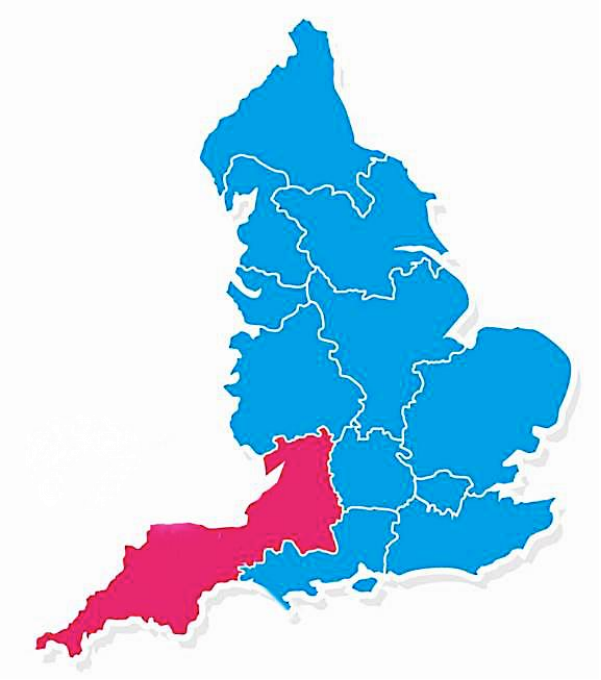
Emergency General Surgery – A review of acute trusts in the South West

NHS
South West Clinical Senate



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February 2017

Background

- September 2014 – Clinical Senate held Deliberative session on Emergency General Surgery

  'Based on available evidence and guidance, how should emergency surgical services be configured in the South West, so as to provide comprehensive, high quality emergency care based on national standards that is sustainable for the future?

- The Senate made 12 recommendations:

Senate Recommendations

- All Providers should participate in national audits relating to the care of patients who undergo emergency surgery.
- Data from national audits should be presented to Trusts and commissioners (CCGs and Specialised) in a way that clearly demonstrates how their performance compares with other units both within the South West and nationally.
- The Royal College of Surgeons of England is approached to undertake a peer review of all current providers of emergency surgery to assess compliance with existing standards relating to the provision of emergency surgery to include verification of the self-assessment against the National Emergency Laparotomy Audit (NELA) organisational audit and the recent RCS survey.
- A clinical lead should be identified in each unit
- An operational delivery (ODN) network should be established with the aim of adopting a consistent approach to the delivery of emergency services across the region. The ODN will have the remit of encouraging standardisation of clinical pathways. It is envisaged that emergency surgery will be organised and delivered in a graded hierarchy of units mirroring the anticipated change in designation as part of the urgent and emergency care review.
- CCGs ensure that all providers participate in NELA as mandated by the requirement to participate in HQIP audits (schedule 4 of the acute provider contract).
- A CQUIN is agreed for 2015-16 focusing on a reduction in mortality following emergency surgery.
- Future commissioning decisions in this area should take account of outcome data including morbidity as well as mortality and patient experience.
- CCGs are encouraged to take account of existing service and patient flow data, including making use of geographical information software.
- There is an urgent need to understand the impact that the reduction in surgical core trainees will have on the ability to staff existing junior doctor rotas and the competency of trainees to undertake emergency surgery. Alternative staffing models should be considered including surgical care practitioners.
- Providers should consider replicating existing models of physician input into the care of pre and post operative patients in all surgical disciplines as is frequently the case in emergency orthopaedic surgery
- Providers should work towards separating facilities for emergency and elective case-load.

Aims

1. To find out how Trusts were delivering their EGS service and to use a series of nationally developed standards to guide this assessment and hence provide an overview for the Commissioners that describes where the South West is in terms of EGS provision

2. To identify common themes, both positive and negative, relating to the delivery of EGS. This was to include current issues and potential future concerns.

3. To identify areas of good/excellent practice for wider use. This was later agreed to comprise a series of recommendations from the report to help improve EGS clinical care in the South West, hence objective 4 was added.

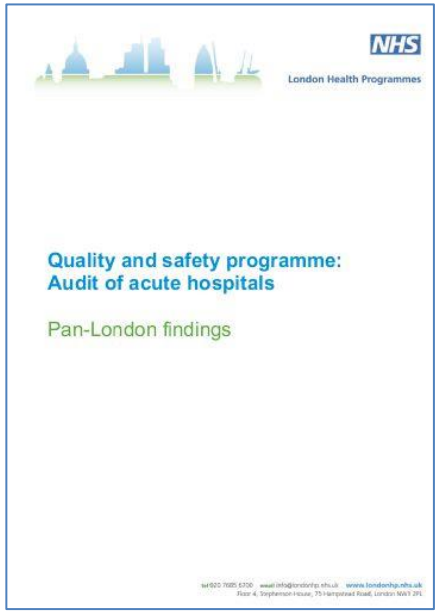
4. To develop an abbreviated set of standards/recommendations that would form the basis of a simple, widely applied Quality Improvement Framework within the South West. We were cognisant of the need for such recommendations to be few, simple, financially pragmatic and achievable.

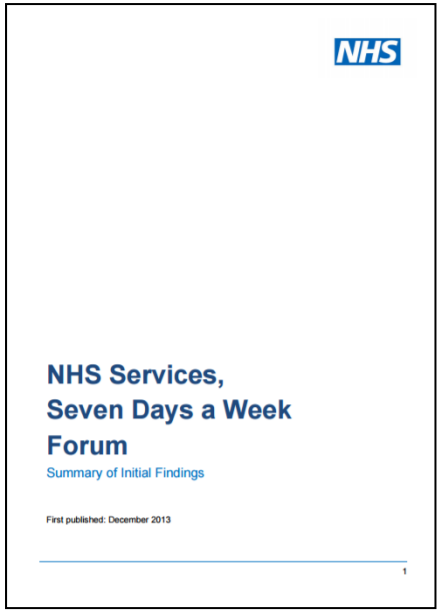
Methodology

Startup/Pre-review visit:

- **A set of 22 Emergency general surgery standards taken from 3 main sources:**

1. **RCS (2011) Emergency Surgery: Standards for Unscheduled Surgical Care**
2. **London Health Audit (2012) Quality and safety programme,**
3. **NHS Services, Seven Days a Week Forum (2013).**





Methodology

Startup/Pre-review visit:

- Standards were reviewed and adapted by an expert panel to be used as the commissioning standards, in order to assess all Southwest acute trusts that deliver an emergency general surgery service.

- Hospital self-assessment - To support the self-assessment, documentary evidence was supplied by the hospital for each of the 22 standards. Where a standard was assessed as not met, the hospital could detail any current plans that would enable compliance with the standard. It was also an opportunity to detail any current challenges faced by the hospital in meeting any of the standa

- The self-assessment information was then summarised and sent to the review team

Methodology

Review visit:

1. Presentation by the Emergency Surgery lead 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. Focus groups with doctors in training and members of nursing and therapy staff.

