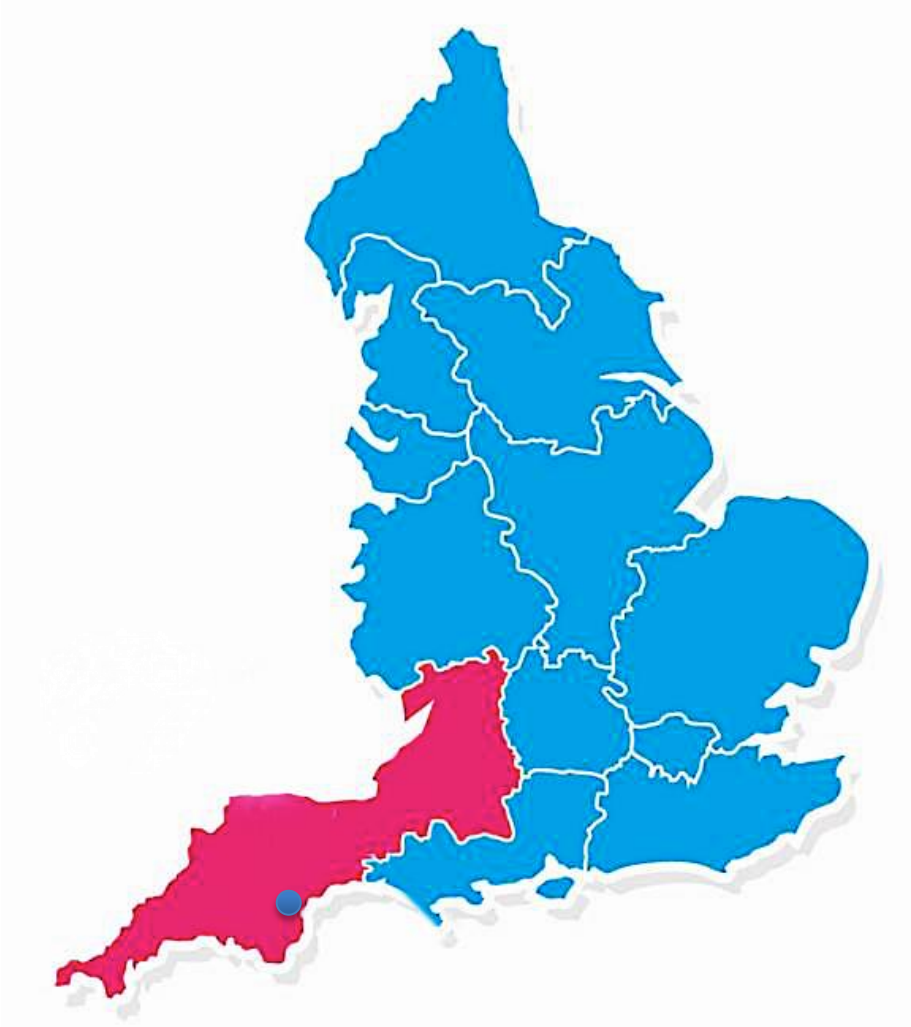
South West Clinical Senate

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



Torbay & South Devon NHS Foundation Trust

4th November 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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Torbay & South Devon NHS trust employs approximately 6000 staff who provide acute care for a population of around 375,000 people which grows by approximately 100,000 in the summer holiday months. The hospital has 354 beds.

Summary of findings

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

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

No.	Standard	Week	Weekend
1	*Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds such that patients are generally seen within 14hrs from arrival. There is evidence of continuity of care ……..(cont)*	Not Met	Not Met
2	*Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.*	Met	Met
3	*All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.*	Met	Met
4	*All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week, either on site or through a formalised network with an agreed SLA (Service Line Agreement). Critical patients - within 1 hour if IR on site, within 3 hours if networked, Non-critical patients - 12 hours. Interventional facilities are safe for emergency patients.*	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.*	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.*	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.*	Partially Met	Partially 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*	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*	Met	Met

