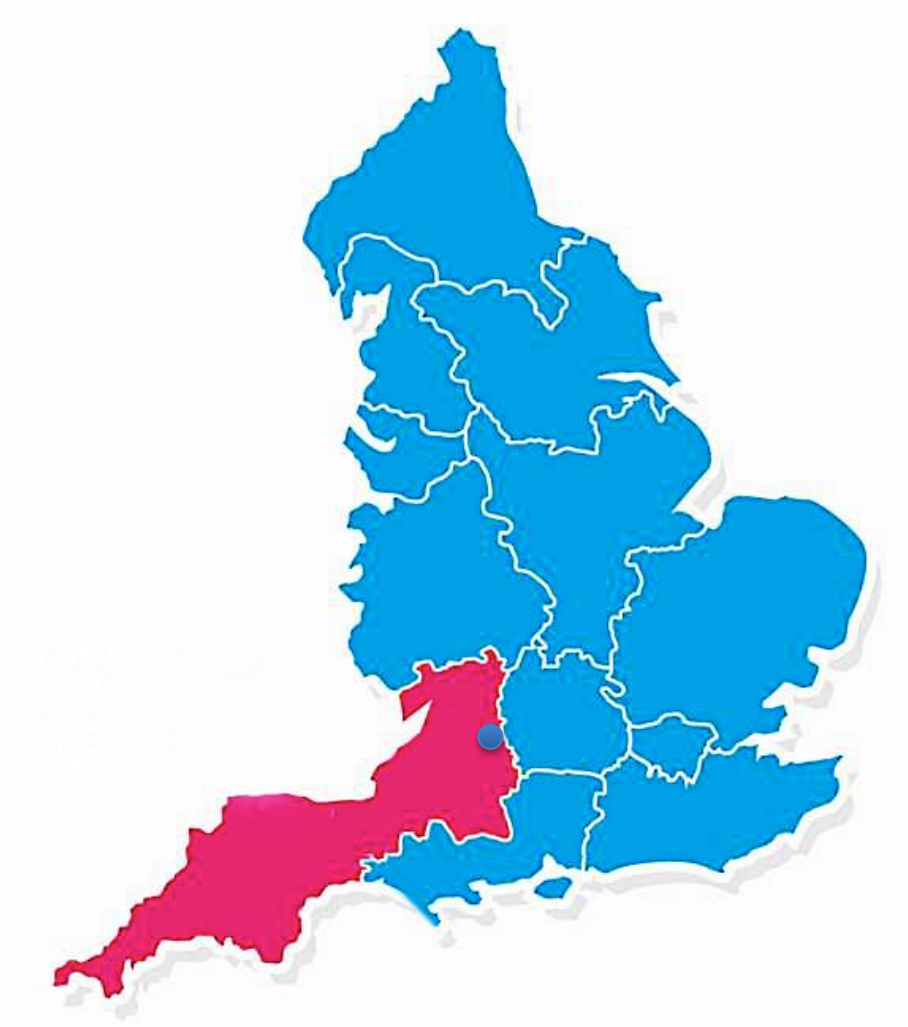
South West Clinical Senate

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



Great Western NHS Foundation Trust

12th October 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.

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Great Western is a Foundation Trust based in Swindon and provides acute and community healthcare services to a population of around 480,000 people from Wiltshire and the surrounding areas. The main acute hospital offers a total of 450 acute beds (including 12 critical care beds and 38 maternity beds).

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)*	Not Met	Not 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.*	Not Met	Not 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.*	Met	Met
8	*Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7*	Met	Met
9	*All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. ……..(cont)*	Met	Met
10	*All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented*	Met	Met
11	*The majority of emergency general surgery to be done on planned emergency lists on the day that surgery was originally planned. The date, time and decision makers should be documented clearly in the patient's notes and any delays to emergency surgery and reasons why recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre*	Met	Met
12	*Handovers must be led by a competent senior decision maker (ST3/SpR & above) and take place at a designated time and place, twice a*	Met	Met

