenham, although there are concerns that some of them feel more confident in some aspects of interventional radiology than for others. There is no formal vascular or interventional radiology network for Gloucester Royal hospital or for the county of Gloucester. The team felt that if they were really struggling they would consider referral to tertiary centres such as Birmingham or Bristol, but again this seemed to be an ad hoc arrangement with no clear designated provider for urgent and emergency cases.		
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.***	In the absence of a Surgical Assessment Unit, this standard was partially met. Rotas are constructed to maximise continuity of care quite clearly for all emergency general surgical patients. The consultant surgeon registrar, core trainee and F1 remain the same for the duration of the on-call period (albeit not for 24 hours at a time) which provides excellent continuity. There was a clear policy for the maintenance and responsibility of all patients under one consultant, and at the end of the on call period, these patients are either transferred back to the elective team of that speciality (GI, colorectal or upper GI) or in certain cases, are handed over to the incoming emergency consultant. They do not have a written policy for this handover but discussions with the team and junior staff would suggest this works very effectively.	**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.***	The review group felt this standard was partially met, in part because the Trust is in a transition period with emergency admission documentation. At present, there is a unitary document for all emergency admissions which	**Partially Met**	**Partially Met**

		occurred through the ED department. There was an attempt to introduce a standardised surgical emergency admission pro-forma but this was seen to be at odds with having a unitary document for the ED department (through which all of their surgical and emergencies are processed) and therefore the decision was made to create an insert into the ED document for the emergency surgical admission. This process has not been fully established, as evidenced by the absence of clear documentation within the patient notes. It was also noted that there was a tendency for the unitary document to be partially, or in some cases barely completed at all, and for the surgical clerking to be completed on standard medical notepaper.		
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 very clearly not met. There is no formalised ambulatory emergency care provided through the Trust. There is no dedicated hot clinic, no dedicated day case pathway, and no dedicated area for managing ambulatory emergency work. The team have a clear aspiration to deliver this and are quite sure, as was the junior staff, that the provision of a properly resourced surgical assessment unit or ESU would be the one thing they believe would make a significant improvement in their provision of emergency general surgical care. At present, there is an ESU which comprises of 6 beds, 3 male, 3 female, which is a bay within the existing surgical	**Not Met**	**Not Met**

		ward. There are no clear facilities that enable ambulatory care to be delivered.		
8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	This standard was met. There is an available CEPOD theatre list 24/7 for emergency surgical work, excluding the orthopaedics, which has a separate trauma theatre. The CEPOD theatre is shared with Gynae, Max-fax, and ENT.	**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 almost certainly met based on the extremely active involvement of the Gloucester team in the NELA and the NELA project work with consultant anaesthetic involvement, and the use of critical care beds. They we able to show data which demonstrated 80% of surgeries with a risk of death over 5% has consultant surgeon and anaesthetist present. P-POSSUM scoring was almost certainly recorded in the NELA data but was not documented in the clinical notes, and the scoring of sick emergency general surgical patients was focussed entirely on those patients likely to require laparotomy. In supporting evidence, it was noted that the newly introduced booking form has a clear slot for recording the P-POSSUM score.	**Met**	**Met**

10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	The review group could not confirm this standard was met as there was an absence of documentation in the majority of notes reviewed (5 out of 6), the documentation of the discussion, and the decision for surgery. However, in talking with the junior and senior teams, they both felt that they would communicate their plans to operate on any cases, and the consultants felt that they were fully aware of what was happening, even if they were not in the hospital.	**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 group felt that this standard was met based on discussion with the junior teams, nursing teams and senior teams. In addition, the notes review would suggest that the majority of emergency general surgical cases are done on planned CEPOD lists on the day the surgery was originally planned. It was noted that there tends to be a lack of documentation of the date, time and decision makers with respect to a plan for surgery. The WHO safety checklist used for all emergency general surgical patients was audited over 100 patients with 100% completion.	**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 is partially met. There was a certain amount of variation and inconsistency in the provision of handover. Whilst it was clear there was a consultant led ward round and handover that happened in the morning, the timing, duration and structure of this process was very variable, and depended upon the individual consultants. The evening handover was depended upon the availability of the Registrar(s) and sometimes was a simple paper	**Partially Met**	**Partially Met**

		handover. Whilst there is a paper and electronic (Excel spread-sheet) document recording the patient details, we are not clear there is a standardised process for recording this, or whether these documents are kept for any period of time after the on call.		
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***	This standard was partially met. Hopefully the upper end of partially met which would be reasonable to state. The Gloucester team are clearly very actively involved in auditing their emergency general surgical practice, partly in relation to the NELA work as well as the ELC-Emergency Laparotomy Collaborative work. There is a proactive approach to this, in part driven by the requirement to achieve certain CQUINS targets for increased funding for the Trust. They have managed to achieve all of these in the last couple of years. They certainly have very complete data in relation to the emergency laparotomy work. In relation to this work, they have clear information on outcomes, deaths, length of stay, return to theatre, readmissions, as well as risk assessments, pre and post-surgery. They also track decision making and investigation. However, as noted in other hospitals, the focus is entirely on the NELA group of patients which makes up about 10 – 15% of the total patient workload. There is no clear audit work being done on the less major cases, although the team do a track of their data in relation to gallbladder work, appendixes on the SWORD database available through the association of Upper GI surgeons. The team acknowledged that they are lacking in any	**Partially Met**	**Partially Met**

