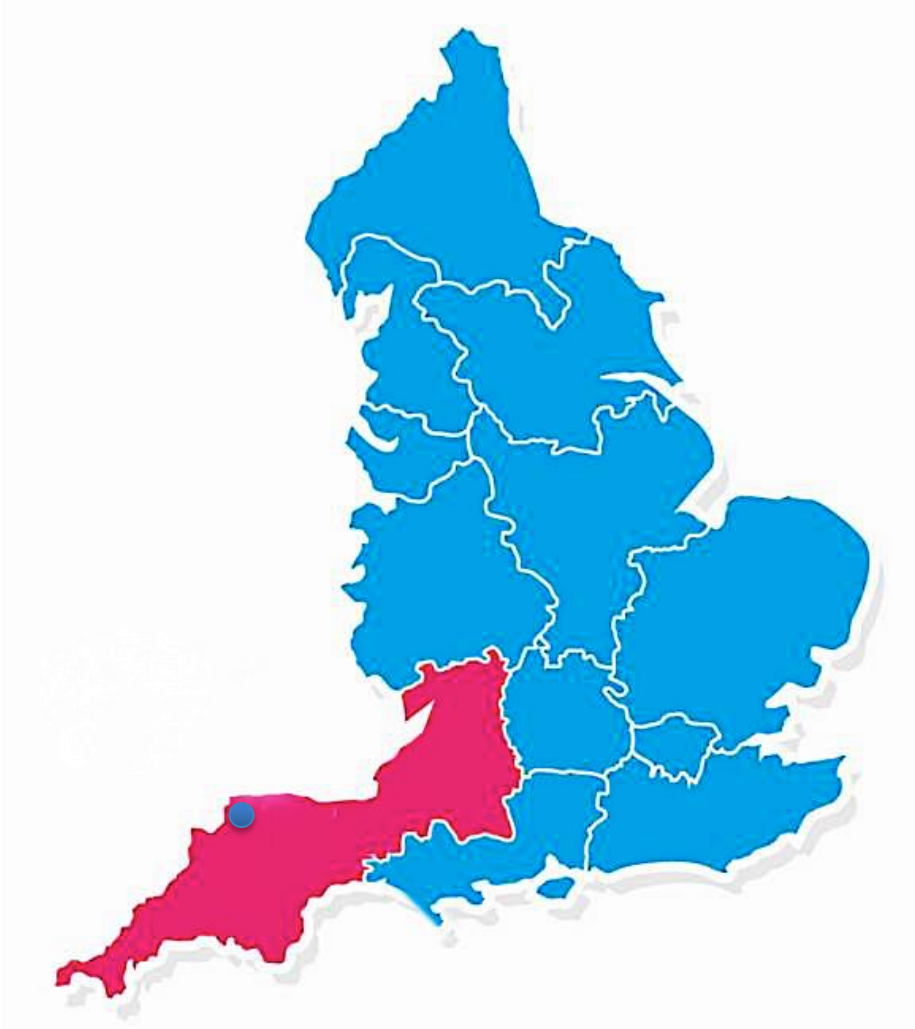
South West Clinical Senate

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



Northern Devon Healthcare NHS Trust

2nd August 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.

Northern Devon Healthcare NHS Trust

Tel No: 01271 322577

North Devon District Hospital
Raleigh Park
Barnstaple
EX31 4JB

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

North Devon hospital provides acute care for a population of around 166,00 people although this population is increased with the number of holiday makers in the summer months. The trust has 644 beds.

The trust employs 4,591 staff, of whom 2,111 work at the North Devon District Hospital and 2,480 work in the community services.

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 almost 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*	Partially Met	Partially 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*	Met	Met

	recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre		
12	*Handovers must be led by a competent senior decision maker (ST3/SpR & above) and take place at a designated time and place, twice a day. These arrangements to be in place for handover of patients at each change of responsible consultant/surgical team/shift or block of on-call days where it should be consultant led. Changes in treatment plans to be communicated to nursing staff and therapy staff ……..(cont)*	**Met**	**Met**
13	*Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. The service has participated in national audits (e.g., NELA, EPOCH - list those known) ……..(cont)*	**Partially Met**	**Partially Met**
14	*Hospitals admitting emergency patients have access to comprehensive (Upper/Lower) 24 hour endoscopy service, that has a formal consultant rota 24 hours a day, seven days a week covering GI bleeding.*	**Met**	**Met**
15	*Training is delivered in a supportive environment with appropriate, graded, consultant supervision.*	**Not Met**	**Not Met**
16	*Sepsis bundle/pathway in emergency care.*	**Not Met**	**Not Met**
17	*There is a policy for review of all Emergency general surgery patients by a consultant, every day, 7 days a week, whilst they remain under the care of the emergency team.*	**Partially Met**	**Partially Met**
18	*Emergency surgical services delivered via a network (e.g. vascular surgery, IR, Plastics,/Burns and Paediatrics.) have arrangements in place for image transfer, telemedicine, and agreed protocols for ambulance bypass/transfer and a formal SLA. Standards for the transfer of critically ill patients are adhered to and regularly audited.*	**Partially Met**	**Partially Met**
19	*For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and ……..(cont)*	**Partially Met**	**Partially Met**
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.*	**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?*	**Partially Met**	**Partially 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 during the week and partially met at the weekend. There were 8 - 20.30 working weeks, Monday to Thursday with a morning and an afternoon job planned ward round. At the weekends the consultants are rostered in for a morning ward round. In practice there is a variation in start time and provision of ward round with some consultants seeing all of the patients and others only seeing those highlighted by the registrar. It was also clear that not all consultants were doing two ward rounds at the weekend. Monday-Thursday all patients are seen within 14 hours and there is good continuity of care throughout the whole of the 7 day working week for patients due to a 4/3 split of working. The night emergency work is 'baby sat' by a different consultant, but the admitted patients remain under the name of the emergency consultant for that 4 day block, hence maintaining the continuity. Consultants are freed of all elective commitments when they are on call including private practice.	**Partially Met**	**Partially Met**

2	***Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.***	The Review Group felt this Standard was clearly met. There were good policies in place for the acceleration of unwell patients in nursing and in medical structures and ultimately to a consultant. Discussions with the junior doctors confirmed that acceleration would happen, and they would be happy to approach the consultant if they had a patient that was unwell and they couldn't contact any more senior staff. In addition, the evidence for the review included up to date and clear documentation of the acceleration policy based around the early warning system, as well as guidance in the Junior Doctors Handbook.	**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.***	This Standard was met in that there was the availability of 24 hour CT scanning as an emergency 7 days a week. The 'out of hours' requesting and reporting was initially run through the PROC system for the Peninsular with a backup from a commercial company Medica for consultant led reporting if there was any doubt. Pathology services were available 24/7. The only slight deficiency would be availability of ultrasound which was present 5 days a week, but only available over the weekend if the US trained radiologist happened to be on duty. From the Junior Doctors Focus Group it was noted that after 16:00hrs they struggled to get any form of scanning or imaging done without the approval by a consultant which they felt slowed the process and management of patients down.	**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 was clearly not met in that there is no network arrangement for interventional radiology services in North Devon. They have access to interventional radiology for vascular service through Taunton Hospital and for urology through the Royal Devon & Exeter Urology service. This is something that is on the Trust/Directorate Risk Register and list of improvement work.	**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.***	This Standard was partially met. The rotas are constructed to clearly maintain continuity of care for all patients admitted as acute surgical cases. A single consultant does retain responsibility for the patient throughout their pathway unless they are transferred for clinical reasons to a different speciality and there is a clear policy for handover of these cases and transfer to another care, although this is usually done verbally. However, a major limitation to the EGS is the lack of an acute surgical unit to provide a dedicated area for surgical patients and EGS staff alike.	**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.***	We felt this was partially met as there was a unitary document available for the medical staff to use for any emergency admission, albeit that it was not usually used to its completeness and in some cases, not even at all by the surgical teams. On occasion there was a tendency to revert to traditional clerking paper rather than the standardised document. It was also noted that the nursing staff and Allied Health Care Professionals did not use this document and tended to have their own separate document, although comments were recorded in the standard medical history sheets, just not in the unitary document.	**Partially Met**	**Partially Met**

