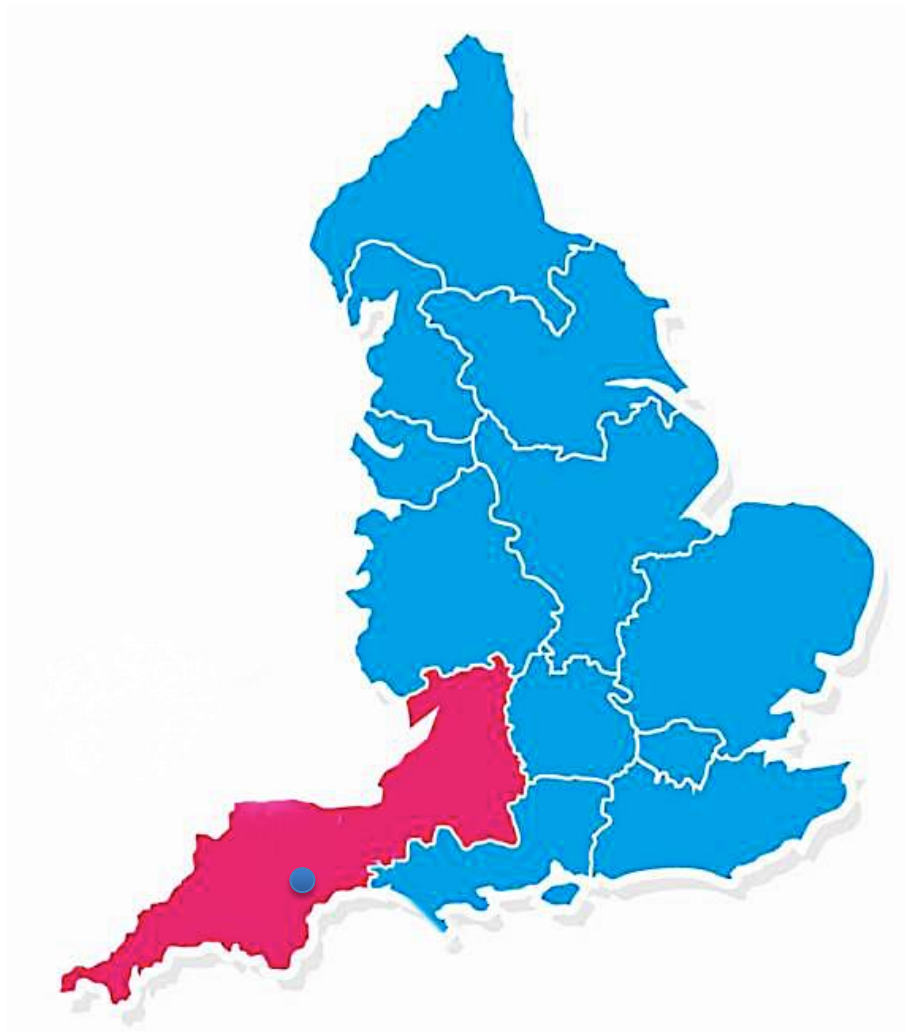
South West Clinical Senate

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



Royal Devon and Exeter Foundation Trust

7th June 2016

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Introduction

As a service, Emergency General Surgery (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, planners 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. Utilising a mixed method approach, this work aims to review 14 South West Trusts in order to provide an overview of performance within the region. 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) Quality and Safety Programme (EGS) and the recent NHS England (2016) 7 day standards.

Following a pilot 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.

Royal Devon and Exeter Foundation Trust (Wonford)

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The Royal Devon and Exeter NHS Foundation Trust is a teaching hospital that employs around 7,000 staff and serves a core population of around than 460,000 people in Exeter, East Devon and Mid-Devon.

