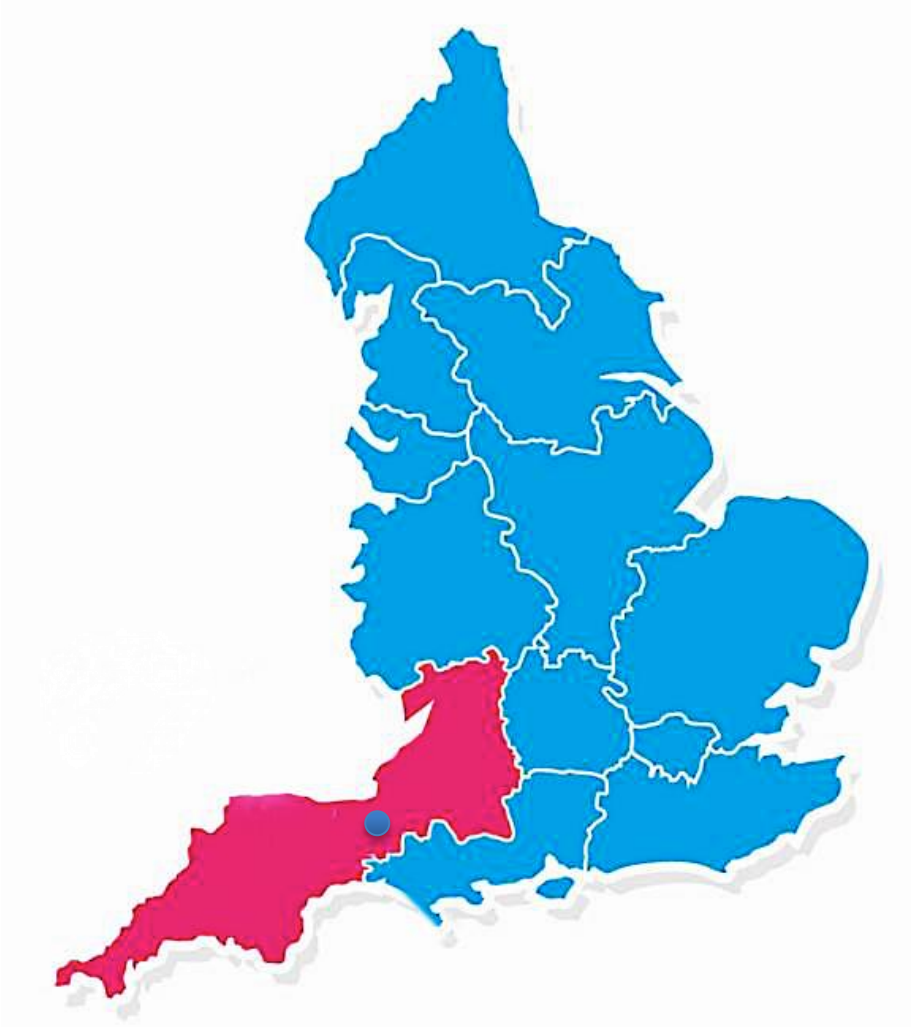
South West Clinical Senate

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



Yeovil District Hospital NHS Foundation Trust

30th June 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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Yeovil District hospital is situated on the Dorset border and serves a population of approximately 200,000 from the rural areas of South Somerset, North and West Dorset and parts of Mendip. The trust employs around 2,200 staff and has 341 beds

(318 acute & 23 escalation). The trust provides a full-range of clinical services, including general medicine, cardiology, general surgery, orthopaedic surgery, trauma and paediatrics.

