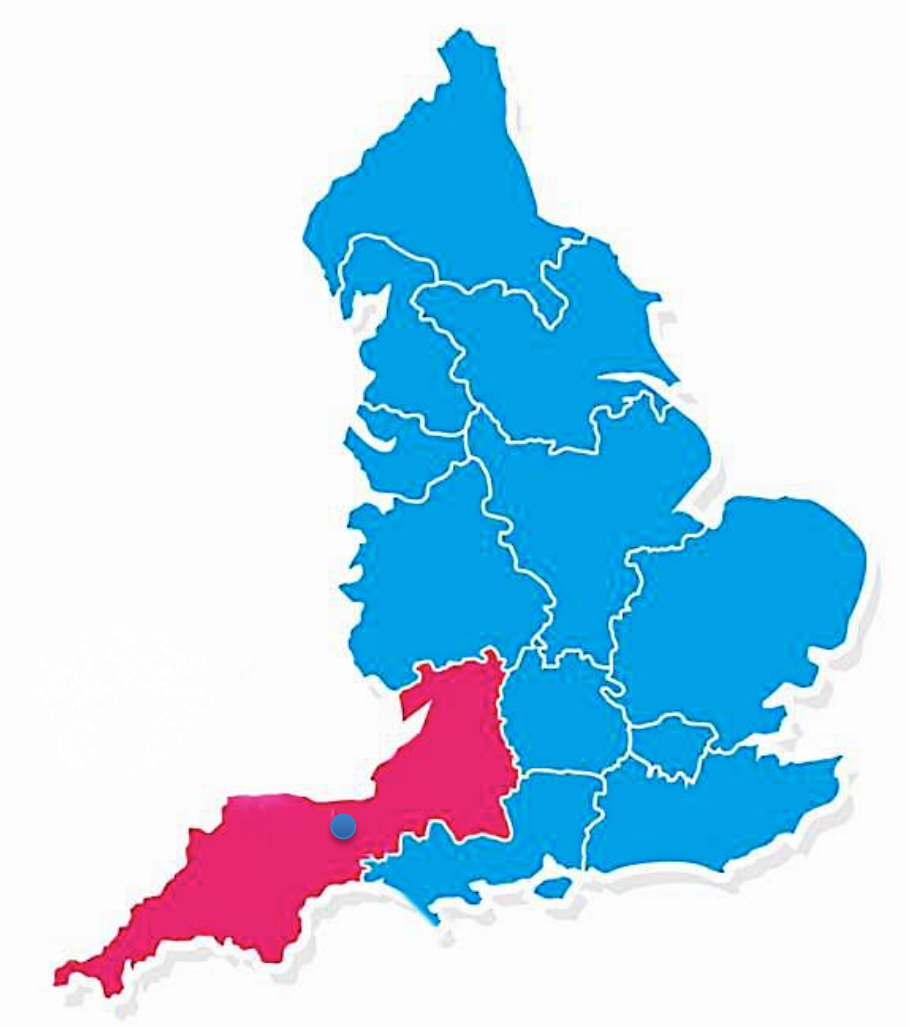
South West Clinical Senate

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



Taunton & Somerset NHS Foundation Trust

29th 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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Taunton & Somerset trust employs approximately 4000 staff who provide acute care for a population of more than 340,000 whilst also proving specialist services for the whole of Somerset, making the catchment population around 544,000. The hospital has 700 beds, 30 wards and 15 operating theatres.

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	Partially Met
2	*Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.*	Met	Met
3	*All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.*	Met	Met
4	*All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week, either on site or through a formalised network with an agreed SLA (Service Line Agreement). Critical patients - within 1 hour if IR on site, within 3 hours if networked, Non-critical patients - 12 hours. Interventional facilities are safe for emergency patients.*	Met	Met
5	*Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.*	Met	Met
6	*A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialities throughout the emergency pathway.*	Met	Met
7	*All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (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)*	Met	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 (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*	Met	Met

	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)*	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.*	Not 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)*	Met	Met
20	*As a minimum, a speciality trainee (ST3 or above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status), is available at all times within 30 minutes and is able to escalate concerns to a consultant. Juniors qualifications - i.e., experience level of team.*	Met	Met
21	*Do you have clear protocols for senior speciality review of all general surgical in-patients to include GI surgery (Colorectal, Upper GI, Hepato-billary), Vascular, Breast & Urology) every day, seven days a week.*	Not Met	Not 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?*	Partially Met	Partially Met