4. A short review of patient notes.

5. Review team discussion and feedback/discussion with trust.

Name of Trust	Date of initial letter to inform of review/outline next steps	Deadline for Self Assessment information to be received	Date of Review Visit	Draft review doc. sent to review team for comments	Draft review completed and sent to Trust lead for comments	Trust Clinical Lead
Taunton (Pilot)	na	na	11/05/2016			Mr Hamish Noble
Royal Devon & Exeter:	12/04/2016	24/05/2016	07/06/2016	16/06/2016	04/07/2016	Mr Rob Bethune
Yeovil	05/05/2016	16/06/2016	30/06/2016	21/07/2016	30/06/2016	Mr Tim Porter
Gloucestershire	31/05/2016	12/07/2016	26/07/2016	29/07/2016	11/08/2016	Mr Mark Vipond
North Devon	07/06/2016	19/07/2016	02/08/2016	08/08/2016	18/08/2016	Mr Mark Cartmell
Cheltenham	12/07/2016	16/08/2016	30/08/2016	12/09/2016	19/09/2016	Mr Mark Peacock
Plymouth	12/07/2016	23/08/2016	06/09/2016	20/09/2016	28/09/2016	Mr Grant Sanders
Weston	20/07/2016	31/08/2016	14/09/2016	29/09/2016	10/10/2016	Mr Kandaswamy Krishna/Rosie Edgerley
University Hospitals Bristol	02/08/2016	13/09/2016	27/09/2016	17/10/2016	01/11/2016	Mr Jamshed Shabbir
North Bristol Trust	09/08/2016	20/09/2016	04/10/2016	19/10/2016	01/11/2016	Miss Anne Pullybank
Great Western	17/08/2016	28/09/2016	12/10/2016	26/10/2016	02/11/2016	Mr John Allen
Cornwall	30/08/2016	11/10/2016	25/10/2016	10/11/2016	17/11/2016	Mr William Faux
South Devon	06/04/2016	21/10/2016	04/11/2016	14/11/2016	21/11/2016	Mr Nick Kenefick
Bath	28/06/2016	08/11/2016	22/11/2016	02/12/2016	12/12/2016	Miss Sarah Richards
Taunton	14/09/2016	15/11/2016	29/11/2016	06/12/2016	14/12/2016	Mr Hamish Noble

Methodology

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Post Review visit:

- Information collated from notes/dictation on the day & Individual report written.
- Report sent to review teams for agreement within 2 weeks from visit. Then sent back to the Trust within 4 weeks.
- Moderation of Trusts together
- Ongoing steering groups to discuss and agree current issues e.g. alterations to standards.

Results

Results... (but.....)

- Lack of consistent and robust data
- Different process to achieve similar results/outcomes
- Standards do not account for service per patient or per head of population – so cannot account for demand
- It was clear from the outset and more so during the review that standards were not of 'equal value' in terms of delivering a high quality service.
- Trusts reviewed early on in the process were very much take us as you find us, later Trusts or those with a member on the Steering Group had time to improve!
- **All of the above make direct or individual comparisons very hard, and possibly 'unconstructive'**

Results... (but.....)

- We did manage to get a feel for the difficulties of delivering EGS, and the key issues.
- We found numerous examples of good practice and processes.
- The review itself appeared to ‘motivate’ Trusts to change.
- We feel we have a good set of recommendations, that if implemented will see an improvement in EGS care across the South West.

Number of emergency general surgery standards met/partially met/not met by acute Trusts in the South West

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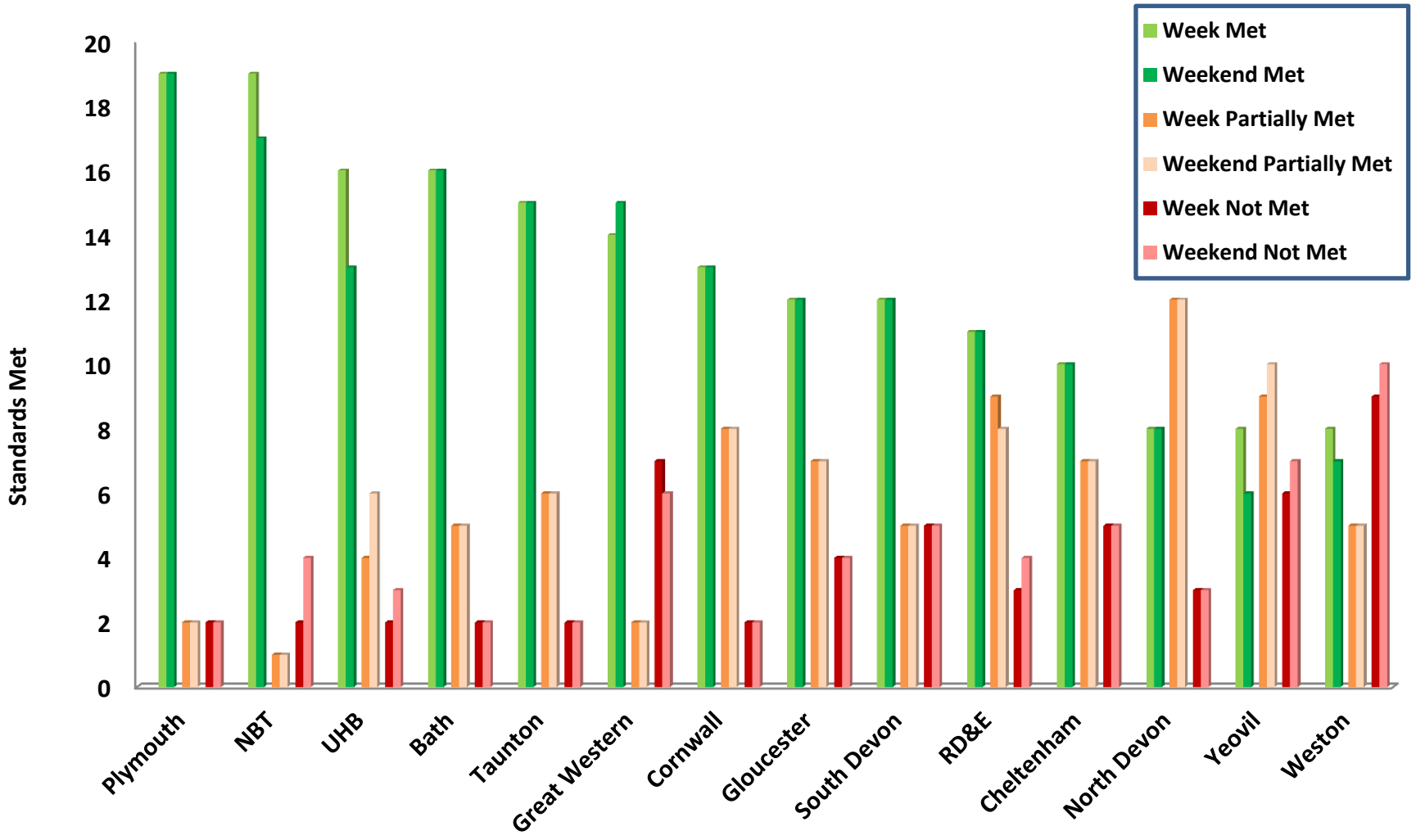
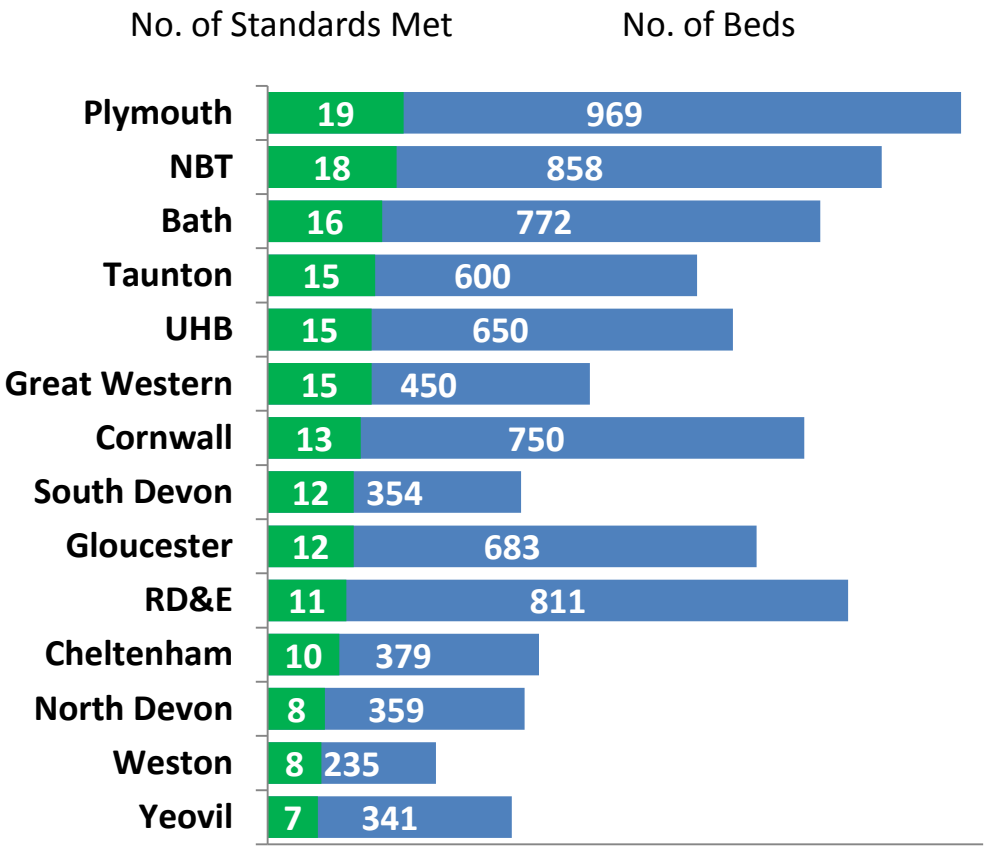