Summary of findings

Table 1 provides a summary of the performance against the commissioning standards. 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.*	Partially Met	Partially Met
3	*All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.*	Met	Met
4	*All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week, either on site or through a formalised network with an agreed SLA (Service Line Agreement). Critical patients - within 1 hour if IR on site, within 3 hours if networked, Non-critical patients - 12 hours. Interventional facilities are safe for emergency patients.*	Met	Met
5	*Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.*	Partially Met	Partially Met
6	*A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialities throughout the emergency pathway.*	Partially Met	Partially Met
7	*All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (ST3/SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.*	Met	Met
8	*Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7*	Not Met	Not Met
9	*All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. ……..(cont)*	Partially Met	Partially Met
10	*All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented*	Partially Met	Partially Met
11	*The majority of emergency general surgery to be done on planned emergency lists on the day that surgery was originally planned. The date, time and decision makers should be documented clearly in the patient's notes and any delays to emergency surgery and reasons why recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre*	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)*	Not Met	Not 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.*	Not Met	Not 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	Not Met
18	*Emergency surgical services delivered via a network (e.g. vascular surgery, IR, Plastics,/Burns and Paediatrics.) have arrangements in place for image transfer, telemedicine, and agreed protocols for ambulance bypass/transfer and a formal SLA. Standards for the transfer of critically ill patients are adhered to and regularly audited.*	Partially Met	Partially Met
19	*For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and ……..(cont)*	Partially Met	Partially Met
20	*As a minimum, a speciality trainee (ST3/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.* *As above where senior specialty review is ST3/SpR & above.*	Not Met Met	Not Met Partially 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.***	This standard is partially met in the week and weekend. There are not two clearly identified consultant led ward rounds of all the acute patients admitted seven days a week. There is a consultant led ward round once a day, which is done in the morning and appears to include the consultant with elective grade and team. During the week, the on-call middle grade and F1 spend their time dealing with on-call issues up to 4.30pm and are separate to the acute on-call team who carry out the ward round. At the weekend, the F1 and middle grade do the ward round and cover the take. 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. There is no evidence of a consultant led ward round in the late afternoon/early evening but the consultants are rostered to be in the NCEPOD list with their elective registrar/middle grade until 5.30pm. Handover between acute consultant and the on-call team was informal and varied according to the consultant.	Partially Met	Partially Met

		Patients do stay under the care of the admitting consultant throughout their admission unless there is a need to transfer their care to the on-coming emergency surgeon or to a different speciality. In this case these admissions are discussed consultant to consultant. All consultants are completely free from all other clinical commitments during their on-call period including private practice.		
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 standard was partially met. There were several areas of uncertainty relating to this standard. Some staff reported that escalation was not a problem and they would be happy to escalate problems to the more senior members of staff. However, at the same time, they acknowledged that they seldom did this. In addition there was some confusion over the EWS/NEWS scoring system used by the Trust. The Trust published version appeared to be at odds with the national version with a considerably longer time trigger for review by staff members when compared to The National Royal College of Physicians Version. It was also noted there was a considerable reliance on the outreach team and that there was a tendency to call the F1 doctors in the first instance, followed by the outreach team and then escalation up to middle grade or consultant. It was reported that some of the more junior members of the medical team felt reluctant to escalate to the more senior members either due to a lack of experience or familiarity. As a consequence there was a tendency to use the outreach team rather than seek medical review. In light of this, the review team felt this	**Partially Met**	**Partially Met**

		standard was not fully met.		
3	***All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.***	The Review Group felt this standard was met seven days a week and also noted there was a commendable availability of ultrasound scans during this time, although, as with many clinical teams there was a tendency to default to CT scanning out of hours. However, it was clear there was a provision for ultrasonography should it be required from the on-call radiology consultant. Emergency imaging reporting was available within one hour with the potential for real time reporting in specific defined cases. Out of hours cross sectional scanning is provided by a commercial company, Medica and there was no suggestion of any difficulties in accessing this with junior staff. There were ring fenced slots for emergency work in CT and ultrasound. For CT at the weekends, there were 10 emergency slots on Friday and a ring fenced CT KUB morning slot Saturday morning. Emergency work is prioritised over scheduled scans as required. There was clear availability of pathology services 24 hours a day, 7 days a week to support routine emergency bloods.	**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.***	The Review Group felt that this standard was met. Yeovil have a strong working relationship with the interventional radiology department in Musgrove Park Hospital. Although there had been some confusion over the clinical pathways and agreements and funding of this, the arrangements had recently been reviewed at Trust Board Level on both sites and there is now a clear agreement.	**Met**	**Met**