Surgical specialties provided at Wonford Hospital include trauma and orthopaedics, general and thoracic surgery, ear, nose and throat (ENT), plastic, breast, ophthalmic (eyes), vascular, head and neck reconstructive and oral and maxillofacial surgery. There are 16 theatres in total, one of which is a 'CEPOD' emergency theatre, which is shared with plastics. Plans to reconfigure the theatre timetable will mean a dedicated theatre available for Emergency General Surgery at the weekend.

The Trust has recently undergone improvements to their Emergency General Surgery (EGS) service, with consultants freed from their elective work and the set-up of a Surgical Assessment Area allowing EGS patients to be triaged in a dedicated space. The service is currently offering a re-review hot clinic where suitable patients can be brought back the following day for their operation, reducing length of stay and improving outcomes for patients.

Summary of findings

Table 1 provides a summary of the performance against the commissioning standard. The following Table 2 provides the standards with commentary from the review process. As shown in table 1 the green, red and amber colours demonstrate whether a standard was met, not met, or partially met.

Table 1: Summary of compliance with the Emergency General Surgery standards

No.	Standard	Week	Weekend
1	*Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds such that patients are generally seen within 14hrs from arrival. There is evidence of continuity of care ……..(cont)*	Partially Met	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.*	Partially Met	Partially Met
7	*All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (ST3/SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.*	Met	Met
8	*Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7*	Not Met	Not Met
9	*All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. ……..(cont)*	Met	Met
10	*All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented*	Partially Met	Partially Met
11	*The majority of emergency general surgery to be done on planned emergency lists on the day that surgery was originally planned. The date, time and decision makers should be documented clearly in the patient's notes and any delays to emergency surgery and reasons why recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre*	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 on-call days where it should be consultant led. Changes in treatment plans to be communicated to nursing staff and therapy staff ……..(cont)*	**Partially Met**	**Partially Met**
13	*Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. The service has participated in national audits (e.g., NELA, EPOCH - list those known) ……..(cont)*	**Partially Met**	**Partially Met**
14	*Hospitals admitting emergency patients have access to comprehensive (Upper/Lower) 24 hour endoscopy service, that has a formal consultant rota 24 hours a day, seven days a week covering GI bleeding.*	**Met**	**Met**
15	*Training is delivered in a supportive environment with appropriate, graded, consultant supervision.*	**Met**	**Met**
16	*Sepsis bundle/pathway in emergency care.*	**Met**	**Met**
17	*There is a policy for review of all Emergency general surgery patients by a consultant, every day, 7 days a week, whilst they remain under the care of the emergency team.*	**Partially 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.*	**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 (consultant) of all general surgical in-patients to include GI surgery (Colorectal, Upper GI, Hepato-billary), Vascular, Breast & Urology) every day, seven days a week.* *As above where senior specialty review is ST3/SpR & above.*	**Not Met** **Met**	**Not Met** **Met**
22	*Do you have clear protocols, including a standard for timing, for consultant medical (physician) speciality review of emergency general surgical admissions?*	**Met**	**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 is not met in its entirety. There are not two clearly identified consultant-led ward rounds of all the acute admitted patients 7 days a week. There is a consultant-led round once a day, usually first thing in the morning, and a second ward round happens but appears to be run by the middle grade staff, the timing of which seems to be ad hoc, with comments ranging from 'lunchtime' to '4 o'clock' to '10 o'clock'. However, there is time within the existing consultant job plans for a specific afternoon/early evening ward round/review of new admissions. There is good evidence of continuity of care with a 36 hour on call cycle and crossover between the consultant finishing on call, and the consultant taking over on call between 8am and 1pm. Patients stay under the care of the admitting consultant throughout their admission unless there is a need to transfer their care to the incoming emergency surgeon. If this is the case, discussions, handover etc. occur in that 5 hour morning crossover period.	Partially Met	Partially Met