	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)		
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.*	Not Met	Not 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.*	Not Met	Not 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
		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.***	On balance, the review group felt that this standard was not met. From our understanding, there are two consultant ward rounds planned Monday to Friday. Discussions with the staff would suggest that this didn't happen in all cases, and although some consultants delivered very much a consultant led two ward round service, others did not. Furthermore it was not available 7 days a week, as there was only one ward round job planned over the weekend period. As a consequence of this, it was not possible to guarantee that all patients were seen within 14 hours of arrival. In addition, there was a problem with medical outliers in the Surgical Assessment Unit, which meant that some acute surgical admissions were placed on "normal" surgical wards, and these would not be picked up by the second ward round (if it occurred) which tended to focus on the SAU during their on-call session. The review team also had concerns about the continuity of care through single day working. On discussion with staff, it became clear that the on-call consultant for the day, along with the on-call registrar for that day, would be	**Not Met**	**Not Met**

		operating on the previous day's patients in many cases. As a consequence, they may know little about these cases, and may not have been involved in the initial part of their care. From discussions during the summing up, it was clear there were plans to address this by extending the on-call consultant's timetabled work into the following morning, so that the CEPOD cases and the post-date ward round would fall to the consultant of the previous day. At present, we did not feel this standard could be marked as 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.***	We felt this standard was met. There was a clear early warning system to highlight deteriorating patients, and both the nursing staff and the junior staff felt able to escalate any concerns and problems as high as consultant level if required. The ward sister felt that some of the junior nurses may be reluctant to contact the consultant, but as there was a ward co-ordinator on each occasion that was more senior, they would automatically contact this individual who would then be very happy to escalate up to a consultant level if required.	**Met**	**Met**
3	***All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.***	The review team felt that this standard was met. There was an acknowledgement that like many other trusts, there is not an availability of ultrasound 24 hours a day 7 days a week. Ultrasound scanning was reported to be available out of hours, but on discussion with the staff, both nursing and juniors, it appeared that it was actually very difficult to achieve this after mid-afternoon or in the out of hours period. There was clear access to plain x-ray and CT scanning, although out of hours CT scanning is managed through RRO (Radiology Reporting Online). An	**Met**	**Met**

		in house consultant radiologist is available on call for any opinions out of hours.		
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 not met in that although the hospital has access to interventional radiology 5 days a week during working hours, there is no out of hours service. There is no weekend service, and there is no networked arrangement or service line agreement with any provider. There is an embryonic relationship for vascular intervention into the Gloucester/Cheltenham hub, but at present this has not been signed off and standardised. At present, any out of hours interventional radiology requires phoning around either to the local team to see if they are free, or to any nearby hospitals to see if they are willing to take the case and manage it.	**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.***	At present the review team felt that this standard was not met primarily due to the issues relating to continuity of care mentioned earlier. Essentially, the on call consultant registrar may well be operating on patients admitted the previous day under a different consultant. Furthermore, once patients are moved from the SAU environment, they come under the care of the elective team, where again, there is a potential for breakdown of consultant continuity. This is more pronounced in view of the fact that the SAU consistently contains numerous medical outliers interfering with its true function. Whilst a single consultant does retain responsibility for the patient, it is not in an acute surgical environment due to the above mentioned problems. However, there is a clear understanding between consultants that if cases need transferring onto specialist colleagues, then this would happen, and	**Not Met**	**Not Met**

		similarly, if a case needed operating on one or two days post take, it would be managed by the on-call team at that time, again creating a potential breakdown in continuity of care. It was also noted that in these circumstances, the operating consultant may not retain responsibility for the patient who would then be transferred back to the admitting consultant.		
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 accordance with decisions on other organisations. There is a unitary document in place that is available to be used by all healthcare professionals in all specialities during the course of the emergency pathway. However, based on the evidence from the notes review, it is not used by the staff in a routine fashion. Frequently the history and initial examination are recorded in this form but no other ongoing documentation or parameters appear to be recorded in the document. The nursing staff did not write in any of the unitary documents that we saw during the notes review, and continued to write on separate nursing sheets.	**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 team felt this standard was met in that the unit has clear arrangements for ambulatory emergency care. It is delivered by a senior decision maker in the form of two consultants and one SAS grade doctor. The ambulatory pathway includes dedicated hot clinics that run 5 days a week, as well as a dedicated day case pathway for abscesses, and this process has a dedicated space within the SAU. It was highlighted by the nursing team, that the availability of ring-fenced ultrasound slots, or an onsite ultrasound machine would improve the flow of the	**Met**	**Met**