12	*Handovers must be led by a competent senior decision maker (ST3/SpR & above) and take place at a designated time and place, twice a day. These arrangements to be in place for handover of patients at each change of responsible consultant/surgical team/shift or block of on-call days where it should be consultant led. Changes in treatment plans to be communicated to nursing staff and therapy staff ……..(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.*	**Met**	**Met**
16	*Sepsis bundle/pathway in emergency care.*	**Awaiting data**	**Awaiting data**
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.*	**Not Met**	**Not Met**
		Not Met	**Not Met**
22	*Do you have clear protocols, including a standard for timing, for senior medical speciality review by a physician of emergency general surgical admissions?*	**Not Met**	**Not Met**

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

No.	Standard	Commentary and Conclusions	Week	Weekend
1	***Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds such that patients are generally seen within 14hrs from arrival. There is evidence of continuity of care either through multiple day working or specific patterns of working that allow continuity of care. When on-take, a consultant and the on call team are to be completely freed from other clinical duties or elective commitments. Surgeon with private practice commitments makes arrangements for their private patients to be cared for by another surgeon/team, when they are on call for emergency admissions.***	This standard was not met. There are not two consultant ward rounds for acutely admitted patients 7 days a week, or even 5 days a week, and the timing of the single ward round means that there are some patients who are admitted and not seen within 14 hours of arrival. However, there is evidence that the consultants are free of all of their elective activities when on call and are providing a 7 day working pattern that provides continuity of care for the acutely admitted patients. Note: There is a business case to provide 2 additional upper GI consultants in the future. If this were to be approved, it may well be possible to address the issue of two consultant ward rounds and allow the standard to be met.	**Not Met**	**Not Met**
2	***Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.***	The team felt this standard was met. There is a NEWS system in place to deal with deteriorating patients. From discussion with the junior and nursing staff, they were very happy to escalate any concerns. In the first instance, they would automatically escalate within the medical team, and then to the outreach team, but they had no concerns with getting in contact with the consultant body. The review	**Met**	**Met**

		team all agreed that the working atmosphere was friendly and constructive, such that staff felt that they could raise their concerns appropriately to consultant level if necessary.		
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 clearly met. There was excellent provision of X-ray, CT and ultrasound 24 hours a day, 7 days a week. Urgent reporting is done real time, usually in direct discussion with the on-call radiologist.	**Met**	**Met**
4	***All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week, either on site or through a formalised network with an agreed SLA (Service Line Agreement). Critical patients - within 1 hour if IR on site, within 3 hours if networked, Non-critical patients - 12 hours. Interventional facilities are safe for emergency patients.***	This standard was met. There is interventional radiology available on site, in-hours, with 3 interventional radiologists who also link into a network with the RD&E hospital out of hours. It was noted that the provision of interventional radiology was so good that surgeons had not operated on an Upper GI bleed over 8 years due to the use of embolization.	**Met**	**Met**
5	***Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.***	The team felt this standard was partially met. There was clear evidence that the rota maximises the continuity of care for all patients. The consultants work 7 days at a time, and hence are able to provide continuity of care throughout that period, despite the fact that the junior doctors do change, and will do even more with the alterations in the junior doctor's contract. In the course of this week, patients remain under a single consultant. At present there are 3 Upper GI consultants and 5 lower GI consultants. There is an attempt to alternate between GI specialities for the on-call work. There is also a business case for 2 extra Upper GI consultants, which if approved,	**Partially Met**	**Partially Met**

		will give a 50 /50 split of speciality. There is a plan to increase access to Upper GI consultant priority work until these two additional Upper GI posts are appointed. It was noted that patients that had been operated on, or were specific to the specialities, stayed under the admitting on call consultant even at the end of their week on-call. However, any "undiagnosed/unsorted" patients were handed over to the incoming emergency consultant, who would then take over their care and ongoing management. There was a clear rule that these transfers did not happen more than twice. The only way the team felt that this standard was lacking was the provision of an acute surgical unit to create the appropriate surgical environment for the management of these patients. Having a single point of focus for the emergency general surgical admissions would allow the process to run more efficiently and avoid the need, as it is currently the case, for safari ward rounds through multiple wards. At present, during a hot week, the median number of wards visited is 6, and the distance travelled up to 3.3 km.		
6	***A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialities throughout the emergency pathway.***	The review team felt this standard was not met. We did not see a unitary document being used either in the notes or on the walk-around.	**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.***	This standard was partially met. There is an excellent day case pathway used for management of abscesses, and whilst there was a clear desire to run a hot clinic with a dedicated area, the lack of an SAU meant that this was not available to patients, and as such this standard could	**Partially Met**	**Partially Met**