		All surgeons are completely freed from all other clinical duties or elective commitments including private practice. The current system is due to be changed in September 2016 where there will be an alternating upper GI surgeon and a lower GI surgeon during the course of the Monday to Thursday period. This will provide some continuity at a specialty level as well as an individual level, i.e., an acute gallbladder will only be 24 hours away from an upper GI surgeon or an acute diverticular complication will only be 24 hours away from colorectal surgeon on call.		
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.***	This was clearly met 7 days a week. The Trust provided evidence of their EWS graded response proforma. There was a clearly identified escalation policy and, on direct questioning of all staff, it was in agreement that this would be used even to the level of contacting the consultant. Evidence was reinforced by some of the notes reviews which identified clear record of the time the junior team were called, and the time they arrived, suggesting an adherence to an escalation policy.	**Met**	**Met**
3	***All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.***	The Review Group felt this standard was met 7 days a week and the only slight variance was the availability of ultrasound scan 24/7, as this was dependent upon having a radiologist on call who was proficient in ultrasonography. The Trust was working on a plan to have a radiologist on SAU to do real time USS. However, all the clinical team, both senior and junior, agreed that in the absence of ultrasound, there would be a natural default to CT scanning or MRI scanning. The current system of out-of-hours reporting is due to change within the next few	**Met**	**Met**

		months to the “PROCS” system which covers out-of-hours reporting for all the hospitals within the peninsula. This will replace the present system where reporting in the early hours of the morning was provided by a commercial company. Of note, any issue with availability of reporting in the current or future system is backed up by the presence of the on call radiologist. Hence, emergency imaging is reported real time and the department felt that urgent imaging would be reported within 12 hours, although there is no audit to support this at the present time.		
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 Review Group felt this was clearly met. There is a strong working relationship and network arrangement between the Royal Devon and Exeter Hospital and Torbay for provision of radiology services. There is a clear clinical pathway and a formalised agreement for this between the two Trusts. The arrangement is such that the interventional radiologists will move to the site where the patient needs care and both sites have an available interventional suite, fully staffed with both interventional radiology nurses and radiographers. Based on the geography, onsite patients should be easily treated within an hour or within 3 hours if there is a need for the radiologist to travel. It was felt that non-critical patients could be managed easily within a 12 hour window.	**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 this standard was met in that the 36 hour on call cycle was constructed to provide a 5 hour crossover period between the two on call teams, giving time for handover if necessary. A single consultant does retain responsibility for the single patient during their acute	**Met**	**Met**

		admission. If the patient requires a prolonged stay and is transferred out to the general surgical ward, the specialty team of that consultant will continue on with the care of that patient but they will remain under the name of that consultant. In cases where a patient needs to be transferred to the incoming consultant on call or to a different specialty, discussions with the junior and senior team suggested this happened during the crossover period in the morning and there was no impediment to this process at present. The Review Group did note that there was no clear policy for this, or any clear standardised documentation of a transfer of care. It was understood this was likely going to be addressed in the ongoing work in the RD&E on the handover process.		
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 partially met. There is a single document for the medical teams to complete, however, based on the notes review, not all of the teams used it and some clerked patients in a standard way using medical notes paper. There did not appear to be any space for other healthcare professionals to enter information into the standardised record, although for those patients whose stay was extended, their notes continued on standardised medical note paper. In some patients the health professional and nursing notes are contemporaneous with the medical notes but in others they were stored in a different place. The Review Group noted there did not seem to be a consistent process for this for the emergency patients.	**Partially Met**	**Partially Met**

7	***All acute surgical units have provision for** formalised **ambulatory emergency care** delivered by senior decision maker (ST3/SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.*	The Review Group felt that this standard was met. It was clear from the review of SAU and discussions with the nursing staff and junior staff, that provisions were in place for a dedicated area for ambulatory care in the dedicated hot clinic that had started and the only area where the system was currently falling down was that for a dedicated day case pathway, although some patients are being currently managed as day cases. Bearing in mind the time frame over recent changes for emergency general surgical care, there was a consensus among the Review Group that a huge amount had been achieved in a very short period of time and that a dedicated day case pathway will be an automatic sequela of the ongoing work.	**Met**	**Met**
8	*Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7*	This standard was not met in that there is not dedicated access to an emergency CEPOD operating list 24/7. The main impediment to this is the lack of afternoon CEPOD operating space. This results in delayed evening starts; prolonged operating into the night, sometimes into the early hours of the morning with extended working time for both junior and senior staff. **Note:** The Trust fully recognises this and is in the process of a theatre reconfiguration which should improve the provision of a CEPOD theatre access for 3 week days a week and Saturday and Sunday. However, there is still	**Not Met**	**Not Met**

