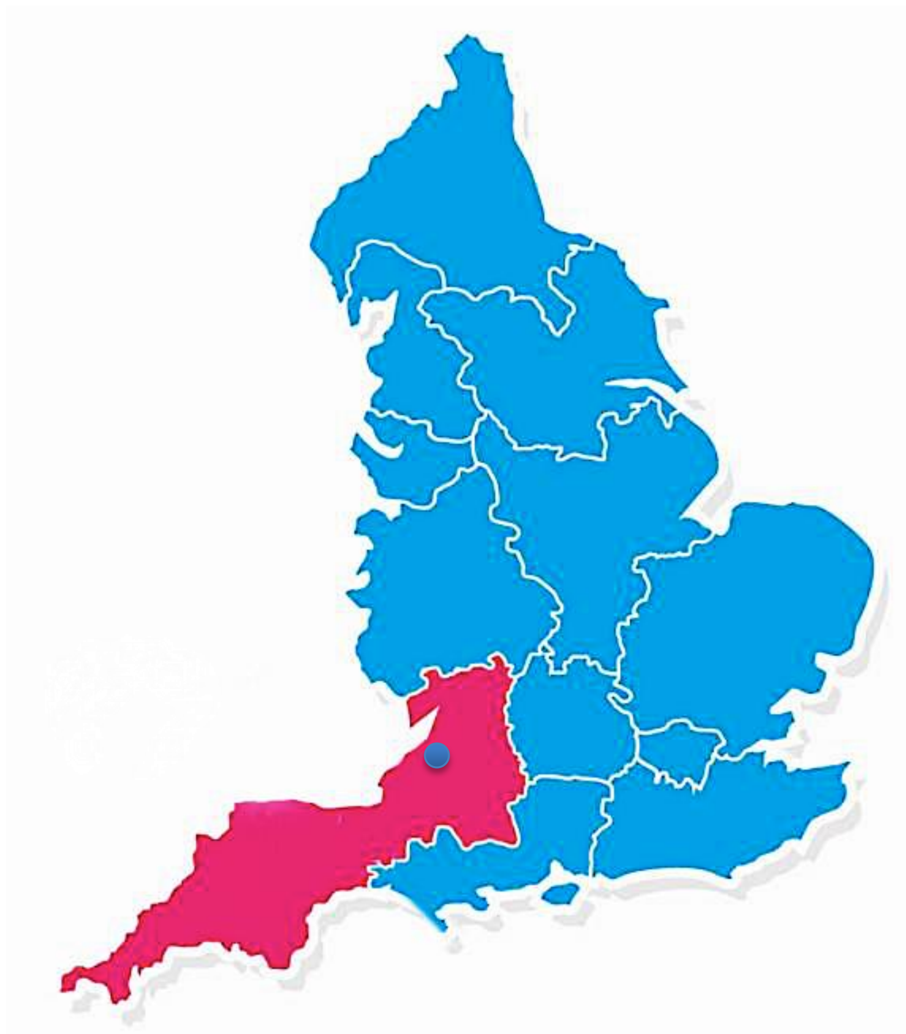
NHS
South West Clinical Senate

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



North Bristol NHS Trust

4th 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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North Bristol Trust employs over 8000 staff and provides general medical and surgical care as well as maternity and specialist paediatric services for a local population of nearly a million people in the Bristol, South Gloucestershire and North

Somerset area. Regional and specialist care for people living in the greater Bristol area as well as Somerset, Gloucestershire, Wiltshire and further afield for services such as neurosciences, orthopaedics, pathology, plastic surgery, renal and transplant services, urology and neonatal intensive care, being the major trauma centre for the Severn region and the lead organisation for the vascular network.
The Trust has an average of 858 beds and this fluctuates depending upon emergency admissions.

