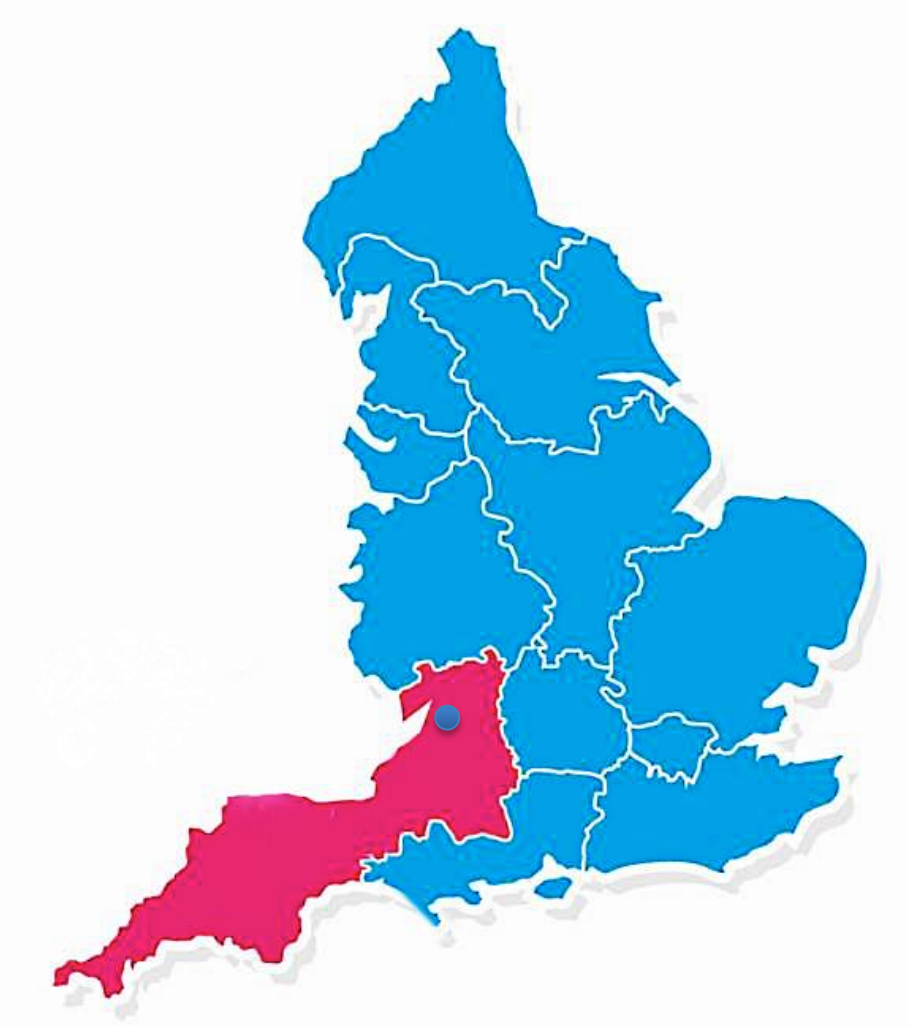
South West Clinical Senate

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



University Hospital Bristol NHS Foundation Trust

27th September 2016

Contents

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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University Hospitals Bristol trust is a large teaching hospital with close links to the University of Bristol and University of West of England (UWE). The trust employs approximately 8000 staff who provides acute care for a population of around 350,000 in central, south Bristol and the north of North Somerset. The trust has 650 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)*	Partially Met	Partially Met
2	*Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.*	Met	Met
3	*All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.*	Met	Met
4	*All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week, either on site or through a formalised network with an agreed SLA (Service Line Agreement). Critical patients - within 1 hour if IR on site, within 3 hours if networked, Non-critical patients - 12 hours. Interventional facilities are safe for emergency patients.*	Not Met	Not Met
5	*Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.*	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.*	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*	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)*	**Met**	**Met**
14	*Hospitals admitting emergency patients have access to comprehensive (Upper/Lower) 24 hour endoscopy service, that has a formal consultant rota 24 hours a day, seven days a week covering GI bleeding.*	**Met**	**Met**
15	*Training is delivered in a supportive environment with appropriate, graded, consultant supervision.*	**Met**	**Met**
16	*Sepsis bundle/pathway in emergency care.*	**Met**	**Met**
17	*There is a policy for review of all Emergency general surgery patients by a consultant, every day, 7 days a week, whilst they remain under the care of the emergency team.*	**Met**	**Partially Met**
18	*Emergency surgical services delivered via a network (e.g. vascular surgery, IR, Plastics,/Burns and Paediatrics.) have arrangements in place for image transfer, telemedicine, and agreed protocols for ambulance bypass/transfer and a formal SLA. Standards for the transfer of critically ill patients are adhered to and regularly audited.*	**Partially Met**	**Partially Met**
19	*For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and ……..(cont)*	**Na**	**Na**
20	*As a minimum, a speciality trainee (ST3/SpR or above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status), is available at all times within 30 minutes and is able to escalate concerns to a consultant. Juniors qualifications - i.e., experience level of team.*	**Met**	**Met**
21	*Do you have clear protocols for senior speciality review of all general surgical in-patients to include GI surgery (Colorectal, Upper GI, Hepato-billary), Vascular, Breast & Urology) every day, seven days a week.*	**Met** **Met**	**Not 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?*	**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.***	The review group felt that this standard was only partially met. There were two consultant ward rounds job planned Monday to Thursday. The timing of these meant there were patients who would be outside the 14 hour target for being seen by consultant from time of arrival. There was only a single ward round job planned at the weekend. However, on discussion with the staff in the focus groups, it was quite clear that while some consultants were delivering two consultant ward rounds during the working week, and in fact some were actually delivering it during the weekend, this was not the case for all consultants. There was clear evidence of continuity of care through multiple day working, and that the patients remain under the same team in the on-call period. The consultant on-call teams were completely free from all clinical duties.	**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.***	We felt this standard was clearly met with a standardised (NEWS) escalation policy, and a clear culture within the organisation from both junior medical staff and nursing staff. Through a mix of walkaround and focus groups, the message was that staffs were happy and willing to escalate clinical issues up the chain of command as high as consultant if 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. Provisional ultrasound was somewhat variable. There is the opportunity for this to be done in the main department, although talking to some of the junior staff; this could be quite a chore and a challenge, particularly during the weekends or out of hours. In addition, however, there had been a set up on the STAU to provide 3 ultrasound slots in the morning and 3 in the afternoon, to manage the take patients. Unfortunately, due to radiographer's sickness, this seems to have fallen into abeyance over the last 6 months or so. It was certainly something that the junior staff and the nursing staff miss as this is impeding a possible efficient patient pathway.	