		assessment unit and overall hot clinic process. The staff were very clear of the advantages of ultrasound slots for the SAU and hot clinic, and have experienced this due to a previous pilot study done several years ago. It was the main thing on their wish list, for anything to improve the service.		
8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	There was access to a fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24 hour a day. Although there were concerns about the adequacy of the CEPOD availability, on reviewing the notes and discussing the situation with the staff, it seemed that most patients were operated on the day that they were listed, or intended for surgery. There were very few cases that rolled on, and if there were, it was only for one day. It was clear from the review team that the processes around the CEPOD theatre had improved considerably, particularly with the 8.15am briefing and list planning, although the review team remained concerned that the list planning and discussion was undertaken by that day's on-call team and not by the admitting team from the day before.	**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 review team felt that this standard was met. It was quite clear from the current NELA run charts, presented by the Trust's NELA lead, that over 80% of the patients were calculating P-POSSUM scores, and there was good attendance of a consultant anaesthetist in theatre, with excellent (100%) access for transfer to critical care following emergency laparotomy cases. The trust was also over 80% for consultant surgeon in theatres for emergency laparotomies.	**Met**	**Met**

	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.***			
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	The review team felt this standard was met based on the review of the notes. In all cases, the decision to operate was either made by a consultant or was discussed with a consultant and this was documented.	**Met**	**Met**
11	***The majority of emergency general surgery to be done on planned emergency lists on the day that surgery was originally planned. The date, time and decision makers should be documented clearly in the patient's notes and any delays to emergency surgery and reasons why recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre***	Again the review team felt that this was met as based on the notes review. Discussion with the staff confirmed the majority of emergency general surgical cases were done on the CEPOD list on the day that theatre was planned. The WHO safety check lists were present in all of the notes and were clearly filled out, and the date, time and decision to operate was also documented.	**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 met. There is a clear morning handover led by the consultant and hence by a competent senior decision maker. It does take place in a designated time and place, and there is a clear opportunity for handover of patients between different consultants if required. In general, the nursing staff were available for this meeting, and if not, the information was communicated to the co-ordinator who would then disseminate it to the patient's nursing staff. The second handover of the day took place at 8.30pm and was uniformly led by the registrar. On discussion with the teams, it became clear that if the consultant was doing two ward rounds a day, they were often available for this	**Met**	**Met**

		second handover, or had made a clear management plan in all cases which facilitated the handover.		
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 team felt that this was partially met. There was some patient experience data captured through the friends and family, but this was not specific to the emergency general surgical service, nor was it reviewed in isolation. There is an emergency general surgery governance board, although according to the Trust team, this seemed to focus more on the CEPOD list rather than the full emergency surgical pathway. However there is the facility for the latter to be included. The Trust has participated in national audits including NELA and EPOCH, and is currently part of the emergency laparotomy collaborative. There were in-house reviews of the abscess pathway and returns to theatre, but no regular rolling audit programme from what we could ascertain.	**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.***	On discussion with the Trust team, it appears there is a 24/7 GI-Endoscopy bleed rota available within Swindon run by the gastroenterology teams.	**Met**	**Met**
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	The review team felt that we would have to score this standard as not met, based on the most recent GMC survey. We understand that efforts have been made since that time to improve the situation and address some of the concerns of the trainee. Unfortunately, our focus group did not contain any trainee grade surgeons (F2s and SAS grades only) and hence it was impossible to determine whether these recent changes had, had any effect.	**Not Met**	**Not Met**
16	***Sepsis bundle/pathway in emergency care.***	This standard is met after seeing the trusts latest screening rate and antibiotic delivery which have shown	**Met**	**Met**