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	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.*	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.*	Met	Met
7	*All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (ST3/SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.*	Met	Met
8	*Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7*	Met	Met
9	*All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. ....(cont)*	Partially Met	Partially 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)*	**Met**	**Met**
14	*Hospitals admitting emergency patients have access to comprehensive (Upper/Lower) 24 hour endoscopy service, that has a formal consultant rota 24 hours a day, seven days a week covering GI bleeding.*	**Met**	**Met**
15	*Training is delivered in a supportive environment with appropriate, graded, consultant supervision.*	**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**	**Not 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.*	**Met**	**Met**
19	*For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and ……..(cont)*	**Na**	**Na**
20	*As a minimum, a speciality trainee (ST3/SpR or above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status), is available at all times within 30 minutes and is able to escalate concerns to a consultant. Juniors qualifications - i.e., experience level of team.*	**Met**	**Met**
21	*Do you have clear protocols for senior speciality review of all general surgical in-patients to include GI surgery (Colorectal, Upper GI, Hepato-billary), Vascular, Breast & Urology) every day, seven days a week.*	**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 group felt that this standard was met for Monday to Friday but was not met over the weekend. On Monday to Friday there were two consultant led ward rounds albeit by different consultants covering different "days" take patients. However, there was the capacity for any particularly sick patients to be reviewed. In addition, there was an alternating Upper GI and Colorectal surgeon on-call through the course of the week, and both of these consultants were freed of all elective and private practice commitments. This way of working ensures a degree of continuity as well as the ability to transfer patients between GI specialities. The consultant on-call for the preceding 24 hours was able to operate on their patients on the morning CEPOD list, and was still available for review of their own patients later on during the day. The only real concern raised by the review group was the potential gap between Friday and Monday. Patients admitted over the course of the 8 o'clock Thursday morning to 8 o'clock Friday morning period would only be seen once on Friday morning by the on-call consultant, and then not again until Monday by a different consultant. Over the course of the weekend, they would be managed	Met	Not Met

		by a Registrar who was of variable seniority from ST4 to ST8 or peri-fellowship. The NBT team were clear that any patients where there was uncertainty were discussed verbally between the two consultants on call for that week, in order to maintain ongoing care and review.		
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 clearly met. There was a good escalation policy in place, and a clear ethos within the organisation for junior staff and the nursing staff that escalation to consultant level was an acceptable option if 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.***	Again, the review team felt this standard was clearly met, possibly to a higher degree than in most other organisations. The access to the emergency radiology was very high with 24 hour plain imaging, 24 hour CT scanning, and if necessary, 24 hours ultrasound and MRI scans. However, both the surgical and radiology teams felt that there was seldom a need for an out of hours MRI or ultrasound scan, although the availability of it 7 days a week, particularly ultrasound, did allow a quicker clinical pathway for patients. It is also worth noting that all radiology was reported in-house, with no outsourcing to commercial providers.	**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 was clearly met. North Bristol Trust has access to a full interventional radiology rota for both vascular and GI patients. The only area where they seem to struggle is the increasing influx of patients from outside their routine catchment, where it was noted there was a need to improve the repatriation of this group.	**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 team felt this standard was met although the rota was slightly different from that seen in other organisations so far. Essentially, two consultants are available for on call each week, Monday to Friday, with a single consultant available over the weekend. During the weekdays, there is an alternating on-call between Upper GI and colorectal, with one surgeon admitting patients and the other one undertaking the CEPOD list of patients who were admitted the previous day. This allowed excellent continuity of care, as well as the opportunity to transfer patients between GI specialities if clinical need required. There seemed to be a clear policy for handover and transfer of care between the teams, as a single consultant retained responsibility for that patient, both on the acute surgical unit (which was usually for a 48 hour period), and subsequently, onto the ward, where their care tended to be managed by the elective teams under the same consultant.	**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.***	The review group felt this standard was met. There was a standardised emergency surgical admission document present in all of the notes, and it tended to be used by the medical, nursing and allied health professional staff as a contemporary and used document. There was a minor issue in the patient notes, whereby a patient who had been in for a longer post-operative stay, had their BRI health professional notes separated completely from their medical notes. It was thought this happened once the patient was transferred from the acute surgical environment to a more standardised ward.	**Met**	**Met**