*Note- this represents ordinal, not interval data

No. of standards met vs. hospital size (no. of beds)

South West Clinical Senate



Number of Met, Partially Met and Not Met standards (average week/weekend) for each trust.

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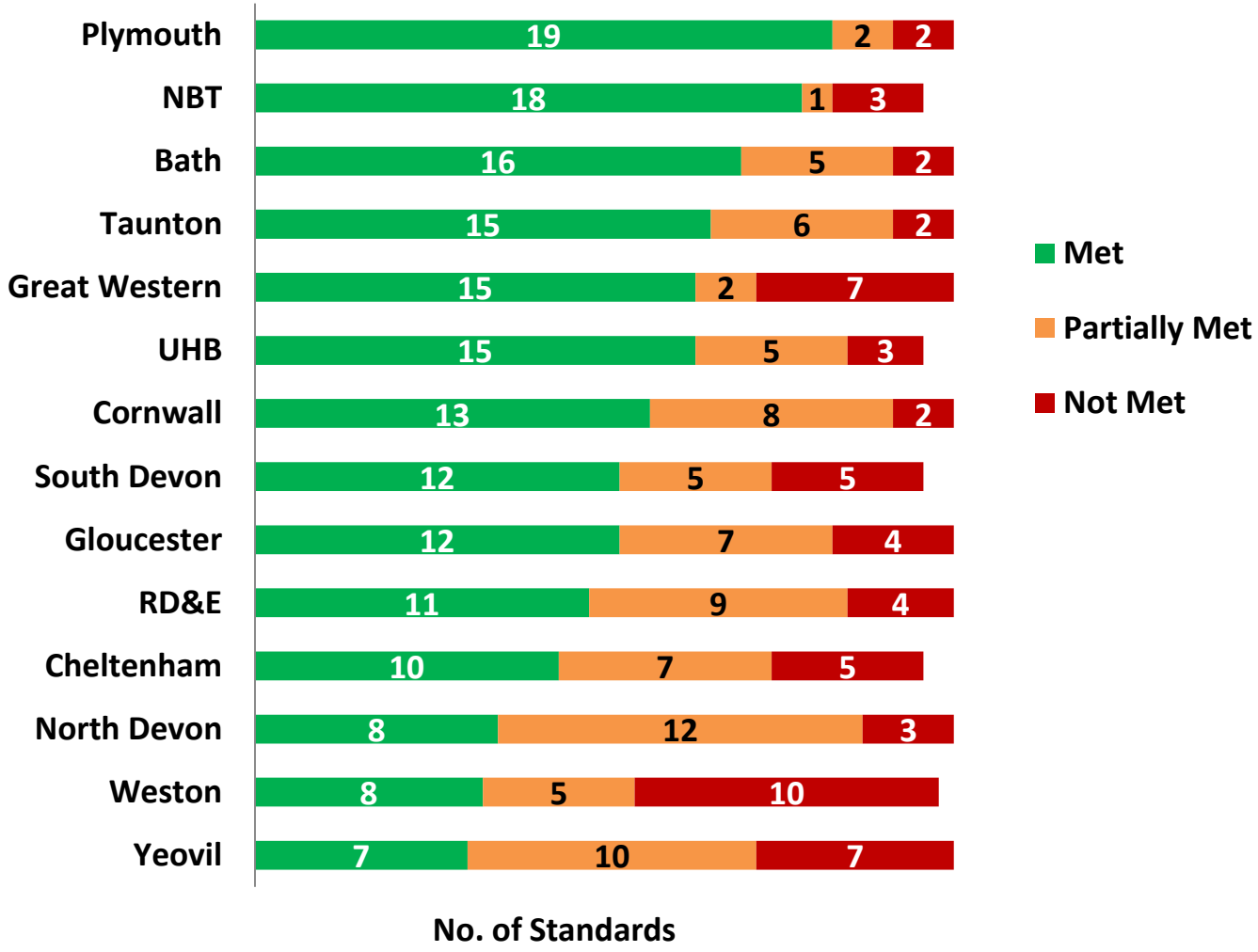
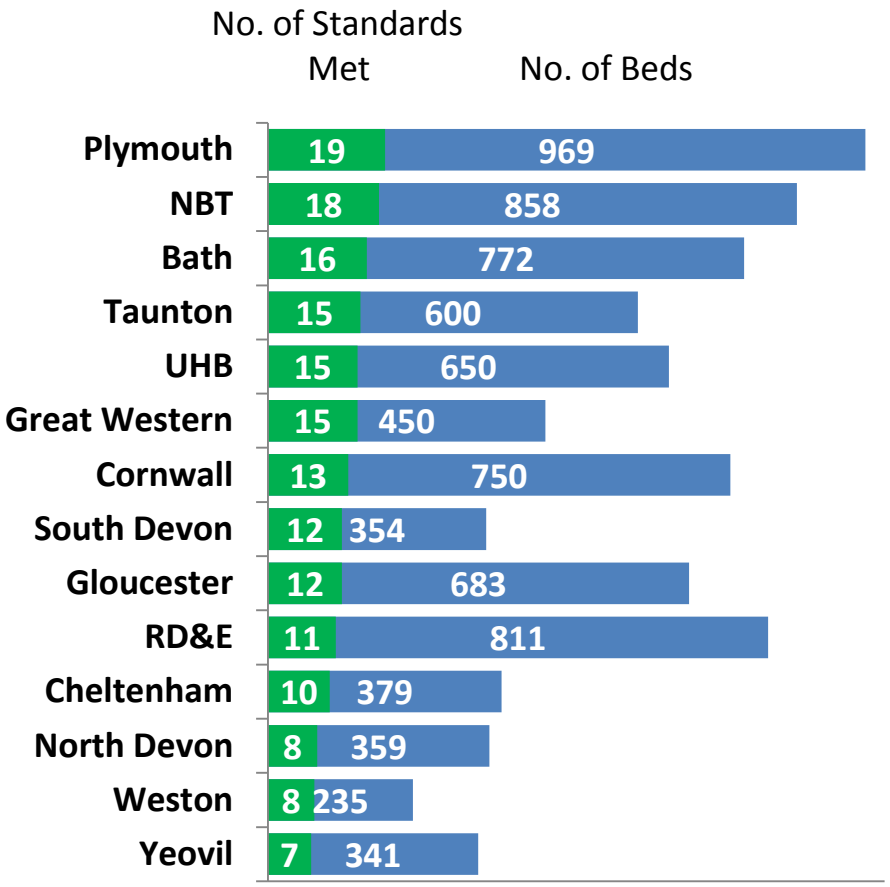
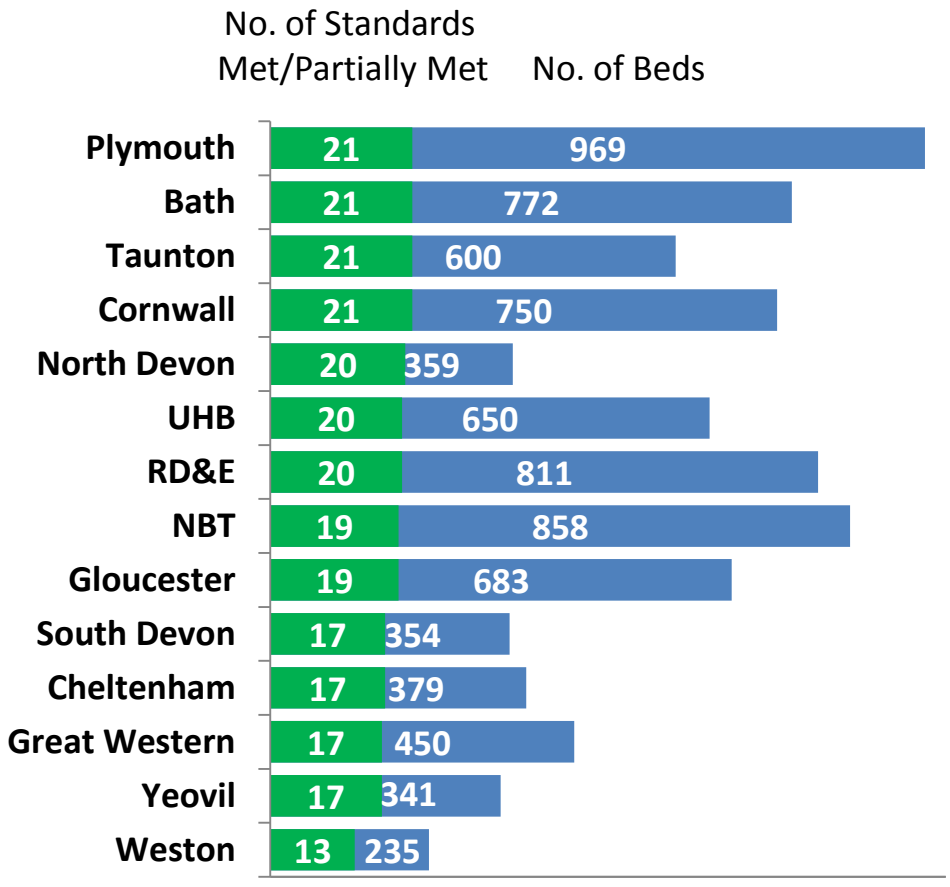