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

No.	Standard	Commentary and Conclusions	Week	Weekend
1	***Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds such that patients are generally seen within 14hrs from arrival. There is evidence of continuity of care either through multiple day working or specific patterns of working that allow continuity of care. When on-take, a consultant and the on call team are to be completely freed from other clinical duties or elective commitments. Surgeon with private practice commitments makes arrangements for their private patients to be cared for by another surgeon/team, when they are on call for emergency admissions.***	The review group felt that this standard was partially met for week and weekend. On Monday to Friday there were two consultant led ward rounds job planned and generally carried out. The morning ward round was at 8am and saw all patients. Although generally consultant led, if they were required in Theatre first thing, the patients would be seen by the registrar. There was some variability in start time of the evening round, and on occasion, not all patients were getting a review unless highlighted by the reg. At the weekend there was a morning ward round but the evening ward round would be registrar led. There was evidence of continuity in that the consultants do four day blocks over the weekdays with three over the weekend; hence, each ward round in the morning allows review of all of the emergency patients. Patients remain under the care of the admitting consultant and day to day care will be taken over by the on call consultant at the weekend. However, emergency patients still in hospital the following week will not necessarily have daily consultant review.	Partially Met	Partially Met

2	***Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.***	The review group felt this was met, and that there was clear documentation for nursing escalation. On talking with both the nursing staff and junior staff, there was a clear willingness to escalate problems up the chain as far as the consultant, should this be necessary.	**Met**	**Met**
3	***All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.***	We felt this standard was met in that the hospital was able to provide plain x-ray and CT 24/7. Radiologists were available until 9pm and after this time, the reporting was outsourced to TMC. There was an issue with the provision of ultrasound after 9pm on weekdays and 6pm on weekends, which was less reliable leading the team to favour other modalities during these periods. During the visit it was highlighted that there was a potential for a delay from the electronic hold system that could be put on a patients scan. Usually the junior doctor was notified via a phone call but there was potential for this to communication to be missed which could lead to the expectation a scan was being carried out whilst it was on hold.	**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.***	There is full interventional radiology available on site with 5 interventional radiologists allowing 24/7 cover.	**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***	The review group felt that this standard was met. The rotas are constructed to maximise continuity of care for all emergency general surgical patients, and the working week is split into a 4/3 arrangement. Patients remain	**Met**	**Met**

	is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.	under the care of the admitting consultant when they are moved off the assessment unit, and transfer between speciality teams is normally done as a consultant to consultant discussion. In addition, the emergency general surgical patients are managed in an acute surgical environment.		
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.***	There is a unitary document. It was noted that in half of the patient notes the sepsis screening box was not ticked to show further sepsis treatment was not needed or whether they had been screened, although their audit of sepsis did demonstrate a good level of screening.	**Met**	**Met**
7	***All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.***	The Review Group felt that this standard was met. There is not a dedicated day case pathway and the hot clinic is used in a limited manner. The pathway could be more efficient with the dedicated job planned provision of a senior decision maker in the morning. This would allow some patients to be seen for ambulatory care in the morning. Two of the patient notes we saw had patients with abscesses stay in for 1 and 2 nights respectively, when a formalised abscess pathway could have seen these turned around the same day, providing better patient care whilst saving hospital bed days. The current environment is also greatly outdated with minimal expected improvement with February's planned move. Despite this, we saw enthusiastic nursing staff and good patient experience feedback.	**Partially Met**	**Partially Met**

8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	There is an available CEPOD theatre 24/7 for emergency surgical work. This CEPOD theatre is shared with gynae, max facs, vascular, urology and ENT. However, a number of specialities also have their own priority lists throughout the week which allows adequate cover for the Emergency General Surgery patients.	**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.***	This standard was met based on the current (2016) NELA evidence which suggests that in 94% of Laparotomy cases with risk above 5%, a consultant surgeon and anaesthetist were present in theatre. There was also a high number of patients (85%) 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.	**Met**	**Met**
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	The team felt that this standard was met. Based on the notes and discussions with the juniors in almost all of the cases, the decision to operate was discussed with a consultant and this was generally 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***	The WHO safety check lists were present in all of the notes and were clearly filled out. Date, time and decision to operate were generally being documented. Discussion with the staff confirmed the majority of emergency general surgical cases were done on the CEPOD list on the day that theatre was planned. However, provision for 'hot' gall-	**Partially Met**	**Partially Met**