7	***All acute surgical units have provision for** formalised **ambulatory emergency care** delivered by senior decision maker (ST3/SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.*	The review group felt that this standard was met. There were processes in place for ambulatory care including a dedicated hot clinic, a dedicated day case pathway (predominately for abscesses) and a dedicated area within the acute unit (although things have just moved over the last 2 – 3 weeks). The hot clinic and review of patients was normally undertaken by a registrar who was of variable seniority. However, if the registrar was called away to medical reviews, ED or theatre, the clinic would usually then be run by the CT (SHO) level trainee.) There is availability of a consultant during the 5 o'clock ward round to discuss clinic issues, but this necessitated the patients waiting, and prevented an appropriate ambulatory pathway. There are plans to address this with future job planning.	**Met**	**Met**
8	*Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7*	This standard was clearly met in spades! 6 emergency theatres in North Bristol trust but on reviewing it, it was quite clear that there was elective work going on within some of these emergency theatre sessions. As a consequence of this, the use of the "general surgery" CEPOD list for both transplant, and occasionally vascular work, has meant that some emergency general surgical work was pushed into the evenings and sometimes even the early hours of the morning because it could not be done in the day. This viewpoint was reinforced by the theatre teams and junior doctors, and to the review team it was apparent these delays related to more inappropriate cases in the emergency theatre of other specialities than due to an actual lack of resource.	**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.***	In general, the review team felt that this standard was partially met. The more recent NELA run charts from the Trust demonstrate a high achievement of both consultant surgeon and consultant anaesthetists present in theatre, and the appropriate scoring was present in the notes reviewed. The only problem raised was the difficulty of getting into critical care. However, on discussion with the critical care team and the surgical teams, the reason for this did not appear to be entirely clear. Critical care felt that if questioned, almost certainly they would have been able to find a bed, and they perceived the block to be more with the patient flow teams who do not tend to have a whole picture to include critical care and emergency theatre work, and hence are not prioritising discharge of patients from the critical care environment back to the wards. It was noted that aneurysms, head injuries and burns patients would automatically make it into ITU beds, and would be moved by the patient flow team, but they did not seem to have the same ethos with respect to emergency laparotomies.	**Partially Met**	**Partially Met**
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	The review team felt that this standard was more clearly met than in any other organisation so far. The notes reviewed clearly identified a discussion with the consultant about the proposed operation, which was generally timed/ definitely dated.	**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***	The team felt that this standard was generally met. The majority of emergency general surgery was done on planned lists on the day that the surgery was originally planned, although it was noted that this was achieved in part by using other operating theatres. On some occasions, this was making use of the other emergency theatres available within the NBT complex, but for others it was moving cases off of the CEPOD list onto elective lists. Furthermore, because of this slight lack of CEPOD capacity for emergency general surgical patients, there was a tendency for some of these operations to happen late at night. We put a question mark here as to the appropriateness of the timing of these operations. Their data showed 11% of patients were postponed to a following day. As noted before, the time and date of decision makers was clearly noted in the patient's notes, and on the notes review only one patient was delayed in reaching surgery. This was apparently due to a very busy CEPOD list which was recorded in the notes. The WHO checklist audit seems to be done over 90% of the time, and on review of the notes, it was slightly less clear with two sets of notes missing the WHO documentation. Based on the audit data, we felt this was met.	**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***	The team felt that this standard was met. Certainly the morning handover and the handover between the consultant shifts was consultant led. On discussions with	**Met**	**Met**

	or block of on-call days where it should be consultant led. Changes in treatment plans to be communicated to nursing staff and therapy staff as soon as possible if they are not involved in the handover discussions. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.	the team and with the juniors, this seemed to be a very robust process with several consultants attending, including the theatre team and anaesthetists, and this took place at 8.30 in the morning in a designated place. The evening ward round was slightly less formal, and was run by the registrars around 8 o'clock in the evening. It was clear there were good links in communications between the on-call consultants in terms of transferring patients between different parts of the GI specialities, and the handover documentation appeared to be very robust. The nursing staff felt that in general, they were able to be present on the ward rounds and hence know the changes in patient care plans. The ward co-ordinator would be able to catch up by notes review.		
13	***Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. The service has participated in national audits (e.g., NELA, EPOCH - list those known)*** ***Do you audit:*** ***a. Outcomes - death, LOS, return to theatre, readmissions*** ***b. Risk assessment prior to surgery*** ***c. Risk assessment post-surgery*** ***d. Time to CT/US from request*** ***e. Time from decision to theatre*** ***f. Proportion of patients having gall bladder out on admission*** ***g. Proportion of patients having gall bladder out on admission for pancreatitis***	The team felt that this standard was very well met by the Trust. There was good involvement in national audits including NELA, EPOCH, and the emergency laparotomy collaborative. Experience data was captured as part of friends and family, with a particular review of the acute admission ward, although the questions remained generic. There were clear examples in the evidence of ongoing in-house audits at numerous occasions over the last 5 years covering time from decision to investigation, and time from decision to theatre for both the gallbladder and pancreatic pathways. In addition, work had been done on the abscess, appendix pathways, as well as the utilisation processes through the CEPOD theatre. It was noted during discussion with the nursing staff that	**Met**	**Met**