No. of standards met and number of standards met/partially met vs. hospital size (no. of beds)

South West Clinical Senate





Percentage of Trusts that meet, partially meet or don't meet each **individual standard**

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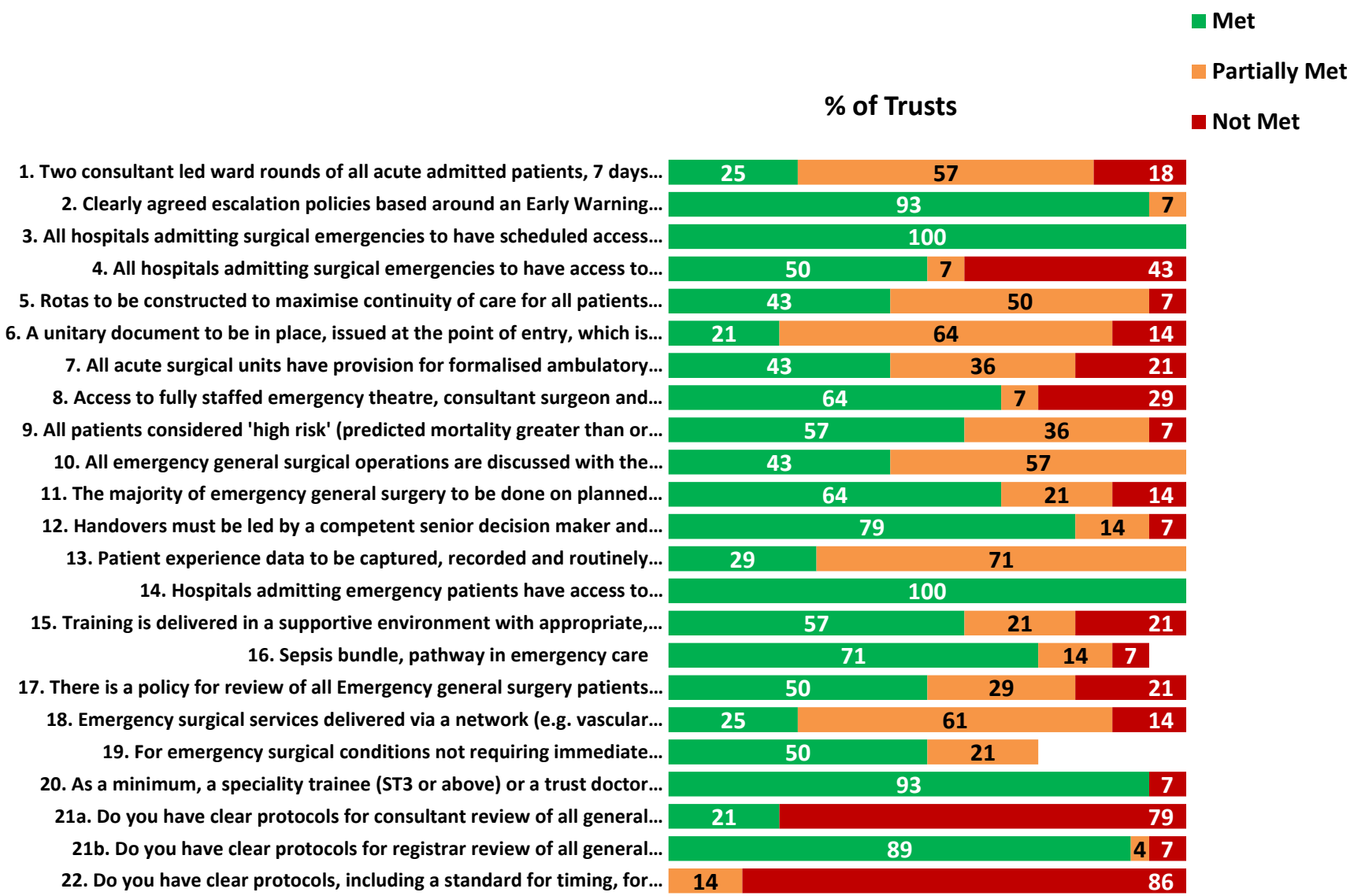

*Note: Standard 16, Sepsis Data not supplied for South Devon

Standard 19, Four trusts n/a due to bypass transfer arrangement for children.

Results – Standards: 1,5,12

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1. Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds…

- In all Trusts the whole EGS team was free from all elective commitments whilst on call.
- Only 4 trusts consistently achieving 2 consultant ward rounds, seeing patients within 14 hours from arrival.

*5. Rotas to be constructed to maximise continuity of care for all patients in an **acute surgical environment**. A sing…*

- Two main elements: continuity of care and the provision of an 'acute surgical unit'.
- The majority of Trusts delivered their EGS through a 4/3 split on-call rota
- SAU helps to prevent ‘safari ward rounds’ which lead to delays in the CEPOD theatre operating, ambulatory care and hot clinics (where present) and to a risk of 'missing' cases.

12. Handovers must be led by a competent senior decision maker and take place at a designated time and place, twice…

- Two types of handover: (1) day to day (usually 8am, 8pm) (2) on-call consultant blocks
- Variable recording systems, not all archived.

Results – Standards: 8,11

South West Clinical Senate

8. Access to fully staffed emergency theatre, consultant surgeon and anesthetist within 30 minutes, 24/7…

- 24/7 Emergency (CEPOD) operating theatre met in nine out of 14 Trusts.
- Other factors could also delay operating – Anaesthetic cover, volume of EGS cases and Orthopaedic and Obstetric emergencies.