		patient experience data other than the generic friends and family available through all Trusts. There is no specific work looking at patient experience for emergency surgical patients.		
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 met. They have 24/7 endoscopy service provided by the gastroenterology team and the pathways are clear with written policies.	**Met**	**Met**
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	The review groups discussed the feedback delivered by the Gloucester group in quite a bit of detail. We were able to talk to Registrars, core trainees and F1s, all of whom felt that they were working in a supportive environment and that their consultants were both keen to train and easy to approach. On review of the Registrar and CT log books, there seemed to be good levels of consultant involvement and presence for both elective and emergency care, which would tend to confirm the feedback from the trainees. The positive feedback meant this standard was met although of note, the 2016 GMC training survey suggests Gloucestershire to be below the national mean for regional teaching in General Surgery.	**Met**	**Met**
16	***Sepsis bundle/pathway in emergency care.***	We felt the sepsis bundle/pathway and emergency care was met. This is due to the fact that all emergency admissions occur through the emergency department where the sepsis process is completed. We have good audit data to say that the majority of the appropriate patients are being assessed and screened for sepsis, although the delivery of antibiotics within an hour is not as good as the screening process. Like many Trusts, where they fail is in the screening and delivery of antibiotics to the cohort of inpatients.	**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.***	They have a policy for review of all emergency general surgical patients by the on call consultant once a day, 7 days a week, hence the standard is met.	**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 some paediatric surgery. Vascular network is provided through Gloucester, Cheltenham and Swindon. Network in urology is provided through Gloucester, Cheltenham and Hereford network. Paediatric patients that are felt to be either too young, too sick or too complex to be operated on in Gloucester are transferred through an agreed protocol and pathway with Bristol Children's Hospital. They felt that they would transfer cardiac, thoracic and plastics cases to Bristol, however there were no clear clinical pathways or SLA demonstrated. Finally, as mentioned before, 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 team felt this was met. There is an excellent policy document on the provision of paediatric urgent and emergency surgery in Gloucester, and then combined working with the paediatric unit means that children receive adequate hydration, symptom control and appropriate dosage of all medications determined by the paediatric team. The access to the CEPOD list was such that it seems likely that most children would have relatively easy access to emergency surgery if required, although there is no clear evidence of a policy suggesting that they would wait no longer than 12 hours.	**Met**	**Met**

		The area that arose some uncertainty was that during discussion with the Gloucester team, it appeared that many of them will undertake paediatric emergency surgery to a variable degree, and in children of a variable age. The key requirements were an availability of appropriately trained anaesthetist and a surgeon who was 'happy' to operate on the age of the child involved. The policy document clearly defines that the emergency general surgeons should be providing at least one general paediatric surgical list per month, if not one every two weeks. We did not get the impression from the Gloucester team that this was the case, but that things were still slightly more ad hoc. However, the document clearly identifies the type of cases to be operated on in Gloucester; there was a clear suggestion from the consultant body present at the review that any consultant who was unhappy with either the age or the condition of the child regularly referred the case on to Bristol children's hospital.		
20	***As a minimum, a speciality trainee (ST3 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 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. The first part of this standard is not met in that there is no 24/7 consultant review of all surgical speciality cases within the hospital. At present the speciality not on call would have a consultant led ward round delivered on the Saturday, but not the Sunday, and this ward round would be totally unsupported and consultant delivered. However, there was clear suggestion that the consultant would liaise with the emergency surgical consultant, should they have any concerns during the course of the ward round. If this arrangement is formal between the consultants, it is ad hoc as far as job planning is concerned, and is not funded or recognised. The Gloucester team clearly recognised this as an aspirational goal but feel that this could only be delivered with further job planning and as part of any reconfiguration of emergency surgical services across the county. 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 (SpR & above) of emergency general surgical admissions?***	This standard was not met (the same as most other hospitals in the South West). It was clear from the Gloucester team that whilst there was ready access to the medical registrar, getting access to a consultant medical opinion of any speciality is not easy any day of the week.	**Not Met**	**Not Met**

Recommendations

There is currently an ESU which is a 6 bedded area within the existing surgical ward although this is not sufficient to enable ambulatory care. The team have a clear aspiration to deliver this and are sure that the provision of a properly resourced surgical assessment unit or ESU would make a significant improvement in their provision of emergency general surgical care. 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. The provision of an SAU is an early step towards running an efficient ambulatory care service.

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.

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.

There is currently no provision of any out of hours interventional radiology rota at Gloucester, 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.

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 to formalise the two consultant ward rounds over 7 days and we would recommend job planning and staffing is reviewed to facilitate this twice daily review by the on-call consultant. In addition, the second consultant ward round would support a more robust handover. 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: 31/5/16
Self-assessment submission date: 12/7/16
Review visit date: 26/7/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Andrew Allison (Surgeon) Anne Pullybank (Surgeon) 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.