**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.***	At present, this standard is not met. There are currently ongoing negotiations between UBHT and North Bristol Trust to provide an interventional radiology service as a network 24 hours a day, 7 days a week. The ultimate plan is that all interventional radiology work for vascular will move to North Bristol. Out of hours, North Bristol will also provide the GI interventional options. The weekdays (and ideally 7 days a week), UBHT plans to offer the GI intervention service during working hours. However in summary, at present this standard is not met.	**Not Met**	**Not Met**
5	***Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.***	The team felt that this standard was met. Rotas were constructed in a way to maximise continuity of care for all patients with the patients remaining under the name of the admitting consultant and under that team, even when they were no longer on-call. In addition, whenever possible, the majority of patients were managed in the acute	**Met**	**Met**

		surgical environment of the STAU. Historically, there have been problems with increased numbers of medical outliers on the unit. Although this has caused significant clinical incidents in the past, the feeling from the nursing staff on the unit was that it is much more under control now, with far fewer medical patients, and also the control of the medical outlier is slightly better than has been in the past. Where there was a need for transfer of care of certain patients between the consultant teams, following the on-call period, the communication was done between consultants on the phone, but there was an increasing use of the trust email system in order to locate patient details and transfer care. This was evidenced during the visit.		
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.***	At present, it would be fair to say that this standard is at the upper end of partially met. There is a unitary document for surgical admissions. There were some examples where this was being used by all health care professionals during the course of that admission. However, this was a culture change for the organisation, and it was not fully embedded at the present time, and hence was only partially achieved.	**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.***	This standard we felt was partially met. UBHT has made concerted efforts to develop an ambulatory emergency care pathway at multiple different levels. There is the provision of a nurse triage on the point of referral whereby GP or the referrer can be questioned as to the need for an emergency general surgical admission, or whether the patient would be better served by an urgent outpatient appointment with frontloaded investigations. In this situation, the decision making is done by the GP, and the	**Partially Met**	**Partially Met**

		nurse simply acts as a facilitator. As patients that are actually reviewed on the STAU, there is an opportunity for these patients to be sent away for scans or review the following day, but this process did not appear to be senior led based on the evidence that we could glean. In many cases, this ambulatory pathway was managed by the F1 or CT1/2. (Although Foundation doctors were not allowed to discharge any patients unless reviewed by a registrar, which could slow the ambulatory pathway). Furthermore this process had been somewhat undermined by the loss of the ultrasound slots on STAU, meaning that many patients were being brought back inappropriately early for scans that ended up being done in the afternoon. However, the Trust does have a dedicated day case pathway, and a protocol for abscess management. In addition, it does have an assessment area and a waiting area which could be figured into an ambulatory service with a hot clinic and fixed appointment slots. However, at present this is not formalised.		
8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	There was access to a fully staffed emergency theatre, consultant surgeon, and consultant anaesthetist within 30 minutes 24/7. This standard was met.	**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),***	The review team felt that this standard was met. Although some of the historical data from the NELA study suggested less than "green" (greater than 80%) performance, the more recent run-chart presented Dr Phoebe Syme, anaesthetist and lead for their NELA work, felt there was considerable improvement both in the involvement of consultant surgeons and consultant	**Met**	**Met**