11. The majority of emergency general surgery to be done on planned emergency lists on the day that surgery was ori…

- Universally the WHO safety briefing was undertaken for all general surgical cases
- All Trusts struggled to deliver all emergency surgical cases on the day of decision to operate due to case load and access to theatre
- Most Trusts operate a policy of only ‘life or limb’ emergency surgery after midnight -some cases rolled onto the following morning to avoid operating in the early hours of the morning,

Results – Standard 7

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7. All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision ma…

- We considered this standard to comprise four elements:
  - The presence of a 'hot clinic' with bookable appointment slots,
  - A daycase pathway and capacity for EGS operations,
  - A dedicated area,
  - Presence of a senior decision maker (SpR/ST3 and above).

- A failure to achieve any or only one of these was marked as not met. Achievement of 2 was partially met and 3-4 was scored as met.

- Across the South West three Trusts failed to provide any realistic provision of ambulatory care for EGS. Five Trusts had two elements of the standard, with six Trusts meeting the standard.

- Within five of the six Trusts meeting the standard there was considerable scope to improve the delivery of ambulatory care.

Results – Standards: 9,10,13

South West Clinical Senate

9. All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) sh…

- We judged this standard in two parts using the NELA data on high risk laparotomies (greater than 10% mortality). The first was a presence of consultant anaesthetist and surgeon in theatre, and the second was whether the patients were admitted to Critical Care following their surgery.
- The reasons for partially meeting the standard were a mixture of critical care bed availability, confusing processes to access critical care beds, or lack of consultant anaesthetist at operation.

10. All emergency general surgical operations are discussed with the consultant surgeon and the discussion is docum…

- Clear from the focus groups and walk around that the majority of cases were discussed with the consultant surgeon.
- Lack of consistently recording this in patient notes.

13. Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a perma…

- All trusts actively engaged in national audits such as NELA, no Trust failed to meet this standard completely
- Lack of standardisation of measures/coding/recording between Trusts makes it difficult to determine precise workload of the majority of EGS i.e. admissions, reviews, in-house referrals, ED referrals etc

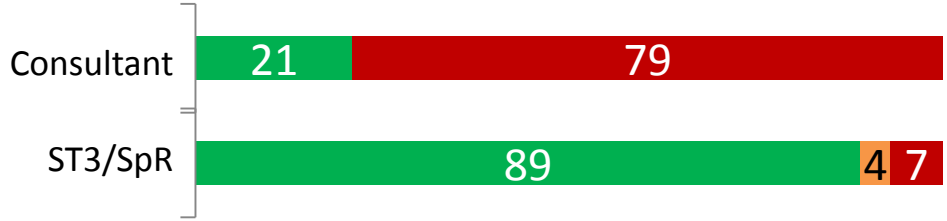
Results – Standards: 17, 21a/b, 22

South West Clinical Senate

17. There is a policy for review of all Emergency general surgery patients by a consultant, every day, 7 days a we…

- In general, on-call teams would review all admissions under that surgeon over course of the on-call period.
- Conflicting pressures created by workload, CEPOD theatre operating and 'safari' ward rounds meant that not infrequently the middle grade would review some of the cases.
- The EGS patients at risk at handover are those admitted under the out-going team, who don't have a clear diagnosis or management plan

21. Do you have clear protocols for consultant review of all general surgical in-patients to include GI surgery (C…



- In the majority of Trusts, the review of all in-patients at the weekend was delivered by the middle grade tier – ok if middle grade is experienced but could be risk if not.
- Provision of a consultant delivered review of all in-patients would have an impact on elective work during the week, and over the weekend; In many cases, it would require a second consultant rostered to review the in-patients.

22. Do you have clear protocols, including a standard for timing, for senior medical (physician) speciality review …

- Only two trusts are 'partially' meeting this standard.

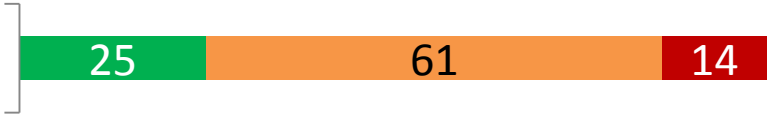
Results – Standards: 4,18,19

South West Clinical Senate

4. All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days…

- Half of the Trusts had availability of Interventional Radiology due to the presence of an on-site service
- Some trusts had a lack of formalised arrangements with local units to provide the service, producing an ad-hoc service which could cause delays

18. Emergency surgical services delivered via a network (e.g. vascular surgery, IR, etc.) have arrangements in place…



- Remarkable lack of formalised clinical pathways and Service Line Agreements (SLAs) between organisations in the South West.

19*. For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer th…

- All Trusts have some provision for EGS care in children
- Universally, children under 1 year referred to BCH, with many units transferring all children under 5yrs
- Some scoring 'partially met' due to lack of clear policies around the management of paediatric EGS cases

*Note: Standard 19, Four trusts n/a due to bypass transfer arrangement for children.

Results – Standards: 6,15,16

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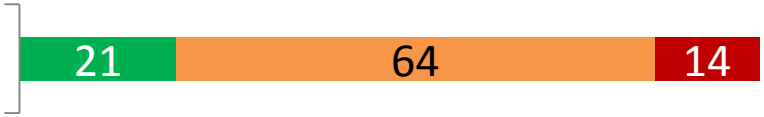
6. A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals a…



- Not everybody had a unitary document.
- Variation in the format of these documents -some being used for all emergency admissions and others for just emergency surgery admissions.
- Variation in in use within and between all hospitals

15. Training is delivered in a supportive environment with appropriate, graded, consultant supervision….

- Using GMC survey data and focus group interviews.
- In general, those Trusts who failed to meet this standard had scored poorly in both

16. Sepsis bundle, pathway in emergency care. …

- Screening levels were very good.
- Delivery of antibiotics could be delayed during transfer from ED to acute surgical environment

Results – Standards: 2,3,14,20

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2. Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deter…

- Majority of trusts demonstrate clear escalation policies and culture/relationships whereby they would not hesitate to escalate up.

3. All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray…

- The majority of Trusts were using private companies to cover their out of hours reporting.
- Some variation in Ultrasound provision which can impact EGS timings

14. Hospitals admitting emergency patients have access to comprehensive (Upper/Lower) 24 hour endoscopy service, …

- Universally met with the majority of the service being delivered by the Gastroenterology teams.

20. As a minimum, a speciality trainee (ST3 or above) or a trust doctor with equivalent ability (i.e., MRCS, with A…

- Only one trust failed this standard with F2 cover overnight

Recommendations

We were asked to consider producing some recommendations, which could help improve the delivery and quality of EGS

Recommendations

Recommendations

Six key recommendations

The recommendations can be summarised as:

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

Senate Recommendations

- All Providers should participate in national audits relating to the care of patients who undergo emergency surgery.
- Data from national audits should be presented to Trusts and commissioners (CCGs and Specialised) in a way that clearly demonstrates how their performance compares with other units both within the South West and nationally.
- The Royal College of Surgeons of England is approached to undertake a peer review of all current providers of emergency surgery to assess compliance with existing standards relating to the provision of emergency surgery to include verification of the self-assessment against the National Emergency Laparotomy Audit (NELA) organisational audit and the recent RCS survey.
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- Future commissioning decisions in this area should take account of outcome data including morbidity as well as mortality and patient experience.
- CCGs are encouraged to take account of existing service and patient flow data, including making use of geographical information software.
- There is an urgent need to understand the impact that the reduction in surgical core trainees will have on the ability to staff existing junior doctor rotas and the competency of trainees to undertake emergency surgery. Alternative staffing models should be considered including surgical care practitioners.
- Providers should consider replicating existing models of physician input into the care of pre and post operative patients in all surgical disciplines as is frequently the case in emergency orthopaedic surgery
- Providers should work towards separating facilities for emergency and elective case-load.

Any Questions?

