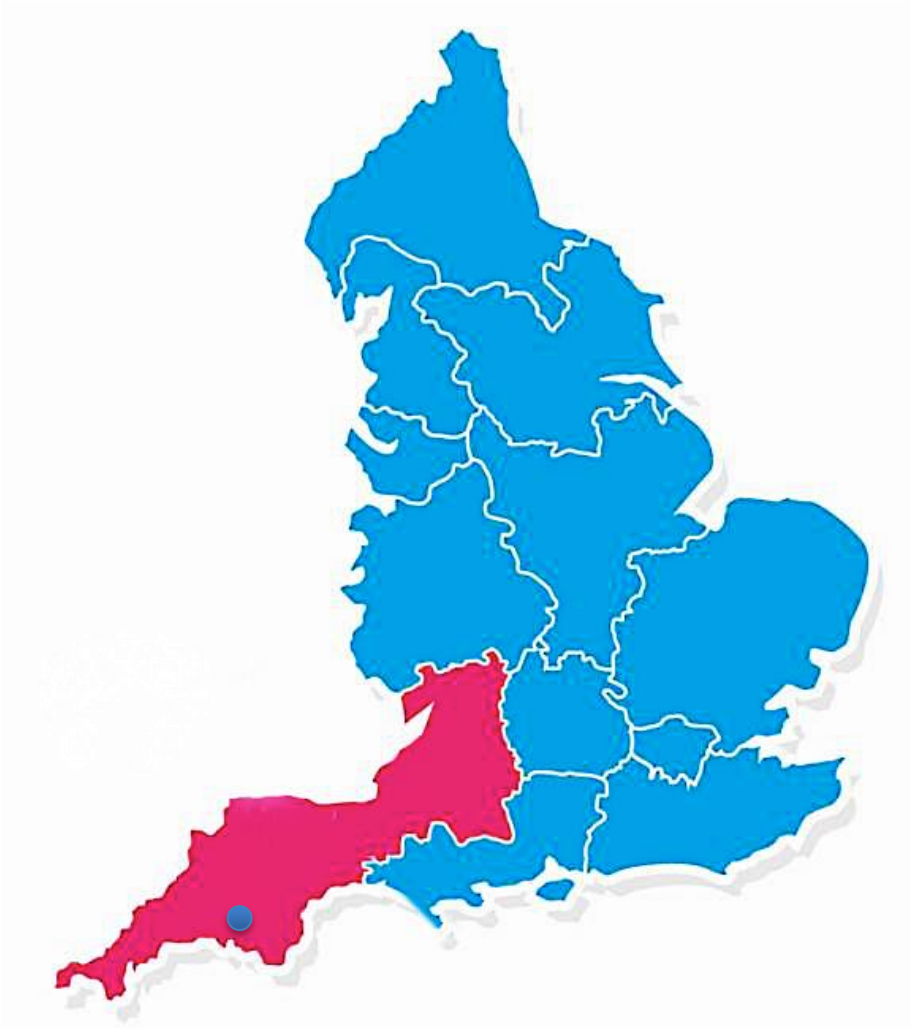
South West Clinical Senate

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



Plymouth Hospitals NHS Trust

6th September 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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Plymouth Hospital trust is the largest teaching trust in the South West Peninsula and employs approximately 5,639 staff who provide acute care for a population of more than 450,000 people in Plymouth, North and East Cornwall and South and West Devon. The Derriford (hospital) has 969 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)*	Met	Met
2	*Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.*	Met	Met
3	*All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.*	Met	Met
4	*All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week, either on site or through a formalised network with an agreed SLA (Service Line Agreement). Critical patients - within 1 hour if IR on site, within 3 hours if networked, Non-critical patients - 12 hours. Interventional facilities are safe for emergency patients.*	Met	Met
5	*Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.*	Met	Met
6	*A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialities throughout the emergency pathway.*	Not Met	Not 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*	Partially Met	Partially 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*	Met	Met

	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**	**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)*	**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.*	**Met** **Met**	**Met** **Met**
22	*Do you have clear protocols, including a standard for timing, for senior medical (physician) speciality review of emergency general surgical admissions?*	**Not Met**	**Not Met**

Table 2: Summary and commentary of compliance with the Emergency General Surgery standards