		there was an ideal opportunity for a comparison of elective and emergency experience through the enhanced recovery programme, which at present was covering both elective colorectal cases as well as emergency ones, and this would seem the best opportunity that we have seen so far for a direct comparison of the patient experience.		
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 was clearly met with a 24 hour endoscopy service provided via the gastroenterology teams.	**Met**	**Met**
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	This standard appeared to be met, and the junior doctors in the focus group clearly felt that they were in a supportive training environment with appropriate consultant supervision and teaching and training. They seem very happy with their training. They felt able to contact their consultant at any time of day or night should there be any concerns or issues. It was noted that historically, the GMC survey had been less favourable about training in North Bristol, but they had taken certain actions to try and improve the situation, and based on the assessment today, these appear to have been successful.	**Met**	**Met**
16	***Sepsis bundle/pathway in emergency care.***	This standard was met after requesting latest batch of sepsis data. We saw evidence of the CEQUIN report for sepsis over the second quarter 2016/2017. For July, August, September, ten patients with sepsis were randomly selected to check their medical records. 100% were screened and for the 3 months, 80, 90 and 100% of patients received antibiotics within 1 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.***	This standard is met 5 days a week but not 7 days a week. We understand that each consultant, whether Upper GI or colorectal on call for that week will see each	**Met**	**Not Met**

		of their emergency admission patients at least once a day, sometimes as part of a post take ward round, but sometimes as part of the general speciality ward round. The area where the service falls down is that at the weekends, the review of speciality patients is often undertaken at registrar level, which can be of variable grades. In particular, it was noted that patients admitted from the Thursday 8.00 am till Friday 8.00 am would be seen on the morning by their on call consultant, but then may not be seen again until Monday morning by that same consultant. Whilst they would be reviewed each day by the registrar, this could be a very junior level.		
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 vast majority of emergency surgical services at North Bristol are delivered on site, and actually form the hub for many of the networks. The only cases that we could see that may be transferred out were cardiac or thoracic. We did not see or have sent as evidence any clear clinical pathways or SLA arrangements for cardiac or thoracic work. However, there is a clear link through the vascular service, linking cardiac surgery and vascular emergency work. Of note, the policy/standards document for the transfer of critically ill patients both internally and externally, was considered excellent by the review team.	**Met**	**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***	This standard is not applicable. All childhood emergency general surgical conditions go to Bristol Children's Hospital.	**Na**	**Na**

	wait until a designated surgeon or anaesthetist is available.			
20	***As a minimum, a speciality trainee (ST3/SpR or above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status), is available at all times within 30 minutes and is able to escalate concerns to a consultant. Juniors qualifications - i.e., experience level of team.***	This standard is met. All trainees are ST3 or above with MRCS and ATLS provider status. They are all available on site and are able to escalate their concerns to a consultant.	**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. At NBT there is not a consistent review by a consultant of all general surgical inpatients, and hence the first part of this standard was not met. There is a consultant led review of vascular and urology patients every day, 7 days a week. However, the GI review is sometimes provided by a registrar of variable seniority.	**Not Met**	**Not Met**
		All patients do get a review by an SpR through the week, hence the second part to this standard is reported as being met 7 days.	**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?***	No clear protocols and following discussions with both the senior and junior NBT team, this standard was clearly not met.	**Not Met**	**Not Met**

Recommendations

With North Bristol Trust now providing services in a new hospital, much of the environment has been purpose built and their provision for theatres and critical care is impressive. In the former, it was quite clear that there was elective work taking place in some of the emergency theatre sessions and as a consequence of this, the use of the "general surgery" CEPOD list for both transplant, and occasionally vascular work, has meant that some emergency general surgical work was pushed into the evenings and sometimes even the early hours of the morning because it could not be done in the day. We recommend the emergency theatres are audited to understand the amount of inappropriate procedures that are happening; ensuring emergency theatres are not routinely used for elective work with a negative impact on emergency work.

Critical care did not seem to be utilised as much as it should be for emergency laparotomies. Both critical care teams and surgical teams were unsure as to the reason why. NELA data is collected to demonstrate this and it is recommended that the Trust review their laparotomy patients to understand which did not go to critical care and the reasons for this

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.

Currently NBT delivers two weekly consultant ward rounds but does not have provision for a consultant review on the weekend, rather patients are managed by an ST4-ST8 or peri-fellowship. We would recommend provision of consultant cover is extended through the weekend period.

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: 9/8/16
Self-assessment submission date: 20/9/16
Review visit date: 4/10/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Nicholas Kenefick (Surgeon) Claire Bradford (Theatre Matron) Siobhan Heeley (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.