		the issue of the two remaining weekdays where we understand there will still be a lack of access to emergency operating in the afternoon.		
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.***	This standard was met. Current (2016) NELA evidence suggests that in 87% of Laparotomy cases with risk above 5%, a consultant surgeon and anaesthetist were present in theatre. There was also a high number of patients (84%) admitted to critical care when risk of death was above 10%. It was acknowledged that in laparotomy cases a P-POSSUM score was probably stored within the NELA dataset but, as this was not part of the contemporaneous medical record, it was difficult to be sure whether it had or had not been recorded, and whether there has been discussions with consultant surgeons and/or anaesthetists as a consequence of this. During the course of the feedback with the RD&E team, the possibility of including the P-POSSUM score within the standardised admission document was raised and the team are going to take this forward as a possible future action. In addition, there was discussion about the inclusion of a risk assessment at the end of surgery to be included as part of the theatre sign out to complete the final part of the standard.	**Met**	**Met**
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	The Review Group felt this standard was partially met There was inconsistent documentation that the decision to operate had been discussed with a consultant surgeon although, where the consultant made the decision themselves, this usually was noted. In some notes, patients were seen, operated on and discharged by the junior team over a 2-3 day period with no evidence from	**Partially Met**	**Partially Met**

		the notes of any consultant review. It was felt that whilst the majority of operations were likely being discussed, this really needed to be better documented in the patient's notes, hence this is 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 partially met. It is clear that the vast majority of emergency general surgical cases are done on a planned CEPOD list although practically, if additional operating capacity became available during the course of the day due to dropped lists in other theatres, teams were flexible enough to make use of this time. The lack of 24hr CEPOD theatre was the biggest limiting factor here. A WHO safety checklist was done for all emergency operations within the CEPOD theatre and the only point at which we felt the standard was not met was clear documentation of the time, date and decision maker, which meant it was very hard to identify delays in surgery. However, on review of the notes in the cases we saw, in general where the decision to operate was noted, the patient did get the operation done on the same day. There was a discussion between the review team and the staff as to whether to use the theatre booking form to record the decision to operate time. It was felt that this action would probably act as a reminder to document this more clearly in the notes.	**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 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***	This standard was partially met. The Trust and the emergency general surgical teams have identified this as a clear area for development and have a work plan in progress (time scale – 6 months) to develop a more robust handover system with some form of documentary	**Partially Met**	**Partially Met**

	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.	evidence. It was noted that there was an opportunity for a clear identifiable time for handover within the programmes but, at present, this did not always seem to happen. Often around 1pm there would be a junior to junior handover which isn't documented although patients are logged on the system. At 8.30pm there is handover which ideally is registrar/SHO led although this conflicts with CEPOD operating time meaning handover is often done with a junior team. It was also noted that the nursing handover occurred at a different time to the medical handover and hence there was a need to repeat changes in management plans on two separate occasions which could possibly be streamlined. It is acknowledged that separate handovers have no doubt evolved from different rota patterns between nurses/medics but suggest this could be reviewed.		
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 this standard was partially met. It was clear that the hospital team had a proactive attitude following the recent reconfiguration on their emergency service and were starting to review their processes and pathways. There was the beginnings of patient experience data being collected, small audits of recent radiology throughput, and an engagement with the recent Royal College process for assessing acute gallbladder admissions. In addition, the Trust actively contributes to National Audits including NELA and EPOCH. There was a discussion between the Review Group and the hospital team about the values of recording the key points of the patient pathway in order to develop future service improvement and this was taken on board by the hospital	**Partially Met**	**Partially Met**