		The clinicians noted that they found the interventional radiology department in Musgrove helpful and supportive with a constructive working relationship with them. Patients were easily transferable to the radiology site within three hours, possibly less pending the availability of ambulance transfer.		
5	***Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.***	The Review Group felt this standard was partially met It was felt that the rotas worked by the consultants allowed for good continuity of care with one consultant being responsible for patients admitted over a four day period and another one over a three day period. The consultants retained responsibility for a single patient during their acute admission and they would only be transferred to another speciality or another consultant based on clinical need. Any patients requiring a prolonged stay were transferred out onto general surgical wards and this was one of the concerns raised by the Review Team. With a lack of a surgical assessment unit/acute surgery ward, the emergency general surgical patients appear to be scattered across the hospital, making it difficult for the consultant and team members to ensure absolute continuity of care. Although there was no evidence at present that this had created a problem, the Review Group felt that there was a potential for this to happen. It was noted that there is no clear policy or documentation for transfer of care of emergency patients from one consultant to the other and we would suggest this is	**Partially Met**	**Partially Met**

		something that could be considered in on-going work on the handover process.		
6	***A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialities throughout the emergency pathway.***	The standard was partially met. Although there is a single unitary document for the medical teams for emergency admissions, it is not used by all health care professionals; hence there are separate records of the emergency admission depending on the staff completing them. In general the medical teams appear to use the acute admission document. However, the Review Group noted that the completion of this document was somewhat perfunctory in some cases, in particular the admitting medication was seldom, if ever, documented in the notes that we reviewed. It was also noted that observations were not routinely recorded within the document and there was no clear inscription of any sepsis screening or physiological scoring from other documents into this unitary document. As a consequence it was felt there was potential for a breakdown in the sepsis pathway. It was also noted that the document itself was rather short and did not allow for either comments by other health professionals or for a more extended day other than the day of admission.	**Partially Met**	**Partially Met**
7	***All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (ST3/SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.***	The Review Group felt that this standard was met although it was noted that the ambulatory care facility was not dedicated to general surgery alone. There is the scope for ambulatory acute care in the annex from the ED department but that this covers medicine, orthopaedics and gynaecology, as well as emergency general surgery. Despite this there was a very proactive team here that work well to protocols to keep emergency patients out of	**Met**	**Met**

		hospital and wherever possible to be reviewed in the hot clinic with delayed investigation, or redirected to an urgent outpatient appointment. Some emergency general surgical patients were being managed through a day case pathway although not as many as the consultant team would like. We understand there is an on-going piece of work to improve this. The future proposed reconfiguration of the acute surgical hub within Yeovil District Hospital should considerably streamline this process.		
8	***Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7***	This standard was very clearly not met in that there is no non-dedicated access to an emergency NCEPOD operating list 24/7. At present there is an NCEPOD list that runs Monday, Wednesday, Thursday and Friday in the afternoons between 1pm and 5:30pm, with access to alternate theatre Tuesday afternoon lists. It is proposed that in the near future there will be availability five days a week during the afternoon but at present there is no morning NCEPOD list Any operating after 5:30pm, the NCEPOD cases are shared with the trauma theatre and the orthopaedic team. As a consequence of this, it was clearly identified within the notes that patient's time to surgery was negatively impacted. For example, patients listed at midday to get their operation that day, would not get access to an NCEPOD operating list until the following day, with a consequential 24 hour delay. The Group noted that this has the potential to increase the length of stay, as the post-operative stay may be longer as a consequence of delayed surgery. The clinical team and Trust fully recognise this situation and have addressed this in their proposed plan to reconfigure their acute	**Not Met**	**Not Met**