No.	Standard	Commentary and Conclusions	Week	Weekend
1	***Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds such that patients are generally seen within 14hrs from arrival. There is evidence of continuity of care either through multiple day working or specific patterns of working that allow continuity of care. When on-take, a consultant and the on call team are to be completely freed from other clinical duties or elective commitments. Surgeon with private practice commitments makes arrangements for their private patients to be cared for by another surgeon/team, when they are on call for emergency admissions.***	This standard was met. The SAU staff and juniors confirmed that there were two consultant ward rounds happening every day and that it would be very unusual for a patient to wait for more than 14 hours from admission without being seen by a consultant. However, it was noted that when patients were transferred out of SAU, usually due to medical bed pressures, they may not get incorporated in this twice daily review. Through the week on-call, the working practices maintain a good continuity of care with an alternating Lower GI surgeon with hepatobiliary and Upper GI surgeon. Both consultants in this rotation are free of all elective commitments including private practice.	**Met**	**Met**
2	***Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.***	There is a clear escalation policy in place. The junior and nursing staff confirmed that they were happy to escalate any problems with no concerns about phoning the consultants, in hours, out of hours or if they had gone home. The review team felt this standard was met.	**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***	This standard was met. Plain x-ray and CT scanning have good 24-hour access delivered by their in-house radiology teams. Emergency imaging was reported real time,	**Met**	**Met**

	time. Urgent imaging reported within 12 hours.	usually by the registrars, but with immediate access to consultant review in more complicated cases. Note, the registrars were specifically trained during their period in Plymouth to be able to handle the on-call/emergency reporting. Access to MRI scanning out-of-hours was mainly in relation to neurosurgery or spinal and only on rare occasions could it be accessed for general surgical cases. There was access to daily ultrasound Monday to Friday on the SAU (8 – 10 slots every morning) as well as the availability of out-of-hours ultrasound scanning if required. Both the junior teams and nursing teams did note that a lack of easy access to ultrasound over the weekend tended to delay the discharge and management of patients admitted on Friday afternoon or Saturday. In addition, a problem was identified for those patients who were transferred off the SAU in the course of the weekend take, as they were no longer able to access the SAU ultrasound slots, which could again delay treatment and discharge. Although most Trusts do not have 24/7 ultrasound services, the general review team has considered this not a rigid part of the standard as most clinicians felt they would cope perfectly well using CT alone. In the Plymouth situation, there is sufficient workload where a 7 day service would be beneficial. The Trust is aware of this but there have been difficulties in recruiting sonographers.		

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.***	The Trust met this standard and was able to provide an interventional radiology service 24/7 with a 1 in 4 on-call rota. They did note that similar to sonographers, there was a difficulty in recruiting interventional radiology consultants due to a national shortage.	**Met**	**Met**
5	***Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.***	The review group felt that this standard was clearly met. As we understand it, the on-call at the weekends is provided by a single consultant surgeon with an F1, CT and SPR on-call team, as well as an equivalent 3 tier team providing cover for the wards. On Monday, the on-call consultant for the weekend is free from elective commitments in order to manage the CEPOD list and operate on any of the patients still requiring surgery from the weekend. There is a different consultant on call for that Monday, who in turn will provide the CEPOD operating session on the Tuesday, with another consultant on call for Tuesday, who will in turn provide the CEPOD operating on the Wednesday. During the Monday to Thursday period, the two consultants, usually one from Colorectal and one from Upper GI/Hepatobiliary provide an alternating service between being on call and providing the CEPOD service. A single consultant retained responsibility for a patient whilst on the acute surgical unit and usually when they are transferred to another ward, unless care has been transferred to a different speciality. Long stay emergency patients are transferred to the consultant of the week within that team, to ensure on-going continuity going	**Met**	**Met**