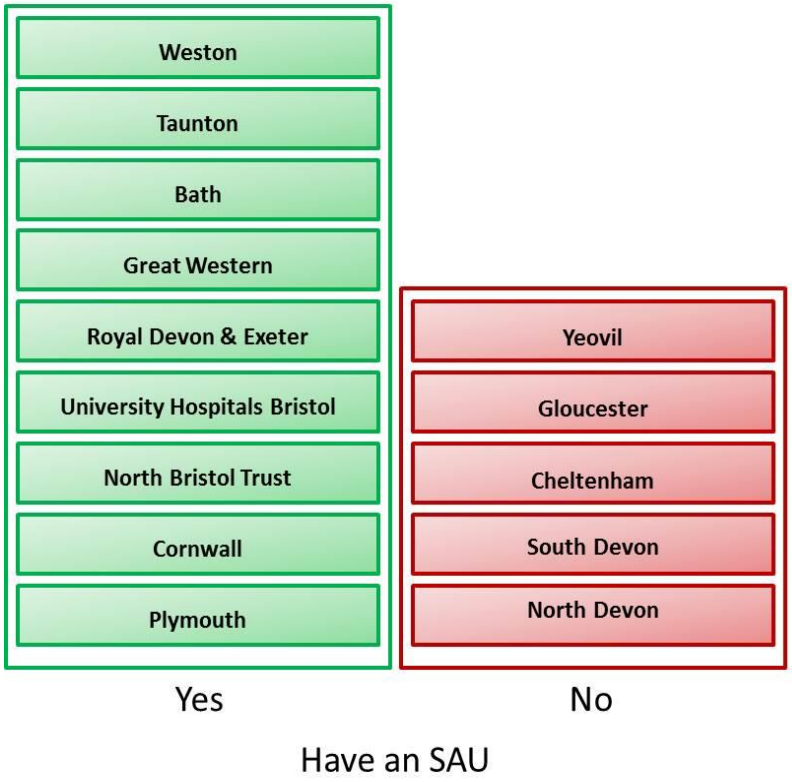
Appendix

Other findings

a. Educational Network
b. SLAs/Clinical Pathways
c. Tariffs
d. Library of Documents
e. Rotas and Continuity of care - 4/3, vs. single day, versus 7 days
f. 7 day working
g. Junior staffing, training and alternatives
h. Ultrasound on SAU

Provision of an SAU

"Much time is wasted in conducting 'safari' ward rounds - trying to find patients who have been admitted to the first available bed and could be on any ward within the hospital. One proven method of controlling admissions is the establishment of a surgical assessment unit (SAU)". (RCS, 2007)



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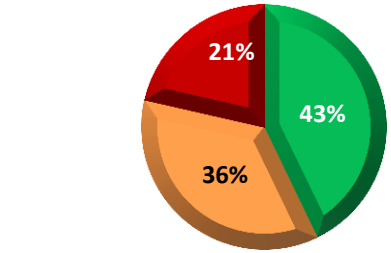
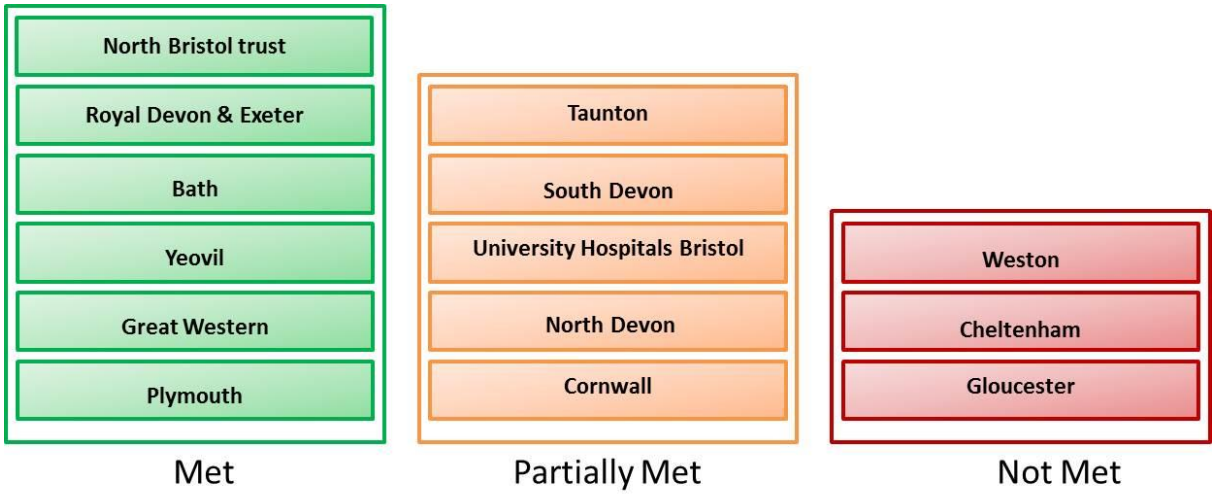
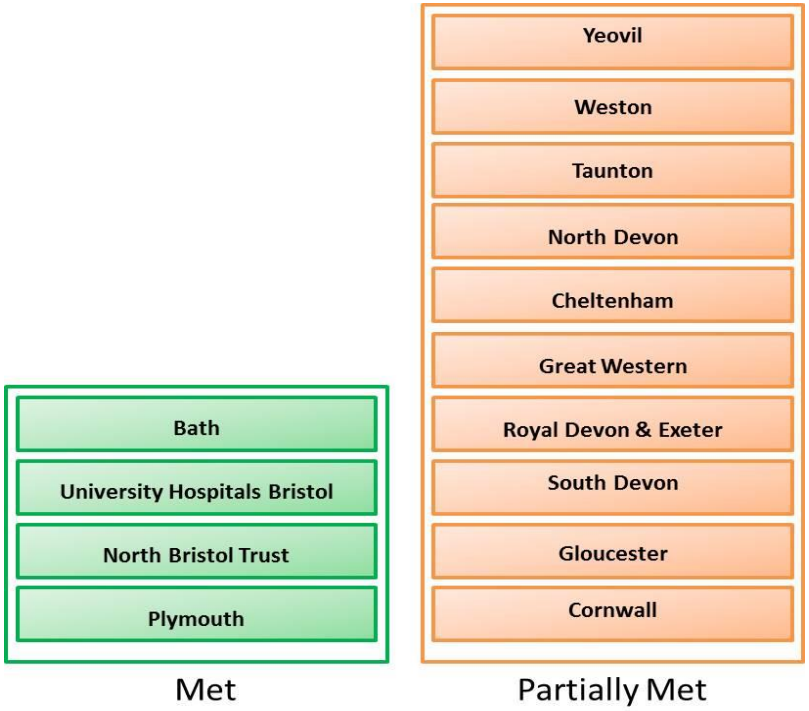
Provision to deliver Ambulatory Care

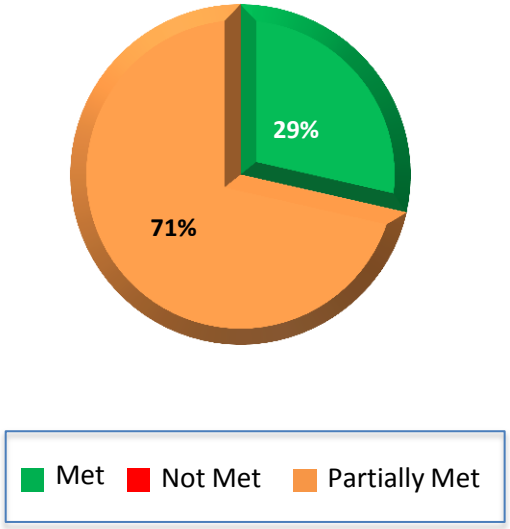




7. *All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (ST3/SpR). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.*