	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.***	anaesthetists, in cases where the mortality was predicted at greater than 5%. In addition, there was access to critical care beds for patients at high risk, (greater than 80% on the current run charts). Both surgeons and anaesthetists felt that the physiological risk scoring of patients post operatively was not done routinely. Most decisions as to the post-operative location of the patient were actually made pre-operatively. On rare occasions, where unexpected findings were found at laparotomy, decisions were made during the operation, rather than as a formal scoring process at the end.		
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	We felt that this standard was partially met based on the evidence obtained from the notes review. Whilst through discussions it was felt that all major operations were being discussed, there was a lack of documentation in the patients notes on decision maker and time and decision made for surgery. In some situations, it was possible to assume that the operation had been discussed from the fact that a ward round was undertaken by the consultant, a differential diagnosis was made, and that job was going to be determined by a scan. However, even in these cases, there was then no documentation that the scan result was in the notes, it had been discussed with the patient, and a clear decision had been made to proceed with surgery. Major cases were being recorded on laparotomy 'boarding cards' as a focus from the NELA work, although other EGS procedures would not undergo this form of documentation.	**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***	The majority of operations were undertaken on the day that surgery was originally planned hence this standard is	**Met**	**Met**

	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. However, the lack of documentation of the date, time and decision makers made it very difficult to be clear of this. There is no doubt that a reconfiguration of the theatre usage at UBHT has meant that there is increased access for the emergency general surgical take team (CEPOD list no longer blocked by thoracic cases and others). In addition to this, there was good ordered evidence that the WHO checklist was being performed almost 100% in the CEPOD theatre.		
12	***Handovers must be led by a competent senior decision maker (ST3/SpR & above) and take place at a designated time and place, twice a day. These arrangements to be in place for handover of patients at each change of responsible consultant/surgical team/shift or block of on-call days where it should be consultant led. Changes in treatment plans to be communicated to nursing staff and therapy staff 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.***	In general, the team felt that this standard was met and there was always a senior level of registrar present Handovers took place at 8 o'clock in the morning and 8 o'clock in the evening in a designated place. In addition, there was an electronic handover system for recording and tracking of the emergency patients. The handover period between the outgoing and incoming consultant teams was managed slightly differently by the different teams. The outgoing colorectal consultant would take the weekend on-call registrar, on a ward round of all of the patients, so they would then be in a position to assess and manage them over the course of the subsequent weekend. The colorectal team then picked up these patients again on the Monday. The OG and hepatobiliary teams tended to do a ward round during the Monday to Thursday period with their elective teams, to ensure that the teams covering the weekend would have a full knowledge of the payment. The focus groups felt that the consultant handover between the incoming and outgoing consultants was	**Met**	**Met**

		slightly less formalised than their 8.00 am and 8.00 pm handovers, as there appeared to be a tendency to use phones and email rather than direct contact. The nursing staff did note that the nurse would attend the ward round on STAU, but on some of the other surgical wards, it was a little difficult for them to attend the consultant ward round as sometimes there were several teams there at the same time, but in general, all of the information of changes of management was communicated to the nursing staff effectively.		
13	***Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. The service has participated in national audits (e.g., NELA, EPOCH - list those known)*** ***Do you audit:*** ***a. Outcomes - death, LOS, return to theatre, readmissions*** ***b. Risk assessment prior to surgery*** ***c. Risk assessment post-surgery*** ***d. Time to CT/US from request*** ***e. Time from decision to theatre*** ***f. Proportion of patients having gall bladder out on admission*** ***g. Proportion of patients having gall bladder out on admission for pancreatitis***	The review group felt this standard was clearly met, possibly to a higher level than any other review that we have so far undertaken. The Trust is clearly engaged in both the NELA, EPOCH and Emergency Laparotomy Collaborate audit. In addition, there was clear evidence of in house review of their emergency general surgical take, including outcomes, time to investigation, time to decision to operate, time to theatre, as well as the review of the gallbladder and pancreatic hepatitis pathway. There was also clear evidence that emergency general surgical care was a regular part of the governance board agenda. The team acknowledged there was not an active review of the emergency general surgical take amongst the surgical teams; it tended to be done on a speciality base.	**Met**	**Met**
14	***Hospitals admitting emergency patients have access to comprehensive (Upper/Lower) 24 hour endoscopy service, that has a formal consultant rota 24 hours a day, seven days a week covering GI bleeding.***	The review team felt that this standard was met. Although the Trust reports only having an Upper GI, 24 hour endoscopy service provided by the gastroenterologists. Any lower GI endoscopy, (which is a very rare requirement out of hours) was available through the	**Met**	**Met**