		team. At present, there is no clear evidence of audit of outcomes although this is something that can be tackled as a 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.***	Essentially the team felt that this was met in that the hospital has an active, functioning 24 hour endoscopy service. This essentially covers upper GI bleeds as the clinical team felt there was little value in endoscopy in lower GI bleeds, although the skill set of the team delivering this (the gastroenterologists) meant that lower bowel endoscopy was available should it be required. This service was clearly available 7 days a week.	**Met**	**Met**
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	The Review Group felt that this standard was met. However, during discussions with the Review Group, it was clear that the workload was such that, on occasion, junior staff would forego training opportunities in order to deliver service commitments because of the pressures they were under. Junior staff reported that increases in time pressure had "understandably left people less keen to teach cause they've just got to get the patients through." ... "people here are fantastic in terms of training, they really make a special effort, the theatre staff and everybody are really patient but I think the system sometimes makes it difficult". Our findings were reinforced by the 2016 GMC survey results for General surgery which showed Exeter had a below mean outcome for workload.	**Met**	**Met**
16	***Sepsis bundle/pathway in emergency care.***	The Review Team felt that this standard was clearly met. The audit data provided as evidence showed a high uptake and a measurement of sepsis scoring with an audit that the pathway was then followed. On the walk around of	**Met**	**Met**

		SAU and talking to the staff and within the notes, there was a clear documentation of sepsis as a priority measure and it seemed to be driven very hard from the Matron of the SAU.		
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.***	There was no clear policy that all emergency general surgical admission patients would be reviewed by a consultant every day of the week and it was suggested that patients could wait for a senior review for a 'long time'. It was felt that during weekdays, there was the potential for each patient to be reviewed by a senior decision maker (registrar or consultant) but that this was not a guaranteed provision out of hours or at weekends. Similarly, there was no clear evidence that all "general surgical" patients (to cover colorectal, upper GI, hepatobiliary, vascular, breast and urology) were seen each day. The Trust has clearly identified vascular and urology ward rounds that happen over the weekend when all patients are reviewed by a consultant but there was no clear protocol for this happening in GI surgery (colorectal, upper GI, hepatobiliary).	**Partially 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.***	The Review Group felt this standard was partially met. The Trust has access to a plastics and burn service on site, its networked for vascular and IR, and there are clear arrangements placed for the delivery of this with protocols, clinical pathways and a SLA. In addition, the Trust has recently lost its thoracic service to Plymouth and in the process of this reconfiguration, has ensured that there are clear pathways and agreements for the transfer of these patients across the network. However, like many of the	**Partially Met**	**Partially Met**

		Trusts in the South West, the arrangement for the transfer of children, cardiothoracic cases and neurosurgical cases was less clear and it was apparent there were no clinical pathways and certainly no SLAs (as per medical director). It was felt that for these few number of patients, a standardised SLA would probably not be appropriate, however, a clinical pathway agreed between both sites (the referring site and the accepting site) would be something that is worth re-visiting and formalising.		
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.***	During the process of the walk around and within the review groups it was clear that, for similar clinical conditions, children will be prioritised above adults to minimise the period of time starvation. All consultants on the general surgical rota are trained to operate on children over the age of 1. In practice this happens very rarely. Under 1 they would automatically get referred to Bristol Children's Hospital. All anaesthetists on the on-call rota are trained for paediatric anaesthesia over 1 year old. However, it was felt that the limited CEPOD theatre capacity had the possibility of impacting time to theatre meaning some operations may end up going to theatre later than the 12hr standard recommended.	**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.*	This was clearly met with registrars resident on site and easily available within 30 minutes and all of them are carrying the appropriate MRCS and ATLS training. It was noted from the Review Group discussions and during the walk around that the workload on the registrars is increasing to the level at which they are struggling to be compliant in any way with working time directives and the New Deal, and are starting to look towards whether it would be more appropriate to be rostered on a shift system. However, the Review Group quite clearly identified that the lack of the afternoon CEPOD list was delaying operating into the late evening and sometimes even into the early hours of the morning, which was prolonging the registrar work day and was having an impact on their protected time. It may be that when the CEPOD lists are reconfigured that the pressures on the registrars will improve.	Met	Met
21	*Do you have clear protocols for senior speciality review (consultant) 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. This standard is not met for a senior review of all patients by a consultant.	Not Met	Not Met