7	***All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.***	This Standard was partially met. There is no structured Surgical Assessment Unit for patients admitted under the Emergency General Surgery take in North Devon. At present, bays and beds are used on the male and female surgical wards which are a floor apart with the junior staff tending to locate themselves predominantly on Lundy Ward. There is a pathway in place for ambulatory/emergency clinic for emergency general surgery patients which have achieved good outcomes as audited by the department. However this is based in the Outpatient Department and is remote from the emergency on call service. In addition, some of the consultants are using Day Surgery as an alternative route for ambulatory cases to have their surgery. However this seems to be very adhoc and there is no formal pathway or structure in place at the present time. It was noted that whilst the wards were geared up to turning the patients around quite quickly and maintaining a minimum length of stay or ambulatory pathway, they did struggle with achieving discharge drugs through Pharmacy. This could delay discharge considerably.	**Partially Met**	**Partially Met**
8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	This was partially met, in that there are two mornings of the week where a CEPOD Theatre is not available 24/7 for the Emergency General Surgical team. In addition, it is not completely met at the weekend in that the CEPOD Theatre list for Emergency General Surgery is shared with the Orthopaedic Trauma list; hence there is competition for slots. However, the volume of work in the unit at present means this lack of morning CEPOD list on 2 days	**Partially Met**	**Partially Met**

		and the weekend does not create a major impediment to the flow of Emergency General Surgical patients sharing lists.		
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 in general, that Standard 9 was met. Based on review of the NELA data for the Trust it would appear that patients do have P-Possum scoring undertaken and this is used in an appropriate way to engage with the consultant surgeons and anaesthetists in the management of these cases. It was noted that as the service is predominantly consultant led it is quite likely that there would be automatic involvement with the consultant surgeons and anaesthetists, but this shouldn't detract from the excellent results seen on the NELA data set. Certainly the Consultant Surgeons and Anaesthetists tended to be present in theatre for all major laparotomy cases. It was noted that the P-Possum score did not appear to be written in the notes much like other Trusts, but did go down on a booking form. The hospital team reported that their post laparotomy risk scoring was not as good as it could be and they are trying to introduce measures in the team debrief in order to improve these figures. Of note, in discussion with the Critical Care team, it seems that access to Critical Care and High Dependency beds was relatively easy and there was an expectation amongst the Critical Care staff that all emergency laparotomies would end up in their unit. However, the most recent trench of NELA data has shown that this was achieved in only 75% of cases which is somewhat lower than many	**Met**	**Met**

		other hospitals in the South West. It seems at odds with the expectation of the Critical Care teams and Surgical teams at North Devon.		
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	We felt this Standard was partially met, although this was mainly in relation to documentation. Indirectly based on the fact that the consultant was involved in most operations, it was felt quite likely that the decision to operate was discussed with the consultant on virtually all cases. However, the documentation within the patient's notes for this was particularly poor. In addition, in some cases the decision to operate was not recorded by any member of staff whatever the level.	**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***	We felt this Standard was met for a variety of reasons. Firstly, we saw data that showed only 6.6% of operations were done after 10.00pm and the workload to the CEPOD theatre was such that the majority of cases were done on the day of decision to operate. This was confirmed when reviewing the patient notes, although as mentioned previously, the date, time and decision makers identity were seldom documented in the patients notes. The audits within the hospital for the WHO Safety Checklist suggested this was being used routinely within theatres, but we struggled to find it in the patient's notes. It appears that the WHO document is not stored in the inpatient notes at North Devon, but is retained within the theatre complex for ongoing audit and review.	**Met**	**Met**
12	***Handovers must be led by a competent senior decision maker (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***	This standard is met as there is a clear structured handover morning and evening by a senior decision maker (SpR) which occurs in a fixed time and place. Note,	**Met**	**Met**