		forwards, in particular to future weekends. The majority of patients are managed on an acute surgical environment, although the nurses, juniors and consultants acknowledge that when the pressures were great from medical admissions, there was a tendency to escalate into the SAU, which effectively stopped it functioning as an assessment unit.		
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.***	This standard was not met and there was not great support for a unitary document on the Plymouth team.	**Not Met**	**Not 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.***	In general the review team felt this standard was met. The Plymouth Trust is in the process of developing and evolving their ambulatory care for emergency general surgical patients. At the present time, there are both clinic slots and investigation slots (ultrasounds) to bring back patients seen the previous day. There has been a slight issue in managing the results of these scans and clinic reviews, as the Consultant who was on-call for the previous day will normally be in theatre on the CEPOD list. However, the future plan is that the incoming on-call consultant is usually free of all elective activity that day and will be available to see patients in the Hot clinic, and review the results of ultrasound scans. There is the potential to manage patients through a day care pathway. There are no separate day case theatres within Plymouth, they all exist within the main theatre complex, but patients can be taken from the SAU to theatre and then returned to the Day Unit ward, whereupon they will have an accelerated day case discharge. The Hot clinic and scanning is all available on the SAU providing ideal co-	**Met**	**Met**

		location.		
8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	This standard was clearly met, as there is 24/7 access to a fully staffed emergency CEPOD theatre.	**Met**	**Met**
9	***All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care.*** ***All patients with a predicted mortality of >5% (SORT or P-Possum), should be discussed with an intensive care consultant preoperatively. A consultant surgeon and consultant anaesthetist must be present for the operation except in specific circumstances where adequate experience and the appropriate workforce is otherwise assured.*** ***Risk of death at end of surgery reassessed to determine location for post-op care.***	The review group felt that this standard was partially met based on one of the key NELA measures within this standard; patients with a mortality of greater than 10% have a consultant surgeon and anaesthetist present in theatre. We have used this measure from the most recent NELA data across the whole of the Southwest to try and provide some degree of comparison. We do acknowledge that in the case of Plymouth, they are green as far as the presence of a consultant surgeon is concerned, but become amber (partially met) because of the presence of consultant anaesthetist. However, it is understood that there are high number of senior trainees in anaesthetics who are not only available to provide the appropriate support but also require opportunities for 'solo' operating as part of their training.	**Partially Met**	**Partially Met**
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	We felt this standard was met based on the presence of two consultant ward rounds and review of the notes. With two consultant ward rounds happening a day, it is quite easy to see that all decisions for surgery are likely to have been made by the consultant. On reviewing the notes, this appeared to be the case with the date, time and decision maker's identity clearly 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***	The group felt that this standard was partially met based on the comments by the team and by the nursing and junior staff. Whilst there is a 24/7 CEPOD theatre, the	**Partially Met**	**Partially Met**

	recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre	volume of work is such that there was a consistent group of patients that tended to get "rolled over" to the following day, sometimes 3 to 4 times in a row. In addition, the team acknowledged that their ability to get biliary colic cases operated on the day of surgery, whilst good compared to national figures, was not at a level they would like it to be. The review team felt there was potential need for two CEPOD theatres in view of the EGS throughput.		
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.***	We felt that this standard was met based on the presence of 2 consultant led ward rounds occurring per day. In particular, it was noted that the doctors assistants that work alongside these ward rounds were able to communicate the decisions and plans to the nursing teams, as well as facilitate many of the actions, thus improving continuity of patient care. The Trust has a bespoke handover document, which is accessible across the hospital to all staff. This document is not stored historically, but is updated in a rolling fashion to maintain a list of patients for review and management plan.	**Met**	**Met**
13	***Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. The service has participated in national audits (e.g., NELA, EPOCH - list those known)*** ***Do you audit:*** ***a. Outcomes - death, LOS, return to theatre, readmissions*** ***b. Risk assessment prior to surgery*** ***c. Risk assessment post-surgery*** ***d. Time to CT/US from request*** ***e. Time from decision to theatre***	This standard was clearly met, possibly the most complete achievement of the standards so far. There was evidence of emergency patient's specific patient experience data extracted from the friends and family review (which we have not seen elsewhere). In addition, there was involvement in national audits including NELA and EPOCH, as well as clear evidence of in-house audits looking at biliary disease, abscess pathways, time to scanning and time to surgery. They also presented GIRFT data looking at the surgery for biliary colic. Finally, there	**Met**	**Met**

