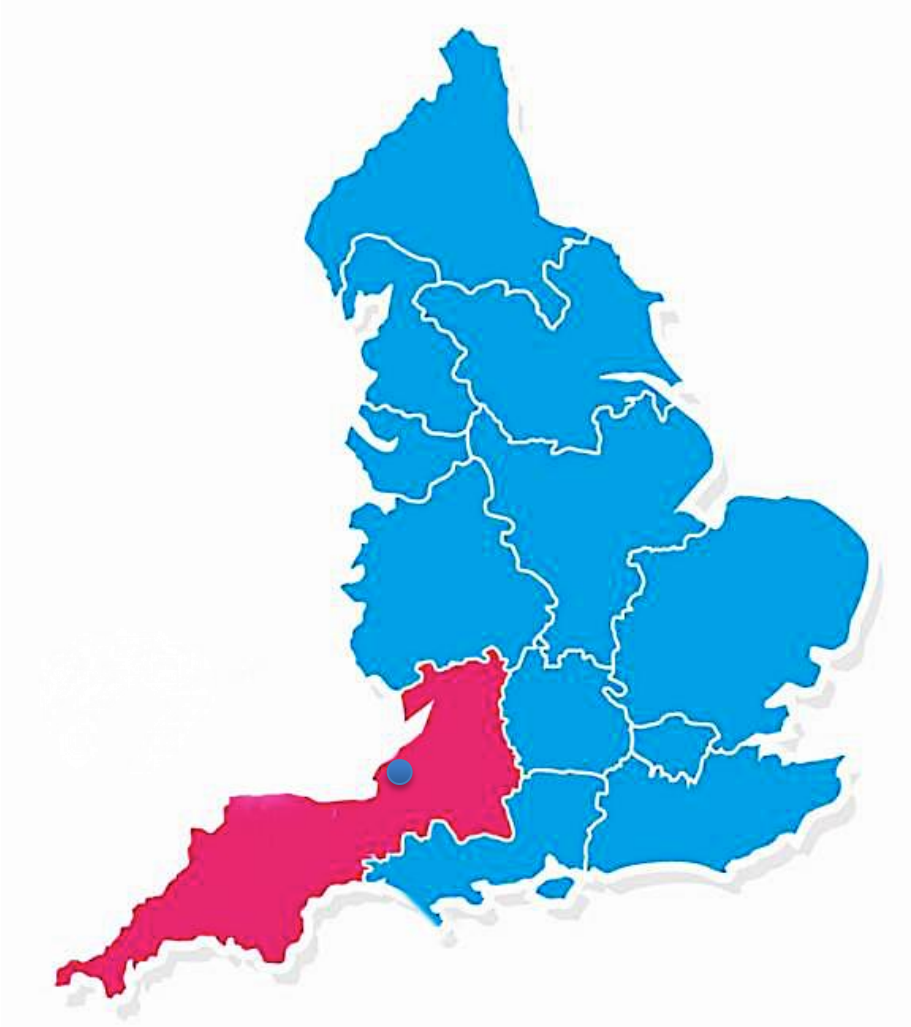
South West Clinical Senate

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



Weston Area Health NHS Trust

14th 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.

Weston Area NHS Trust

Tel: 01934 636363

Weston General Hospital
Grange Road
Uphill
Weston-super-Mare
Somerset
BS23 4TQ

Website: http://www.waht.nhs.uk/en-GB/

Weston General Hospital is located in the main town of Weston super Mare and there are two children's centres providing community children's services located in Weston super Mare and Clevedon.

The Trust has 235 beds and serves a resident population of around 212,000 people in North Somerset, with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year.

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.*	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.*	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.*	Not Met	Not Met
8	*Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7*	Not Met	Not Met
9	*All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. ……..(cont)*	Met	Met
10	*All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented*	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*	Not Met	Not 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.*	**Partially Met**	**Partially Met**
16	*Sepsis bundle/pathway in emergency care.*	**Not Met**	**Not 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**	**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.*	**Not Met**	**Not 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.*	**Not Met**	**Not 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** **Met**	**Not Met** **Met**
22	*Do you have clear protocols, including a standard for timing, for senior medical (physician) speciality review of emergency general surgical admissions?*	**Not Met**	**Not Met**