		bladders' was limited, the review team felt that having formal pathway and priority lists, for example 3 half day lists, would greatly help flow and allow the gall bladders to get done more efficiently. Where the team felt the service was potentially being left 'light' was anaesthetic cover. At present there is only a consultant covering emergency theatres and interventional radiology out of hours. There is a registrar from the ITU, not for theatres, who is also covering obstetrics and airway issues elsewhere in the hospital. It was felt this was not representing a significant safety issue, rather could delay operating on some cases. As a consequence of this 'lighter' anaesthetic cover, the review team felt this was partially met.		
12	***Handovers must be led by a competent senior decision maker (SpR & above) and take place at a designated time and place, twice a day. These arrangements to be in place for handover of patients at each 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. Handover is consultant led in the morning 7 days a week and registrar led in the evening. Clinical data is recorded electronically on EPRO which generates patient lists and plans etc. Handovers were taking place twice a day in a clearly designated area. On the changeover between the 4/3 split of the consultant's on-call, there was a consultant to consultant handover of all patients on the surgical assessment unit and who needed ongoing care.	**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***	The review team felt that this was partially met. The trust participates in GIRFT, EPOCH, NELA for laparotomy and SWORD was being used for tracking Upper GI – cholecystectomy/appendectomy. We found it extremely useful that the friends and family data was split by ward and could be seen specifically for emergency patients on	**Partially Met**	**Partially Met**

	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***	SAU. However, there was limited data of in-house audits presented in the evidence from the trust, and we did not see any data being collected as part of improvement work in EGS. Having seen that the trust has an electronic system which will collect data it was felt that there should be a move to this process in order to quickly and accurately track activity for improvement and assurance. On a separate note, the team were made aware that there had recently been a lot of dedicated work on theatre efficiency.		
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.***	There is a 24/7 GI-Endoscopy bleed rota available within Taunton run by the gastroenterology teams.	**Met**	**Met**
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	In the GMC survey, Taunton is performing well above mean levels on almost all measures for general surgery. This was reinforced by positive feedback on the day from F1's to Reg. level.	**Met**	**Met**
16	***Sepsis bundle/pathway in emergency care.***	The Review Team felt that this standard was being met based on the high screening rate/antibiotics data we saw and discussion with the nurses. However, It was noted that in half of the patient notes the sepsis screening box was not ticked to show further sepsis treatment was not needed or whether they had been screened.	**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.***	The Review group felt that this Standard was not being met. There was no policy for review of all general surgical patients by a consultant. Whilst the new emergency and general surgical patients were seen by a consultant	**Not Met**	**Not Met**

		usually within 14 hours, the follow up of emergency patients once admitted, would sometimes be in the hands of the Registrars who would escalate any particular issues up to the consultant provided they recognised there was a concern.		
18	***Emergency surgical services delivered via a network (e.g. vascular surgery, IR, Plastics,/Burns and Paediatrics.) have arrangements in place for image transfer, telemedicine, and agreed protocols for ambulance bypass/transfer and a formal SLA. Standards for the transfer of critically ill patients are adhered to and regularly audited.***	Vascular and IR are provided on site. Burns and Neuro would go to North Bristol Trust. As is the case with many of trusts in the region, informal arrangements are in place but there are not formalised into SLA, policy or repatriation documents.	**Partially Met**	**Partially Met**
19	***For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and competence to handle the emergency surgical care of children, including those with life-threatening conditions who cannot be transferred or who cannot wait until a designated surgeon or anaesthetist is available.***	Operating on under 5 year olds was very rare and children generally went to the Bristol children's hospital unless there was a paediatric surgeon available, of which the trust had one for general surgery. Although the review team felt from talking to the teams and reviewing the policies that children would not wait for longer than 12 hours, we would caveat this with the need for assurance – there was no audit or data available to demonstrate this was the case.	**Met**	**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.***	The review group felt 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. There is not a consistent review by a consultant of all general surgical inpatients, and hence the first part of this standard was not met.	**Not Met**	**Not Met**