		surgical hub, although it needs to be acknowledged the current situation presents considerable problems in terms of processing emergency general surgical cases in a timely fashion. Weekend NCEPOD operating from what we can understand is available but in competition with the orthopaedic team and the trauma list.		
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 Partially Met. NELA evidence suggests that only 67% of Laparotomy cases, with risk above 5%, had a consultant surgeon and anaesthetist present in theatre. The Review Group felt it was quite likely that many of the patients involved in the NELA data set would have a P-Possum Score recorded; this was in the NELA status set and was not transcribed into the medical records. As a consequence, it was difficult to determine whether this was routine practice and whether the cases were then subsequently discussed between the consultant anaesthetist and surgeon as to the level of supervision of the surgery and level of placement post-surgery. The team felt that the P-Possums were being recorded, in the major cases, at the end of the operation, but usually in a retrospective fashion for completion of the NELA data set. Because of this, they felt there was some consideration of the physiological score of the patient at the end of the operation but it was not consistent. More promising was the NELA data which reflected a high proportion (96%) of patients admitted to critical care following surgery when	**Partially Met**	**Partially Met**

		risk of death exceeded 10%. It was noted that there had been an attempt at developing physiological scoring prompts or aide memoir on the booking form for the emergency cases, although this was not a formal P-Possum. In addition there is planned introduction of a new system (CRAB) which may help improve physiological scoring of patients. The Review Team did raise the possibility of including a P Possum score, or a place for a P-Possum score, within the emergency document. This was in addition to the possibility of including a physiological score at the end of the theatre sign out in order to help achieve this standard.		
10	***All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented***	We felt this standard was partially based on conversations with the consultant team present during the review. We noted that in the review of the patient notes, cases were being discussed with the consultant and the time and date of this was being documented. We felt that the evidence produced demonstrated that discussions/documentation was inconsistent hence this standard is partially met.	**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***	The Review Group felt this standard was not met. Because of the lack of availability of planned CEPOD lists, it was clear that it was very difficult for patients to be operated on, on the day the decision for surgery was made. In fact, the lack of CEPOD access meant that patients were waiting 24 to 36 hours from the time of decision to operate, to the time of actually getting to theatre. This was acknowledged during our discussions with staff as well as identified in two of the case notes. From discussion with the staff it appears that the WHO	**Not Met**	**Not Met**

		safety check list is done for emergency operations, although the design and make-up of the notes documentation meant that it was quite difficult to find this and link it to the operation.		
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.***	This standard was not met and this was acknowledged by both senior and junior medical teams as well as by the nursing team. At present from what we can gather, there is a handover of cases that occurs first thing in the morning between the on-call consultant and the outgoing middle grade, who had been on-call for the previous 24 hours. There was a slight uncertainty as to whether there was a clearly allocated time for this and whether the process was always documented. During discussion with staff it was noted that handover was done verbally, with one statement noting 'the on-call F2 from the night has to verbally handover to the on-call registrar from that night (because the F2 has to go to the orthopaedic/trauma meeting) and that on-call registrar for the night then verbally hands over to the team in the morning'. The Review Team felt that if this was the case there was considerable scope for loss of patients or failure to hand over appropriate information. We were aware that there is a documented electronic record that allows the consultant to know all of the patients who are currently under their care but we struggled to identify any consistent handover between the medical teams and/or the nursing teams to ensure that the	**Not Met**	**Not Met**

		documentation was up to date. The afternoon/evening handover again seemed to be somewhat ad-hoc both in timing and occurrence; although it was noted by the review team there was the potential time for this to be done at the end of the consultant led NCEPOD list in the afternoon.		
13	***Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. The service has participated in national audits (e.g., NELA, EPOCH - list those known)*** ***Do you audit:*** ***a. Outcomes - death, LOS, return to theatre, readmissions*** ***b. Risk assessment prior to surgery*** ***c. Risk assessment post-surgery*** ***d. Time to CT/US from request*** ***e. Time from decision to theatre*** ***f. Proportion of patients having gall bladder out on admission*** ***g. Proportion of patients having gall bladder out on admission for pancreatitis***	The Team thought this standard was partially met. There was evidence of involvement in National Audits including NELA and also evidence of focused audits of cholecystectomy/pancreatitis pathways, in view of operations times, surgery and admission rates. However there was no clear evident structure or plan for review of emergency general surgical work. There was a discussion between the review team and the hospital team about the value of recording key points in the patient pathway in order to develop their future service. This was taken on board by the hospital team. This combined with an audit of outcomes and patient experience should allow for a more complete audit/governance process around emergency general surgery.	**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.***	The Review Team felt that this standard was met by the hospital in that it had an active functioning 24 hour endoscopy service. Out of hours, this is provided by both gastroenterologists and surgeons and essentially covers upper GI bleeds but can also provide an LGI service if indicated (especially volvulus reduction). In hours it is provided by either gastro or surgical, depending on whom has the endoscopy list.	**Met**	**Met**