		surgical team themselves.		
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	Discussions with the trainee and review of the GMC data would suggest that training is clearly delivered in a supportive environment with appropriate consultant supervision, and the trainees are unanimously happy with their education, the training opportunities, and the levels of support available to them both during the day and out of hours.	**Met**	**Met**
16	***Sepsis bundle/pathway in emergency care.***	This standard we felt was clearly met, based on the evidence shown to us prior to the visit, and based on the clear highlighting and documentation of sepsis protocols within the notes and on walk-around.	**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 team felt that this standard was partially met. It was clear that all patients on the STAU were reviewed daily by the consultant 7 days a week. However, the review of patients once they had moved off STAU became slightly more ad-hoc and informal, with the consultants only reviewing patients with a high NEWS score if requested by the junior team. In addition, the patients admitted are from a Monday to Thursday on a colorectal take week, and were only reviewed by a registrar over the weekend, whereas for OG and hepatobiliary, HPB were reviewed by a consultant over the weekend.	**Met**	**Partially Met**
18	***Emergency surgical services delivered via a network (e.g. vascular surgery, IR, Plastics,/Burns and Paediatrics.) have arrangements in place for image transfer, telemedicine, and agreed protocols for ambulance bypass/transfer and a formal SLA. Standards for the transfer of critically ill patients are adhered to and regularly audited.***	The Trust has a clear network pathway arrangement for vascular and urology with North Bristol Trust and although we saw no documentation for it, we understood that all plastic cases and burns cases are automatically transferred to North Bristol from the ED department in	**Partially Met**	**Partially Met**

		UBHT and do not involve the surgical take team. All paediatric cases are transferred from the ED department or are admitted straight to the Bristol Children's Hospital without the involvement of the emergency general surgical team. The only area where there was uncertainty remains with interventional radiology, where there is no formal network or SLA currently in place. The question of standards and policies for the transfer of critically ill patients was discussed, but the critical care team felt that this was such a rare occurrence ("once in the last 10 years") that this was not a requirement.		
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.***	This standard is not applicable to UBHT as all paediatric emergency general surgical cases are managed by the Bristol Children's Hospital co-located on site.	**Na**	**Na**
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.***	This standard is split with the first requirement being a senior specialty review by a consultant, and the second requiring review by SpR and above. Consultant review is met for the week but not weekend. The Colorectal team provide 50% of acute on call service and is on call on alternate weeks, when all the colorectal and emergency	**Met**	**Not Met**

		patients are reviewed by the consultant on call. The weekend when colorectal team is not on call, the elective and emergency patients under colorectal team are reviewed by the on call Registrar (ST5 & above). The second part to this standard was met both week and weekend because all patients are reviewed at a minimum by the level of registrars in the colorectal, Upper GI, and hepatobiliary specialities. They have no vascular, breast or urology inpatients.	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?***	As with all hospitals reviewed to date, this standard was not met.	**Not Met**	**Not Met**

Recommendations

UHB has made concerted efforts to develop an ambulatory emergency care pathway at multiple different levels. Currently the ambulatory pathway is managed by the F1 or CT1/2 who cannot discharge patients and we would recommend that the service be senior led (SpR/ST3 & above). The loss of Ultrasound slots did seem to cause a delay for patients and we would recommend reviewing this resource, alongside formalising the ambulatory service, hot clinic and fixed appointment slots.

Improvements in the delivery of EGS care will require ongoing audit and review, in particular there is a need for the systematic collection of outcome data, audit of processes and of patient experience. The review group felt this could only be delivered with a dedicated lead for EGS, appropriately resourced with time and support. In view of the key role that nursing staff play in EGS the report also recommends a lead EGS nurse be appointed.

There is currently no provision of any out of hours interventional radiology for EGS at UHB, no network service and no clear pathway to refer onto another provider. Arrangements are currently ad hoc, based on goodwill from the existing interventional radiologists locally and at North Bristol, although there are concerns that some of them feel more confident in some aspects of interventional radiology than for others. We would recommend this is looked into and a formal arrangement for IR is put in place to ensure there is no delay in urgent and emergency cases.

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: 2/8/16
Self-assessment submission date: 13/9/16
Review visit date: 27/9/16

Review team: Paul Eyers (Clinical Lead), Scott Watkins (Senior Project Manager), Mark Cartmell (Surgeon), Anne Pullyblank (Surgeon), Liz Varian (Nurse Manager), Alison Norbury (Emergency Sister), Peter Goyder (GP/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.