	As above where senior specialty review is ST3/SpR & above.	However, all patients do get a review by a senior registrar	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?***	There are no clear protocols for this and it varies. If an urgent review is needed it is usually dealt with by the on-call medical registrar within 2 hours but timings vary depending on the medical problem.	**Not Met**	**Not Met**

Recommendations

The EGS service at RD&E was undergoing a period of recent change during the review visit with positive alterations already being made towards offering better patient care. The ambulatory care component of EGS was being planned and it was clear to the review team that a dedicated daycase pathway would improve the timeliness of patient's treatment. Looking to the results in Bath as a model, further improvements to the ambulatory pathway will enable a reduction in admissions and Length of stay, greatly improving the timeliness of treatment and patient experience. However, in order to progress the ambulatory service it was clear that the Trust must first ensure adequate day case emergency theatre access.

The Trust is clearly operating with a volume of patients whereby theatre capacity is impacting patient care. Without availability of a 24/7 CEPOD theatre, there was at times a delay in managing EGS patients. This frequently led to delayed surgery and an extended LOS, as cases were rolled over to the next day, or operated on late into the night, which is proven to have poorer outcomes. Consideration should be given to whether theatre access conflicts with other services, creating significant or frequently occurring delays in surgery for EGS patients. There should be adequate anaesthetic cover to support the CEPOD list and emergency obstetrics separately, and that all EGS cases should be run through the CEPOD process, even if the procedure is to be performed elsewhere - such as in radiology or endoscopy.

The recent developments in EGS care at the RD&E hospital require ongoing audit and review to ensure continued improvement in the delivery of care. 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.

Finally, there is currently one consultant ward round that happens in the morning with a second ward round which is ad-hoc and run by the middle grade staff. There is an opportunity in the current consultant job plans for the consultant to run two consultant rounds enabling all patients to be seen within 14hours of arrival. In addition, the second consultant ward round would support a

more robust handover. These recommendations form part of the six final recommendations proposed following the EGS review of all Trusts in the South West:

1. The provision of a protected Surgical Assessment Unit (SAU).
2. The provision of 24/7 CEPOD or Emergency Theatre.
3. A 'South West' standardised, rolling audit of EGS.
4. The appointment of an EGS lead and an Emergency Nurse lead in each Trust.
5. Delivery of 2 consultant led ward rounds per day of EGS patients.
6. Development of a fully integrated ambulatory EGS service.

Further information on the findings from the EGS review can be found at: http://www.swsenate.org.uk/

Appendix 1 – Key information relevant to the hospital review

Emergency General Surgery

Notification of review: 12/4/16
Self-assessment submission date: 24/5/16
Review visit date: 7/6/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Mark Cartmell (Surgeon) Jan Hanousek (Anaesthetist) Julie Smith (SAU Sister) Tracy Day (SAU Junior Sister) Dawe Caroline (Commissioner)

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 twenty two 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 walkaround of the Surgical Assessment Unit, Theatres, Radiology, Critical Care and the Emergency Department, that included discussions with all levels of seniority and staff professions.
3. A focus group with doctors in training and members of nursing and therapy staff
4. A short review of patient notes from typical EGS procedures.

To ensure consistency of reviews, the programmes clinical lead and project manager were present on every review.