15	***Training is delivered in a supportive environment with appropriate, graded, consultant supervision.***	The Review Group felt this standard not met. Of positive note, the teams working alongside the on call consultant during the day on the NCEPOD felt there was ample opportunity for supportive training and development. The Trust does have six doctors most of whom are quite experienced. However there was a clear lack of supervision and support for the F2 doctors that provided the cover of all surgical patients on all different sites including ITU overnight. It was felt that this group was particularly vulnerable to errors and was a group that was in particular need of support and engagement. This was acknowledged by the Trust and there is some on-going work at looking at providing a more robust hospital at night service, in order to reduce some of the pressures on these individuals. In addition, the 2016 GMC training survey for General Surgery showed Yeovil had the lowest overall satisfaction in the South West, as well as below average measures on clinical supervision and clinical supervision out of hours.	**Not Met**	**Not Met**
16	***Sepsis bundle/pathway in emergency care.***	The Review Team felt that this standard was met. The majority of emergency general surgical patients admitted to Yeovil District Hospital do so through the ED department where sepsis screening appears to happen fairly consistently. A concern was the lack of transcription of the sepsis screening decision/plan onto the emergency surgical admission documentation. It was felt therefore there was a chance that the full sepsis package may not be administered as a consequence of this. On the evidence provided by the Trust, there seemed to	**Met**	**Met**

		be a wide variation over the adherence to the sepsis bundle which was at odds with the information garnered from the walk around.		
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.***	This standard is met in the week and not met at the weekend. There is no clear policy that all emergency general surgical patients will be reviewed by a consultant every day, seven days a week. The consultant will tend to review their own patients and any patients that are specifically handed over to them, otherwise the other inpatients, some of whom will be previously admitted emergency patients, are reviewed by the middle grade ward round. At the weekend this middle grade ward round happens in a rather ad-hoc fashion as far as timing is concerned. This is due to the need to cover the CEPOD list as well as the emergency admission. Whilst there is a consultant ward round of the emergency admissions Monday to Saturday, it was clear from discussions with staff that the Sunday ward rounds were not consistent.	**Met**	**Not Met**
18	***Emergency surgical services delivered via a network (e.g. vascular surgery, IR, Plastics,/Burns and Paediatrics.) have arrangements in place for image transfer, telemedicine, and agreed protocols for ambulance bypass/transfer and a formal SLA. Standards for the transfer of critically ill patients are adhered to and regularly audited.***	The Review Group felt that this standard was partially met although we did not receive any SLAs or clinical pathways. However we are aware that the Trust has clear arrangements for the transfer of young children to Bristol Children's Hospital and also has formalised rotas for vascular and interventional radiology with Musgrove Park and the Somerset and North Devon Vascular Rota. In addition there is an across counties urology network which allows for easy transfer of patients between the two sites. The only area we were uncertain of was arrangements for transfer of cardiothoracic, neurosurgical or plastics patients. Whilst we acknowledge the numbers of these	**Partially Met**	**Partially Met**