		All patients do get a review by an SpR through the week, hence this is met 7 days.	**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?***	This standard was partially met which puts Taunton ahead of most trusts in the Southwest. As of October they have a POPS (Proactive care of older people) service based on the SAU featuring an Out of program experience medical care practitioner ST8 and consultant support, who will see admissions with a frailty score above 5 (Rockwood measure) and all NELA patients over 70 years.	**Partially Met**	**Partially Met**

Recommendations

It was clear throughout the South West Emergency review that all Trusts recognised the value of ambulatory EGS care where appropriate, but most had struggled to deliver this effectively. The exception was Bath, which had significantly developed its service to focus on ambulatory care with a resultant impact on admissions, bed occupancy and an ongoing improvement in the delivery of acute gall bladder surgery. As such it serves as an example and model for EGS ambulatory care.

There were certain issues related to the delivery of a high quality ambulatory EGS care service, which came out during the discussions in Bath and other Trusts. Firstly, there was a need for senior decision makers within the ambulatory care part of the service. Junior or nurse led decision making did not appear to deliver the same benefits. There was a need to link this service with day surgery list access (and with staff to run these lists) separate to the CEPOD list. Failure to do this resulted in delays to the 'day cases' with a potential risk of admission. Taunton had no dedicated day case pathway and lacks a senior decision maker in the morning. We would recommend the Trust look at their current provision for formalised ambulatory care. Whilst the SAU environment is greatly outdated, it is separate from medical wards and as such, is less occupied with outliers. The adaptability of the current unit will need to be considered in any future planning.

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.

Finally, there was some variability in the provision of two consultant led ward rounds of all acute admitted patients 7 days a week and it is recommended this is reviewed to ensure practice reflects the formalised job plans. These recommendations form part of the six final recommendations proposed following the EGS review of all Trusts in the South West:

1. The provision of a protected Surgical Assessment Unit (SAU).

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

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

Appendix 1 – Key information relevant to the hospital review

Emergency General Surgery

Notification of review: 14/9/16
Self-assessment submission date: 15/11/16
Review visit date: 29/11/16

Review team: Scott Watkins (Senior Project Manager) Mark Cartmell (Surgeon) Rob Bethume (Surgeon) Will Faux (Surgeon) Claire Bradford (Matron) Rebecca Snell (Surgery Manager) Alison Rowswell (Commisioner).

Emergency General Surgery Programme team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Ellie Devine (South West Clinical Senate Manager).

Appendix 2 – The review process

A set of 22 Emergency general surgery standards were taken from three main sources: RCS (2011) Emergency Surgery: Standards for Unscheduled Surgical Care, London Health Audit (2012) Quality and safety programme, NHS Services, Seven Days a Week Forum (2013). These were reviewed and adapted by an expert panel to be used as the commissioning standards to assess all South West acute trusts that deliver an emergency general surgery service.

Hospital self-assessment

The purpose of this stage was for the hospital to self-assess the current status of each of the 22 standards as either met or not met. To support the self-assessment, documentary evidence was supplied by the hospital. Where a standard was assessed as not met, the hospital had the opportunity to detail any current plans that would enable compliance with the standard or to offer further detail on any current challenges faced by the hospital in meeting any of the standards.

The hospital was given six weeks to complete the self-assessment stage. The hospital was supplied with standard pro formas to complete.

Review of evidence

The evidence submitted by the hospital was reviewed by members of the review team (members detailed above). Any initial points of clarification relating to the adult emergency standards were sent back to the hospital team. The review of evidence ensured that the review team was able to identify key lines of enquiry for the review visit day. Prior to the visit the hospital was informed of the key lines of enquiry and asked to address these as part of their presentation.

Review visit

The purpose of the review visit was to understand how the hospital had implemented the adult emergency standards and to discuss and clarify outstanding challenges to implementation and the plans and timeframes in place to address them. The day had four key components which all contributed to the overall assessment of whether a standard was being met. The 4 components were:

1. Presentation by the trust executives on how the hospital was meeting the standards
2. Hospital walk round that included discussions with all levels of seniority and staff professions, including medical, nursing and therapies
3. A focus group with doctors in training and members of nursing and therapy staff
4. A short review of patient notes

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