	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.	unlike the majority of SouthWest trusts, the consultants are not always present for the morning handover. At present the staff use an Excel spreadsheet which is easily transferrable from computer to computer about the hospital in order to maintain their patient's lists and hand these over. Examples of good practice include a Friday afternoon ward round with all of the surgical teams to hand over the patients that require particular review or assessment over the weekend. This part of the handover process seems to work well.		
13	***Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. The service has participated in national audits (e.g., NELA, EPOCH - list those known)*** ***Do you audit:*** ***a. Outcomes - death, LOS, return to theatre, readmissions*** ***b. Risk assessment prior to surgery*** ***c. Risk assessment post-surgery*** ***d. Time to CT/US from request*** ***e. Time from decision to theatre*** ***f. Proportion of patients having gall bladder out on admission*** ***g. Proportion of patients having gall bladder out on admission for pancreatitis***	The Review Group felt this Standard was partially met. Whilst the Emergency General Surgery was actively involved in the NELA and EPOCH audits and data collection, in additional a Critical Care team were involved in the ICNARC. There was very little evidence of any in-house auditing or the Emergency General Surgical pathway or processes. They had access to the GIRFT review of Emergency Surgery which has helped to identify some of their process to them and this was externally led. Apart from the generic 'friends and family' patient experience assessment, there was no direct assessment of the Emergency General Surgery service in North Devon. The team had recognised issues with their gall bladder pathway and have introduced a new 'hot gall bladder' pathway, although this is in its early stages and difficult to know whether it is being effective at the present time. During the course of the feedback, the team discussed with the North Devon team the opportunity to audit their	**Partially Met**	**Partially Met**

		Emergency General Surgery clinical pathways after the introduction of their new SOP. The Review Group felt this was an ideal time to introduce a more comprehensive review of their Emergency Surgical Services to help guide them with future development.		
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 a GI rota provided partly by surgeons and Gastroenterologists.	**Met**	**Met**
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	There were variable reports on the training environment and as such the Review Group felt that this Standard was not met. The GMC reported good outcomes and a good report for the senior surgical trainees (SPR), but a poor report for the core trainees. However, on discussion with the junior staff in the Focus groups, it was clear that their training was not satisfactory or what they had expected. All the junior staff reported that it was a friendly, pleasant environment and that the consultants were available and supported in their work roles; however they felt that their training opportunities were not maximised, and in some cases were not delivered. There was an issue of expectation for the ST trainee, however the Review Group felt that with 8 consultants it should be possible to deliver a senior training environment requirement. In addition, the more junior doctors (F1) felt there was limited bed side ward round teaching, clinic teaching available to them, despite efforts that they had made to set up teaching programmes with limited engagement from the consultant body. As a consequence we have scored this Standard as not met.	**Not Met**	**Not Met**

16	***Sepsis bundle/pathway in emergency care.***	The Review team felt that this Standard was not met. On reviewing the evidence that was available, it was quite clear that the appropriate patients were being screened for sepsis. This was all done in the Emergency Department which is the central point for arrival of all emergency surgery cases. However, despite adequate screen levels, the patients flagged up as requiring ongoing treatment seldom received their antibiotics within one hour, if at all (5 out of 6 did not receive their antibiotics). During the course of discussion with hospital team it was raised that the local microbiology team felt that some aspects of the sepsis six bundle was not evidenced based. There was some discussion about the introduction of a local sepsis screening process. This review and process has not been completed and so hence at the present time the sepsis screening and action on this is not met as a Standard.	**Not Met**	**Not 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 was reviewed as partially met based on discussions with the focus group staff. Whilst it appeared that the Consultants were job planned to be available for 10 hours during the day time on-call, with no other commitments at this time, hence in a position to review all the emergency and general surgical cases (as per the new SOP), in fact, this was not actually happening from the reports from both the Medical and Nursing staff. In particular, it was noted whilst the all new emergency and general surgical patients were seen by a consultant usually within 14 hours, the follow up of emergency patients once admitted, tended to be in the hands of the Registrars who would accelerate any particular issues up to the consultant provided they recognised there was a	**Partially Met**	**Partially Met**

		concern.		
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.***	We felt this Standard was partially met in that the hospital has a network arrangement for Vascular Surgery and for Urology emergencies. There is an automatic default to Bristol Children's Hospital for complex paediatric surgical issues, although there is no clear clinical pathway that the hospital team had been able to find. (We believe that this is now in the process of being developed). In particular it was noted that there are no clear pathways for the referral of Plastics, Burns, Thoracics, or Cardiac Surgical cases. The team did point out that most of these cases get referred on from A&E and felt that there probably were pathways present in the ED Department. There were good policies and guidelines for the transfer of critically ill patients between hospital sites, but as mentioned before, there was no network IR provision for the hospital.	**Partially Met**	**Partially Met**
19	***For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and competence to handle the emergency surgical care of children, including those with life-threatening conditions who cannot be transferred or who cannot wait until a designated surgeon or anaesthetist is available.***	The Review Group felt that the care of Emergency General Surgical paediatric cases was on the whole good, but in the absence of a clear document policy determining who is caring for these patients, we felt this Standard would only be scored as partially met. It was clear from discussions with the Focus Group that any Paediatric Emergency General Surgery case admitted was given priority on the CEPOD theatre list in order to improve the time to surgery and reduce their length of stay. However there was uncertainty about who was actually caring for the patient between the General Surgical team and the Paediatric team, with the potential for clinical incidents.	**Partially Met**	**Partially Met**