		are likely to be very small and that there may be pathways available in the Trust, we did not see them. We would suggest it is something that the Trust could review and ensure these policies are up to date and there are agreed arrangements with their linked hospital.		
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 was partially met. There is a clear policy whereby all children under the age of 2 with surgical emergency conditions would transfer to The Bristol Children's Hospital. However there was variability in the provision of care for those patients between the age of about 2 and 5, which was dependent upon the anaesthetic consultant and the on-call surgeon. Some of these were transferred out; others were operated on site depending on the case. All paediatric cases were managed by the paediatric team to ensure adequate pain control, appropriate dosage and hydration. However, because of the issues relating to the CEPOD list, there was no guarantee these cases could be done within 12 hours, although there was a prioritisation of the cases and sometimes a delay beyond 12 hours.	**Partially Met**	**Partially Met**
20	***As a minimum, a speciality trainee (ST3/SpR or above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status), is available at all times within 30 minutes and is able to escalate concerns to a consultant. Juniors qualifications - i.e., experience level of team.***	This standard was met with all training registrars or Trust grade doctors having only appropriate MRCS and ATLS training. However, it was noted that the registrars were not resident on site and went home when they finished the evening operating and patient review. As a consequence of this, which undoubtedly supports the working of the registrars, there was reluctance from the more junior grade F2 doctors to contact the registrars out of hours for review of patients.	**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 no clear protocol for consultant review of all general surgical inpatients within the hospital seven days a week.	**Not Met**	**Not Met**
		However, patients do get a senior review by a SpR during the week, although with the need to cover CEPOD operating and emergency admissions on the weekend, timings could be ad-hoc.	**Met**	**Partially 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?***	Much like most of the other hospitals in the South West, this was not met. There is clearly an issue with getting senior medical speciality review of surgical emergency patients, seven days a week. This was acknowledged by the Review Group and the hospital team as to be a problem in most places but there was an agreement this was an aspirational standard that should be aimed for.	**Not Met**	**Not Met**

Recommendations

With no morning CEPOD availability and evening lists shared with the orthopaedic team and trauma list, there was at times a delay in managing EGS patients. This frequently led to delayed surgery and an extended LOS, as cases were rolled over to the next day, or operated on late into the night, which is proven to have poorer outcomes. Consideration should be given to whether theatre access conflicts with other services, creating significant or frequently occurring delays in surgery for EGS patients. There should be adequate anaesthetic cover to support the CEPOD list and emergency obstetrics separately, and that all EGS cases should be run through the CEPOD process, even if the procedure is to be performed elsewhere - such as in radiology or endoscopy.

There was no doubt from our review of all Trusts in the South West that a Surgical **Assessment** Unit where the majority of the EGS take patients are located and which provided a hub for the on-call surgical team was considered invaluable to both senior and junior medical staff. In some Trusts, this was sometimes called, and indeed used, as a Surgical **Admission** Unit. Patients on an assessment unit are triaged prior to admission to ensure they are moved onto the appropriate pathway. (Note: this has implications for patient expectation, Length of Stay and how clinical data is coded to be used later in audit). A functioning SAU was recognised as a key requirement to maintaining an efficient and effective EGS service. When integrated with EGS ambulatory care and co-located close to the Emergency Theatre, the SAU provides a 'hub' to focus delivery of EGS care in a more efficient way.

At the time of the review, there was no SAU at Yeovil which can result in the review of patients being delayed as the on-call ward rounds become what is colloquially known as 'safari ward rounds'. This means the ward round covers multiple different wards, often including the ED. It was clear that in order to function the SAU must be ring fenced from medical outliers or its ability to function will breakdown. Ideally, the SAU should incorporate, geographically, the Ambulatory care aspect of the service. This allows flexible working of the on-call team, maintains the basis of senior decision making and allows co-ordination of the EGS referrals.

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.

It is recommended that the Trust revisit their arrangements on handover and ensure that this is planned to take place at a dedicated time and place which fits with the timetabling of other responsibilities

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

Finally, there is currently one consultant ward round that happens in the morning with a second ward round run by the middle grade staff. At the weekend this second evening ward round is ad-hoc. There is an opportunity to formalise the two consultant ward rounds over 7 days and we would recommend job planning and staffing is reviewed to facilitate this twice daily review by the on-call consultant. In addition this would improve support to the junior team which was noted as lacking during the review. 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: 5/5/16
Self-assessment submission date: 16/6/16
Review visit date: 30/6/16

Review team: Paul Eyers (Clinical Lead) Scott Watkins (Senior Project Manager) Anne Pullybank (Surgeon) Julie Smith (SAU Sister) Tracy Day (SAU Junior Sister) Karen Rayson (Theatre sister) Jean Perry (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.