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

No.	Standard	Commentary and Conclusions	Week	Weekend
1	***Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds such that patients are generally seen within 14hrs from arrival. There is evidence of continuity of care either through multiple day working or specific patterns of working that allow continuity of care. When on-take, a consultant and the on call team are to be completely freed from other clinical duties or elective commitments. Surgeon with private practice commitments makes arrangements for their private patients to be cared for by another surgeon/team, when they are on call for emergency admissions.***	We felt this standard was partially met. There was good evidence of continuity of care through multiple day working with the consultant of the week on call for 7 days and the Monday, Friday, Saturday and Sundays evenings with another consultant colleague, 'baby sitting' the take patients and the admissions on the Tuesday, Wednesday and Thursday night. All consultants were completely free of elective commitments whilst on call. There is clearly one ward round a day for all of the emergency admission patients. It was noted by the junior staff that some of the consultants will go round in the evening, but this was by no means a consistent pattern. The SAU staff felt that there was a consultant ward round twice a day. However, in view of the pressures on the beds, very few of the surgical take patients were actually located on the SAU which used the benefit of a 2nd ward round on the unit.	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. There was an easily identifiable early warning system and policy. From discussions with the nursing staff and junior staff, it was quite clear that they felt no reservations or concerns about escalating any worries about patients to a consultant.	**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 the Trust met this standard in that it had 24/7 availability of plain x-ray and CT scanning. In the hours up until 18:00 hrs, this is provided by the in-house radiology team, and out of hours it is provided by Medicare, a commercial radiology company. The service provided by this company was felt to be of a high standard, with regular quality control, audits, and results available in prompt time. There was not 24/7 ultrasound or MRI scanning, although ultrasound is available 5 days a week during working hours and possibly at weekends between 13:00 – 17:00 hrs, when the consultant radiologist was in-house. The more general training of the radiology team meant more of them were still able to do ultrasounds. As with all of the other hospitals, pathology services are available 24hrs a day, 7 days per week.	**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 not met as there is no formalised interventional radiology rota or pathway supporting Weston General Hospital. They do link to Bristol for vascular services, but for other interventional cases, they have to phone around to arrange transfer on an ad-hoc basis.	**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***	This standard is partially met. The rotas are clearly constructed to maximise continuity of care for all patients. The consultants are on call for a week at a time, covering 24 hrs on Monday, Friday, Saturday and Sunday and	**Partially Met**	**Partially Met**

	is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.	covering day time work during the Tuesday, Wednesday and Thursday period, with a consultant colleague "baby sitting" the on call take over the evening period. The Consultant then retains responsibility for all of those patients in the subsequent period, unless they are transferred to another colleague as part of a specific management plan. It is in the surgical acute environment where the trust begins to fail this standard. The SAU in Weston Hospital is struggling to function as an SAU unit due to the over spill of medical patients into the unit. On talking to the staff, there are times when the unit is completely occupied by medical patients and during the course of our visit, there were 11 medical patients (some of which were long term) and 4 emergency surgical patients. Many of the surgical patients find themselves sitting on chairs waiting for processing.		
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.***	We felt this standard was at the upper end of partially met. There was certainly a unitary document for emergency surgical admissions in place and on some of the notes we reviewed this was clearly used by all members of staff to record the patients care. However, in other sets of notes there was a clear distinction between the medical notes and the nursing & allied health professional notes, and not necessarily a complete utilisation of the admission document.	**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.***	We felt that this standard was not met although the Trust and the surgeons were clearly working towards this. At present there was no dedicated area or 'hot' clinic. There was an 'abscess' pathway for abscesses as ambulatory cases. However, the absence of an all-day CEPOD theatre	**Not Met**	**Not Met**

		list, and emergency operating only available in the afternoon, limited this pathway.		
8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	This standard was not met. Theatre lists were available on Monday, Wednesday and Friday 13:30 – 17:30hrs. This could be impacted on by the late finishing of the morning list and obviously limited the ability to get day case or ambulatory patients through first thing in the morning and discharged by the end of the day. The team said they were in a position to 'crash' lists on the Tuesday and the Thursday or even during the morning if required but they had seldom done this. This is probably more a reflection of the volume of work than a functional process.	**Not Met**	**Not Met**
9	***All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care.*** ***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 96% of Laparotomy cases with risk above 5%, a consultant surgeon and anaesthetist were present in theatre. There was also a high number of patients (84%) admitted to critical care when risk of death was above 10%. It was acknowledged that in laparotomy cases a P-POSSUM score was probably stored within the NELA dataset but, as this was not part of the contemporaneous medical record, it was difficult to be sure whether it had or had not been recorded, and whether there has been discussions with consultant surgeons and/or anaesthetists as a consequence of this.	**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. In part this was because the majority of significant operations were done by consultant surgeons as the junior staff were quite junior. Based on the notes and discussions with the juniors in almost all of the other 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 team felt that in view of the fact that the Trust does not have a 24hr CEPOD theatre, this standard cannot be met. The volume of patients coming through the unit meant it was possible to manage the patient within one or two days of decision to surgery, and in very urgent cases, elective lists could be 'crashed'. The processes were not in place for the resources to achieve this standard. The check lists were done for all the emergency lists. It was also noted that out of hours and at weekends, the emergency general surgical cases were in competition with the orthopaedic team for access to emergency operating space.	**Not Met**	**Not 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.***	We felt this standard was met. There is a day to day morning handover involving the consultant, with clear documentation which is present on the shared drive of the Trust IT system. This document is a contemporaneous document and is not stored or archived. The evening handover between the day team and the night team is almost always registrar led. The handover between the on call teams (the consultant of the week handing over to the next consultant of the week) was clearly a structured	**Met**	**Met**