		The hospital standard on this could not be found and is in the process of being redrafted. There was good evidence that Surgeons and Anaesthetists were undertaking paediatric life support as part of their standard annual update process. Although there is no pathway written, there seems to be a clear link to the Bristol Children's hospital for any complex cases or any cases under the age of 1 yr.		
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.***	The Review Group felt this Standard was met, albeit because it was consultant led after 20:00hrs and hence would be delivered above ST3 level. At present there is an ST Trainee available from 08:00 – 20:00 hrs, but after this, the service is managed by a core trainee and the on call consultant. The consultants all live within 30 minutes of the hospital and hence access to senior decision making and review is available in accordance with the Standard.	**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.***	The Review Group felt this Standard was not met for a consultant review of all patients.	**Not Met**	**Not Met**
		There is a review of all general surgical in-patients by a specialist registrar (Sp3 & above) everyday, seven days a week.	**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?***	The Review Group felt that this was partially met, and ahead of most of the trusts in the South West! Present access to a senior medical review is usually available within 24hrs due to the 'familiar' nature of the working environment in North Devon. Most of the consultants know	**Partially Met**	**Partially Met**

		each other by first name and can simply phone and call for review which tends to happen that morning or afternoon. Other than this, out of hours reviews are managed by the Medical Registrar who apparently is readily available.		

Recommendations

There was no doubt from our review of all Trusts in the South West that a Surgical **Assessment** Unit where the majority of the EGS take patients are located and which provided a hub for the on-call surgical team was considered invaluable to both senior and junior medical staff. In some Trusts, this was sometimes called, and indeed used, as a Surgical **Admission** Unit. Patients on an assessment unit are triaged prior to admission to ensure they are moved onto the appropriate pathway. (Note: this has implications for patient expectation, Length of Stay and how clinical data is coded to be used later in audit). A functioning SAU was recognised as a key requirement to maintaining an efficient and effective EGS service. When integrated with EGS ambulatory care and co-located close to the Emergency Theatre, the SAU provides a 'hub' to focus delivery of EGS care in a more efficient way.

At the time of the review, there was no SAU at North Devon which can result in the review of patients being delayed as the on-call ward rounds become what is colloquially known as 'safari ward rounds'. This means the ward round covers multiple different wards, often including the ED.

It was clear that in order to function the SAU must be ring fenced from medical outliers or its ability to function will breakdown. Ideally, the SAU should incorporate, geographically, the Ambulatory care aspect of the service. This allows flexible working of the on-call team, maintains the basis of senior decision making and allows co-ordination of the EGS referrals.

There was a consensus 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.

The North Devon team felt that a 24/7 CEPOD theatre was not necessary due to low volumes, arguing they were able to 'break into' an elective list if needed. We would recommend that this is reviewed alongside the EGS workload to ensure that access to theatre is not impacting on the EGS procedures and patient experience.

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 North Devon. There are formalised arrangements for Vascular and Urology, but no networked service and no clear pathways for GI or EGS cases. Arrangements are currently ad hoc, based on goodwill from the existing interventional radiologists between Taunton and RD&E. We would recommend this is looked into and a formal arrangement for GI/EGS Interventional Radiology is put in place to ensure there is no delay in urgent and emergency cases.

Finally, there was some variability in the provision of two consultant led ward rounds of all acute admitted patients 7 days a week and it is recommended this is reviewed to ensure practice reflects the formalised job plans. 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:
Self-assessment submission date: 19/7/16
Review visit date: 2/8/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Andrew Allison (Surgeon) Grant Sanders (Surgeon) Deborah Harman (Theatre sister) Caroline Dawe (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.