		an improvement over time. However, on the day of the visit we did struggle to find evidence. In particular, there was a sepsis screening tool within the unitary document, and this was not completed in any of the notes. In part, this may have been because the unitary document was photocopied, and the sepsis document became somewhat "greyed out", making it difficult to register or complete. However, there was limited highlighting of sepsis screening throughout the walk-around, and in addition, there was limited understanding of the documentation of sepsis screening from the junior team. It appeared that they would make a sepsis judgement in their head and act accordingly, but were not documenting this.		
17	***There is a policy for review of all Emergency general surgery patients by a consultant, every day, 7 days a week, whilst they remain under the care of the emergency team.***	This standard was met although there were some issues around continuity of care mentioned earlier. From our understanding, a patient could be admitted on Monday, be seen by the responsible consultant on Tuesday morning, and then transferred to the normal surgical ward. Thereafter they may only be seen by less senior staff and could be discharged home without seeing a consultant again. Of note, there is excellent provision for the review of all non-take patients over the weekend by a consultant who comes in and does a ward round of all of the other surgical patients. As a consequence of this, any emergency patients admitted during the week would actually be seen over the weekend albeit possibly by a different consultant. However, we would note this provision of a weekend review of patients exceeds that found in many of the other Trusts so far in our review visits.	**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.***	The review team felt this standard was not met. Despite the fact that there is a networked arrangement for vascular surgery between Swindon, Gloucester and Cheltenham, through the Cheltenham vascular hub, it appeared that the actual clinical pathways and SLA were not functioning fully. At present, the SLA has not been signed off, and the clinical pathways are throwing up certain problems with patient management. In addition, there appeared to be no clear SLAs for interventional radiology, and because of its geography, only ad hoc arrangements for cardiac, neuro, and trauma between the John Radcliffe in Oxford and the Bristol Trusts. There was no documentary evidence of a transfer policy for patients outside of the organisation. Note: this is a system finding in the majority of Trusts reviewed so far.	**Not Met**	**Not Met**
19	***For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and competence to handle the emergency surgical care of children, including those with life-threatening conditions who cannot be transferred or who cannot wait until a designated surgeon or anaesthetist is available.***	The review team felt that this standard was met. Paediatric surgical patients are clearly admitted and initially cared for by the paediatric team, and hence their fluids and pain management are adequately managed. Wherever possible, paediatric cases are prioritised on the CEPOD list, and are operated on first, except in cases of clinical need. On discussion with the team and on review of the notes, it was quite clear this was the case, including one child, reviewed by a consultant at 2.00 in the afternoon, and in the emergency theatre by 4 o'clock.	**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.***	In general, the review team felt this standard was met, but it was noted by the Trust team that they were struggling to fill all the slots on their registrar rota, and hence on occasion, were reliant on locums or on-call trainees acting	**Met**	**Met**

		up. In the vast majority of cases, there was the availability of an ST3 or higher grade doctor for the on-call.		
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 review is done by consultant or SpR and above. For consultant, this standard was not met during week as there are no clear protocols for consultant review of all general surgical inpatients. However, the standard is met at the weekends, when all inpatients are reviewed by a consultant; either the on-call consultant for the emergency patients, or a separate consultant on the inpatients. However, during the weekdays, patients are often managed by the registrars. All patients do get a review by an SpR through the week, hence this is met 7 days.	**Not 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, but this is in keeping with all other Trusts reviewed so far. The access to urgent physician/medical review, whilst available, seems to take anything from 2 – 4 days, and this was echoed by the staff in Swindon.	**Not Met**	**Not Met**

Recommendations

There were clear arrangements for ambulatory care at Great Western. However, it was apparent that the SAU at Great Western struggled to function at times due to medical outliers. This was demonstrated in delayed/prolonged ward rounds and patient reviews (including hot clinic reviews), delayed Emergency Theatre starts, increased length of stay (LOS) and delayed transfers from the Emergency Department (ED). We recommend the review of SAU and frequency of outliers. Whilst we understand the urgent need to provide beds for patients, this will cause the SAU to stop functioning in the manner it was intended which will further impact on the ability to see and treat patients. We would also advise reviewing the availability of ultrasound (ring fenced slots) or onsite machine which would improve the flow of the assessment unit and overall hot clinic process.

Great Western are running a 'single day on call' consultant rota, which the review team felt impaired continuity of care with the incoming consultant operating on cases from the previous day with limited involvement in the prior care. Ongoing care of non-operated cases was also raised with the outgoing consultant occupied with normal elective work the following day. Furthermore, once patients were transferred from the SAU they came under the care of the elective team further fragmenting the emergency admissions for that day. This impacted on handover and training, and may have contributed to the poor trainee feedback.

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.

Whilst Great Western has access to interventional radiology 5 days a week during working hours, there is no out of hours or weekend service. We would recommend that there is a networked arrangement or service line agreement with another provider to ensure this service can be provided without delay. There is an embryonic relationship with Gloucester and Cheltenham for Vascular Interventional Radiology; however this does need formalising.

Finally, there was some variability in the provision of two consultant led ward rounds of all acute admitted patients Monday-Friday and it is recommended this is reviewed to ensure practice reflects the formalised job plans. There is currently one formalised consultant ward round at the weekend with an opportunity that a second evening round could be planned. 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: 17/8/16
Self-assessment submission date: 28/9/16
Review visit date: 12/10/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Mark Cartmell (Surgeon) Simon Higgs (Surgeon) Sharon Bonson (Matron) Ellie Devine (Manager)

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.