		process, where the bleep was handed over from one consultant to the other. Cases that needed ongoing review and attention were detailed and discussed. In addition to this, on the Friday an inpatient review sheet was completed for all patients to identify cases that needed review or action over the weekend.		
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 this standard was partially met at best. It was clearly identified that there was a lack of IT infrastructure that would support data collection for the emergency general surgical take. The theatre data system was being improved to allow collection of operating metrics, but at present this was not possible. The trust had audited the gall bladder pathway and they have recently changed their CEPOD form to try and record the time of listing to the time of operation. However, at the present time apart from the NELA data, there was very little evidence of any in house audits within the last five years which tracked their emergency general surgical practice.	**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.***	This standard is met. There is a comprehensive 24hr upper and lower endoscopy service for GI bleeding.	**Met**	**Met**
15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	We felt this standard was partially met. The GMC survey (which is slightly historical) reports that the Trust performed below standard for overall satisfaction, clinical supervision, handover and feedback. However on discussion with the focus groups, it was clear that the handover process had been improved and the focus group juniors felt that the consultant care and support was very good within the Trust. However, it was noted by the middle grades that although there are 4 of them, there was really only enough training	**Partially Met**	**Partially Met**

		work for 2 of them; hence this did limit their training opportunities.		
16	***Sepsis bundle/pathway in emergency care.***	At present we would have to say that this standard is not met. Based on discussions with staff, there was no clear evidence of any sepsis or any form of sepsis screening. On the feedback session at the end, it was quite clear that the Trust felt that this was data that they were recording and were achieving as it was a local CQUIN. Since the review we have seen Sepsis screening data with levels between 25-50% which would score the standard as not met.	**Not Met**	**Not 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.***	For this standard we felt this was met during the week days but not during the weekends. There appears to be a policy for discussion of all emergency general surgical patients, although they were not necessarily seen by consultants 7 days per week.	**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.***	Apart from vascular surgery where there is a clear protocol and process for transfer and management of cases within a network, there appear to be no other network arrangements for interventional radiology, burns, paediatrics, cardiac or thoracic to nearby centres. There was no evidence of any agreements or clinical pathways or SLAs.	**Not Met**	**Not 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.***	This is not applicable; Weston does not take general surgical paediatric cases. However, we did not see evidence of a network pathway or SLA for the transfer of these patients.	**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 standard was not met as at night as there are only F2's providing cover with the consultants. In this particular house, several of the F2s were actually into their 3rd and 4th years and therefore had many of the qualifications, but as a standard they do not achieve ST3 level or above.	**Not Met**	**Not 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 team felt this standard was not met at consultant level but was met for Registrar review. There was no clear protocol for consultant review of all general surgical inpatients 7 days per week. The Trust had a clear weekend handover policy such that patients from all specialities were identified to the on call consultant for review during the weekend. In the absence of special requests, all ward rounds tended to be done by registrar. There was absence of the availability of urology support over the weekend. Therefore, with regard to inpatients the F1 and the F2 needed to liaise with Southmead on-call urology service for back-up. There is the potential for issues relating to the management of torsion at the weekend, as at present this falls to the on call general surgical consultant to manage this. Most of the current team are confident with managing this, but in the future it may become more of an issue and not sustainable. Certainly this lack of urology support meant that the junior doctors felt that they would not be happy to be admitted to the Trust over the weekend with a urology problem.	**Not 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?***	This standard, as for most trusts in the Southwest, was not met.	**Not Met**	**Not Met**

Recommendations

It was clear that the SAU at Weston struggled to function at times due to medical outliers. This was demonstrated in delayed/prolonged ward rounds and patient reviews, delayed Emergency Theatre starts, increased length of stay (LOS) and delayed transfers from the Emergency Department (ED). We recommend the review of SAU and frequency of outliers. Whilst we understand the urgent need to provide beds for patients, this will cause the SAU to stop functioning in the manner it was intended which will further impact on the ability to see and treat patients.

There is not access to a 24/7 emergency theatre and lists were available on Monday, Wednesday and Friday 13:30 – 17:30hrs. This could be impacted on by the late finishing of the morning list and obviously limited the ability to get day case or ambulatory patients through first thing in the morning and discharged by the end of the day. Whilst the volume of operation at Weston is no doubt lower than the majority of other South West Trusts, without availability of a 24/7 CEPOD theatre, there could be at times a delay in managing EGS patients.

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. At present Weston has no dedicated area or ‘hot’ clinic. There is an ‘abscess’ pathway for abscesses as ambulatory cases. However, the absence of an all-day CEPOD theatre list, and emergency operating only available in the afternoon, limited this pathway.

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 interventional radiology rota at Weston, 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 between Taunton and 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.

Finally, it was felt that although 2 consultant ward rounds of the SAU was consistent, it was more ad-hoc whether a surgical patient admitted to another part of the hospital (due to outliers on SAU) would be seen twice a day by the consultant. Certainly they would be seen in the morning by a consultant but an evening round of all patients may be led by the middle grade staff. There is an opportunity in the current consultant job plans for the consultant to run two consultant rounds enabling all patients to be seen within 14hours of arrival.

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: 20/7/16
Self-assessment submission date: 31/8/16
Review visit date: 14/9/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Simon Higgs (Surgeon) Jamshed Shabbir (Surgeon) Jeremy Reid (Anaesthetist) Julie Smith (SAU Sister) Tracy Day (SAU Junior Sister).

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.