	f. Proportion of patients having gall bladder out on admission ***g. Proportion of patients having gall bladder out on admission for pancreatitis***	was evidence from discussion with the teams and the junior and nursing staff that the information gained from these audits was being used to develop and improve the service.		
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. There is a 24-hour, 7-day a week endoscopy service for GI bleeds provided by the gastroenterology team.	**Met**	**Met**
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	This standard was met. The juniors were very positive in their feedback on both their training and the support provided for them by the senior teams within Plymouth Trust. The GMC reports over the last 5 years were reviewed as part of the evidence. They are below the mean for local and regional training, but good for overall satisfaction and clinical supervision both in and out of hours. There was some uncertainty due to the reported poor local/regional training, but it was not something that was highlighted by the junior team's focus group.	**Met**	**Met**
16	***Sepsis bundle/pathway in emergency care.***	This standard was met. There is a clear sepsis bundle and up until recently, there had been a weekly review of their sepsis pathway but the outcomes were sufficiently good that the Trust now felt that they were able to shift these audits to a less frequent rolling programme.	**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.***	By October of this year, there is provision in place for all elective and emergency patients under each individual team to be reviewed by a consultant every day of the week. There is the potential that if the on-call consultant is too busy, that they will not be able to get to all of the elective and previous emergency patients under the speciality name. However, the cover registrar is able to review these and discuss the cases with the on-call	**Met**	**Met**

		consultant should this situation occur.		
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.***	In general this standard is met as Plymouth is in fact the hub for most of the networks for the more complex and specialised surgery, in particular: neurosurgery, cardiac surgery, plastics and paediatric surgery. For those paediatric cases that were felt too complex to be managed in Plymouth, there was a clear transfer policy and agreement in place for the case to be moved to the Bristol children's hospital. There is a vascular network currently in existence between Plymouth and Truro providing alternating weeks on-call. There was uncertainty to the actual formal arrangements for this network and no documentation was available. It was noted that obscure patients in Plymouth were not reviewed over the weekend when the Truro team were on call, and would only be seen by the cover/on-call registrar. However, it was generally felt that if the registrar did identify a problem that one of the Plymouth vascular team would be available. This arrangement appears to be ad-hoc with no formalisation at present.	**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 wait until a designated surgeon or anaesthetist is available.***	We felt this standard was clearly met. There was a clear pathway for admission of surgical paediatric cases. The cases are admitted under the care of the paediatrician to provide adequate input into fluid replacement, dosing and pain control. In addition to this, there is a prioritisation of children's cases on the CEPOD list wherever possible. Due to the pressures on the CEPOD list, the Trust has generated 3 paediatric CEPOD lists within the paediatric theatre complex to maintain the flow of children with emergency general surgical problems.	**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.***	Yes this standard was clearly met.	**Met**	**Met**
21	***Do you have clear protocols for senior speciality review of all general surgical in-patients to include GI surgery (Colorectal, Upper GI, Hepato-billary), Vascular, Breast & Urology) every day, seven days a week.***	We report two outcomes for this standard according to whether the review is undertaken by a consultant or SpR. Both outcomes are met, as there were protocols for review of all emergency general surgical patients, and all general surgical inpatients by the on call consultant. Note, there is a caveat on vascular surgery on the weekends, when the on call services were being provided in Truro.	**Met** **Met**	**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?***	In discussion with the team, this was not met, and there was usually a delay of 1 – 3 days getting senior medical (physician) review input.	**Not Met**	**Not Met**

Recommendations

Plymouth is currently meeting more standards than any other Trust in the South West but would acknowledge there are improvements that should be made to the EGS service. Whilst their provision of theatre time is ahead of the majority of South West Trusts, they are also subject to a great deal more patients and can, at times, experience delays with availability of theatre operating slots.

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 the provision of ambulatory care incorporates a number of recommended elements including dedicated ultrasound slots and co-located next to SAU, there is an issue of continuity with consultants scheduled for CEPOD lists after their on-call. This can mean that patients seen and scanned the day before in a hot clinic may see a different consultant the following day. Looking to the results in Bath as a model, there are opportunities for the ambulatory pathway to be expanded which would further enable a reduction in admissions and Length of stay, greatly improving the timeliness of treatment and patient experience.

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: 23/8/16
Review visit date: 6/9/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Andrew Allison (Surgeon) Melanie Feldman (Surgeon) Andrew Baker (Anaesthetist) Amanda Stevens (Theatre sister) Fiona Phelps (Commissioner) Phil Yates (GP).

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.