		not be fully met.		
8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	In general, the review team felt that the Trust was meeting this standard, but there were some concerns from the review team about the fact that the CEPOD theatre was shared with acute obstetrics. It was noted that there was a second theatre available, and a clear policy for opening such a theatre, but there were concerns about the timelines for this to be done, and the tendency to delay emergency general surgery in the face of a possible "crash" section. There was also some concern expressed over the fact they were reliant on the recovery nurse for patients overnight.	**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 team felt that this standard was partially met based on the currently available NELA data. At present, the consultant surgeon and anaesthetist were present in less than 80% of cases with a greater than 10% mortality (which is below the 'green level'). However the access to critical care following major laparotomies was excellent being 96% for patients where the risk of death was 10% or greater.	**Partially Met**	**Partially Met**

10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	The review team felt this standard was partially met in that on our short review of the patient's notes, we found no documentation that the emergency general surgical operations were being discussed with a consultant surgeon. However, the team did think this was more a case of documentation not being completed as more often than not, the consultant surgeon was present in theatre.	**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***	This standard was met in that the majority of work was done in the emergency CEPOD theatre on the day at which surgery was originally planned. The WHO checklists are completed and were present in the notes on review. The only area of slight discrepancy was the date, time and decision makers, which were not documented in the notes. However, the booking form for emergency laparotomies does have a space to record the date, time and decision maker but this was not present in the more generic emergency booking forms. The review team suggested that the generic form should also have space to include this information.	**Met**	**Met**
12	***Handovers must be led by a competent senior decision maker (ST3/SpR & above) and take place at a designated time and place, twice a day. These arrangements to be in place for handover of patients at each change of responsible consultant/surgical team/shift or block of on-call days where it should be consultant led. Changes in treatment plans to be communicated to nursing staff and therapy staff as soon as possible if they are not involved in the handover discussions. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.***	The review team felt this standard was met in that there was a clear, well-constructed handover document. Handover processes were fairly robust. There was a clear "whole team" handover first thing in the morning involving the consultant. The later handovers were multiple, and happened at 2 to 3 different times over the course of the afternoon and evening. This was partly due to the rota of the junior doctors, but on discussion with the junior team, there was clear evidence that this was a robust process and the repeated handovers were a safety net to ensure	**Met**	**Met**

		all patients were discussed. There was also evidence of a clear consultant led handover between changes of on call weeks, which were mandated by the need to clearly handover any "unsorted" emergency general surgical patients. The staff noted they were not always aware of any changes to the management. The review team felt it would be simple to provide the nursing team with access to the handover sheet if they were not able to be present at the actual discussion. The hospital team did note they are in the process of rolling out a new electronic that should be accessible by both medical and nursing staff.		
13	***Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. The service has participated in national audits (e.g., NELA, EPOCH - list those known)*** ***Do you audit:*** ***a. Outcomes - death, LOS, return to theatre, readmissions*** ***b. Risk assessment prior to surgery*** ***c. Risk assessment post-surgery*** ***d. Time to CT/US from request*** ***e. Time from decision to theatre*** ***f. Proportion of patients having gall bladder out on admission*** ***g. Proportion of patients having gall bladder out on admission for pancreatitis***	The review team felt that this was partially met but have asked the hospital team for any more available audit data. We felt there was probably more information available as the surgical team were in the process of working up a business case for ongoing development of the emergency service. On the data that was available, it was clear there is some tracking of patient experience, including friends and family, as well as a voluntary team that goes around the wards collecting patient experience data. However, there is not a clear distinction between emergency and elective patients, which means there is no focal assessment of the emergency general surgical pathway. The review team did notice this was a good opportunity for a piece of work to be done in this area that could then be rolled out to the rest of the region. There was limited data of in-house audits presented in the	**Partially Met**	**Partially Met**

		evidence from the Trust, and although there were two presentations of the processes of emergency general surgical admissions, these were from 2011 and 2012, and nothing more recent. However, the Trust does contribute to national audits including the NELA database.		
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 clearly met. They have got a 24 hour endoscopy service, 7 days a week which covers GI bleeding.	**Met**	**Met**
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	The review team felt this standard was met in that the trainees felt that the hospital provided a very positive and supportive environment for training. The core trainees were particularly happy about the one week they spent in dedicated CEPOD theatre training, but unfortunately this was not viewed favourably by the deanery or by the GMC survey. Possibly as a consequence of this, the GMC survey reports have been below average for local teaching, although we did not have any evidence for the trainees, or any evidence of the views of the more senior specialist training.	**Met**	**Met**
16	***Sepsis bundle/pathway in emergency care.***	We are unable to make any comment on this standard, as there was no evidence or data available to us or presented on the review day. The nursing staff commented that they use the sepsis 6 pathway as all patients were admitted through ED and assessed at that point. They felt that the antibiotics were usually given there. However, there was no data to support this, but on discussion with the Torbay team this data is available.	**Awaiting data**	**Awaiting data**

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.***	We felt this standard was very clearly met in that all emergency general surgical patients are seen every day by a consultant over the course of their 7 day on-call cycle. Any that have not been effectively managed or are undiagnosed, are handed over to the incoming on-call consultant, who will then see them each day of their week on-call.	**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.***	There is a clear vascular network which diverts 2/3 of the time to the RD&E at weekends and out of hours, although during week days and in hours, the vascular work is done on site. There is a clear pathway for children under the age of 5 who are transferred to the Bristol Children's hospital for on-going emergency general surgical management, and the Trust links into Plymouth for major trauma. The Torbay team felt that they did have transfer documents of critically ill patients, although they were not presented as part of the evidence. In addition, there was uncertainty as to whether there were formal SLAs or clinical protocols for other surgical conditions. This is in common with most other Trusts in the region.	**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.***	The team felt that this standard was met. Children under the age of 5 were transferred to the Bristol Children's hospital for ongoing management. Children between the ages of 5 and 18 were dealt with initially by the paediatric team, who ensured they received adequate hydration, pain relief and appropriate dosage of all medication. The patients were then managed jointly with the on-call surgical team, and were given priority for theatre, provided there was no adult case of greater clinical need.	**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.***	This 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. The review team felt that this standard was not met on either measure. A consultant does not review general surgical inpatients either for 5 days a week or 7 days a week. Furthermore, they are not reviewed each day of the week by a registrar, and at weekends, the on-call registrar only reviews selective patients.	**Not Met** **Not Met**	**Not Met** **Not 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?***	Although this standard was not met, Torbay does have a very constructive arrangement with their gastroenterology team who provide senior medical review for GI surgical patients, but only within a gastroenterological remit. There is no similar arrangement or provision of service by the other medical specialities.	**Not Met**	**Not Met**

Recommendations

The South West EGS review recognised that provision of two consultant ward rounds is essential to the delivery of a high quality EGS service and ensuring patients' received timely senior decision making. At present, 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 to formalise the two consultant ward rounds over 7 days and we would recommend job planning and staffing is reviewed to facilitate this twice daily review by the on-call consultant.

One of the contributing aspects to this is the ‘safari’ ward rounds which take place due to a lack of dedicated area for patients. 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.

Without an SAU, Torbay is limited to the ambulatory care service they are able to provide and whilst there is an excellent day case pathway used for management of abscesses, and a clear desire to run a hot clinic with a dedicated area, they are currently limited by the estate provision. We would recommend the Trust looks into future plans for this. As a Trust providing integrated care to a particularly ageing geography, the advantages of a fully functioning SAU and hot clinic for reducing length of stay and complications would be valuable.

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.

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: 6/4/16
Self-assessment submission date: 21/10/16
Review visit date: 4/11/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Simon Dwerryhouse (Surgeon) Nic Mathieu (Matron) Sharon Bonson (Matron) Alison Norbury (Emergency sister) Christine Branson (Commissioner) Ellie Rowe (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 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.