Collection of specific EGS data/regular audit





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

Collection of specific EGS data/regular audit

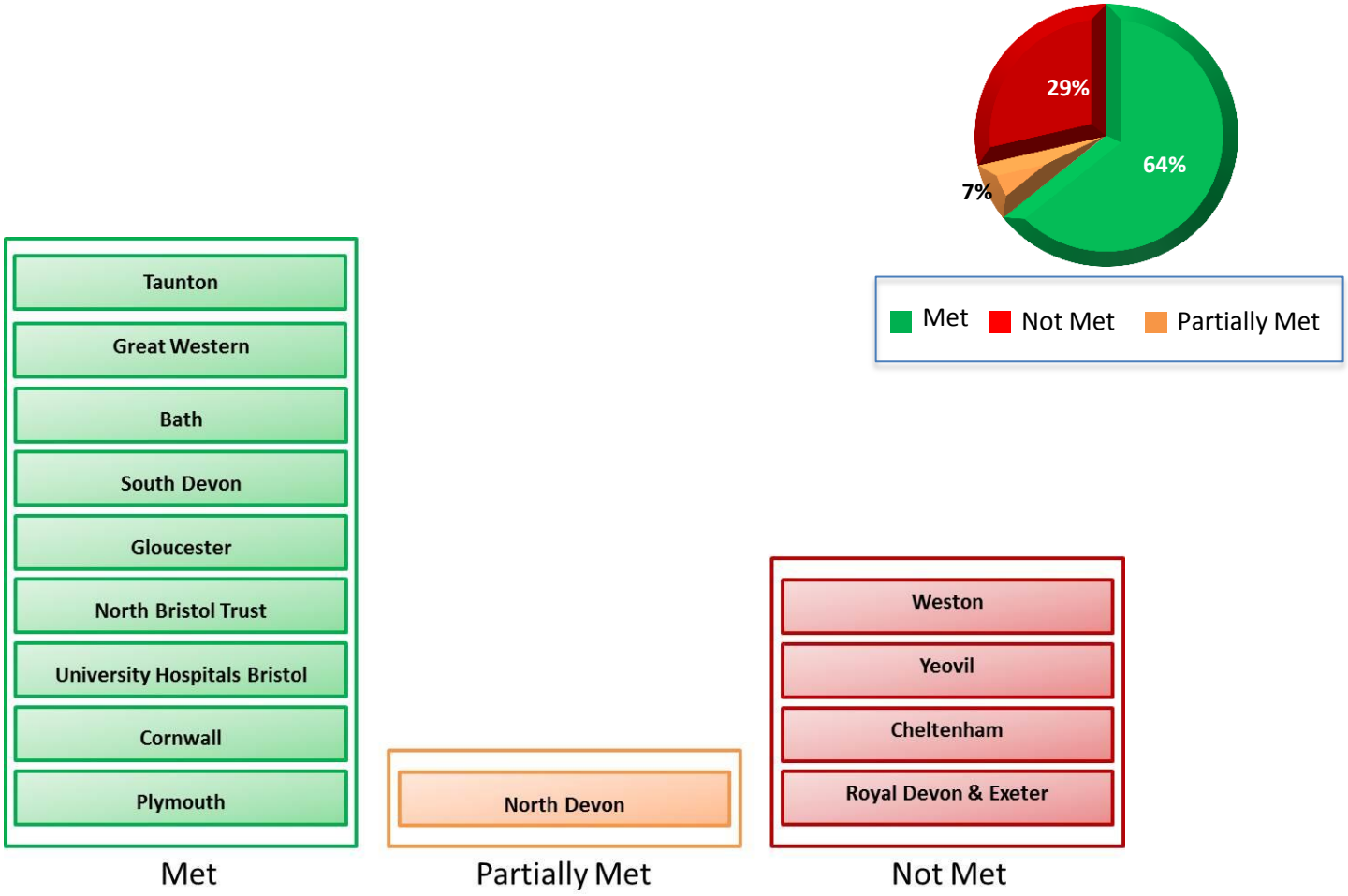
The 3 parts to this recommendation cover

1. Outcomes - we recommend that Trusts routinely record and report on their outcomes for 4 key or index 'operation groups' - Abscesses, Appendectomy, Cholecystectomy and major Laparotomy (covered by the NELA project). For each of these groups the following measures should be recorded: Length of Stay (LOS), readmission rates, re-operation rates, delay to theatre, complication rates and mortality.

2. Process - The proposed measures include: time of medical/consultant review from arrival, time from request to investigation and time from decision to operate to actual operation.

3. Patient Experience - We recommend that Trusts review their Friends & Family (F&F) data with respect to EGS (and probably emergency medical admissions).

Dedicated 24/7 emergency 'CEPOD' theatre.



8. Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7

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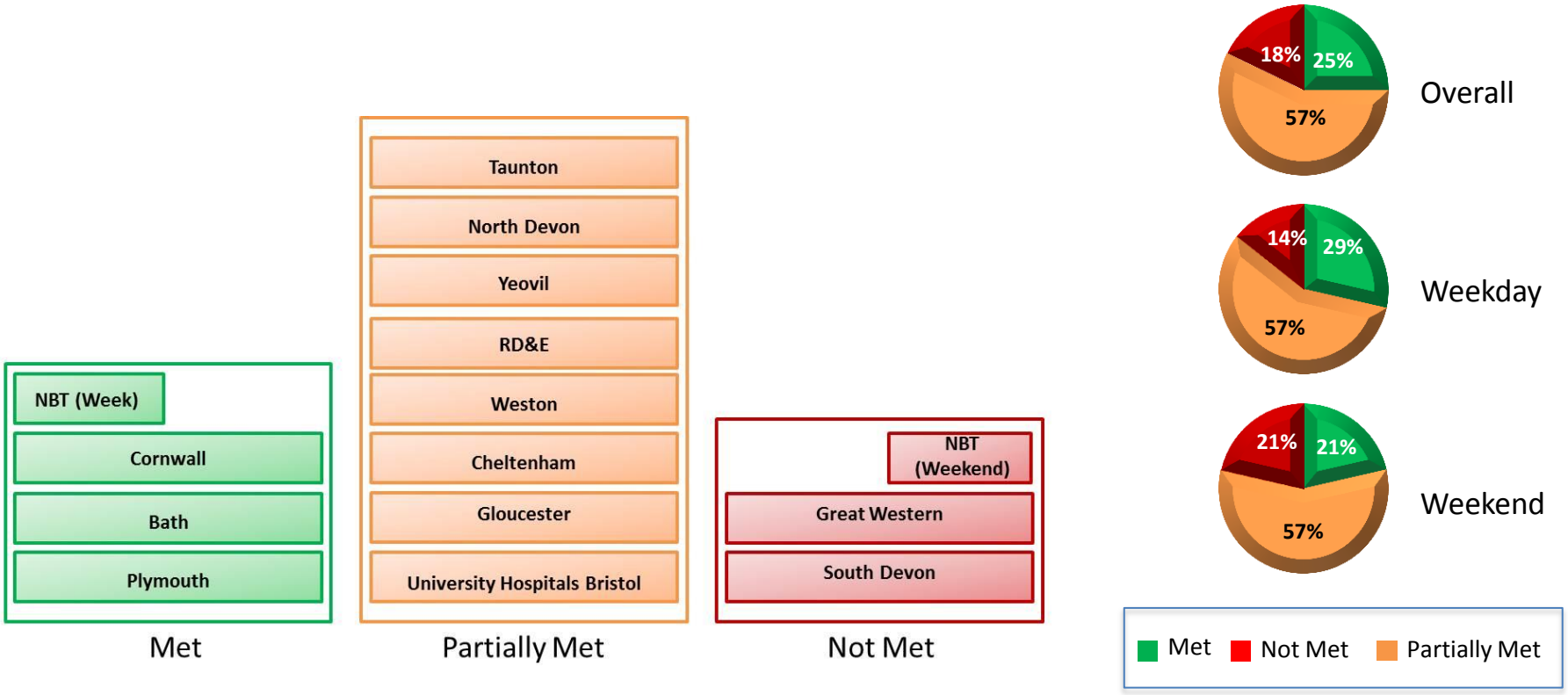
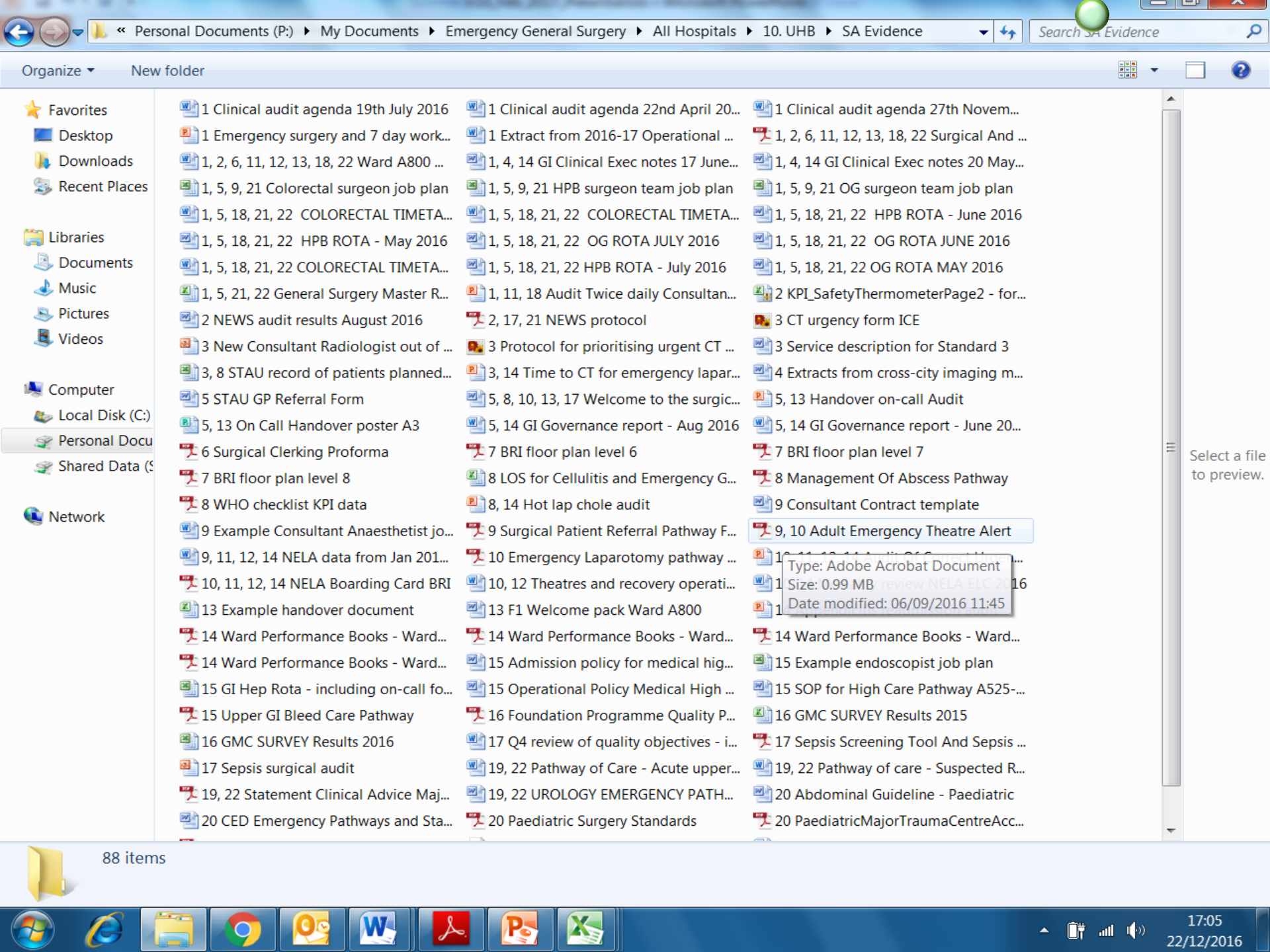
Two consultant ward rounds



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.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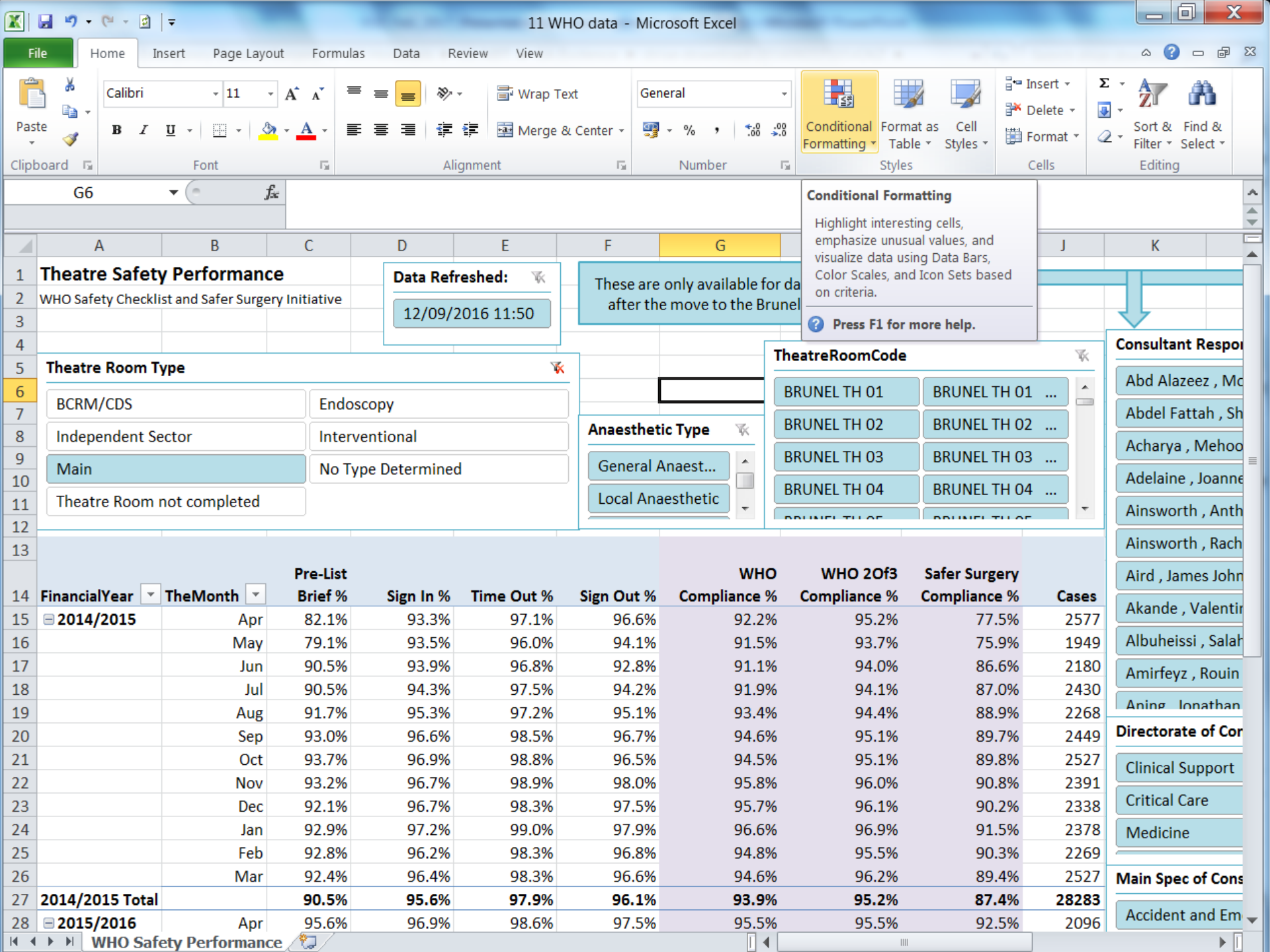
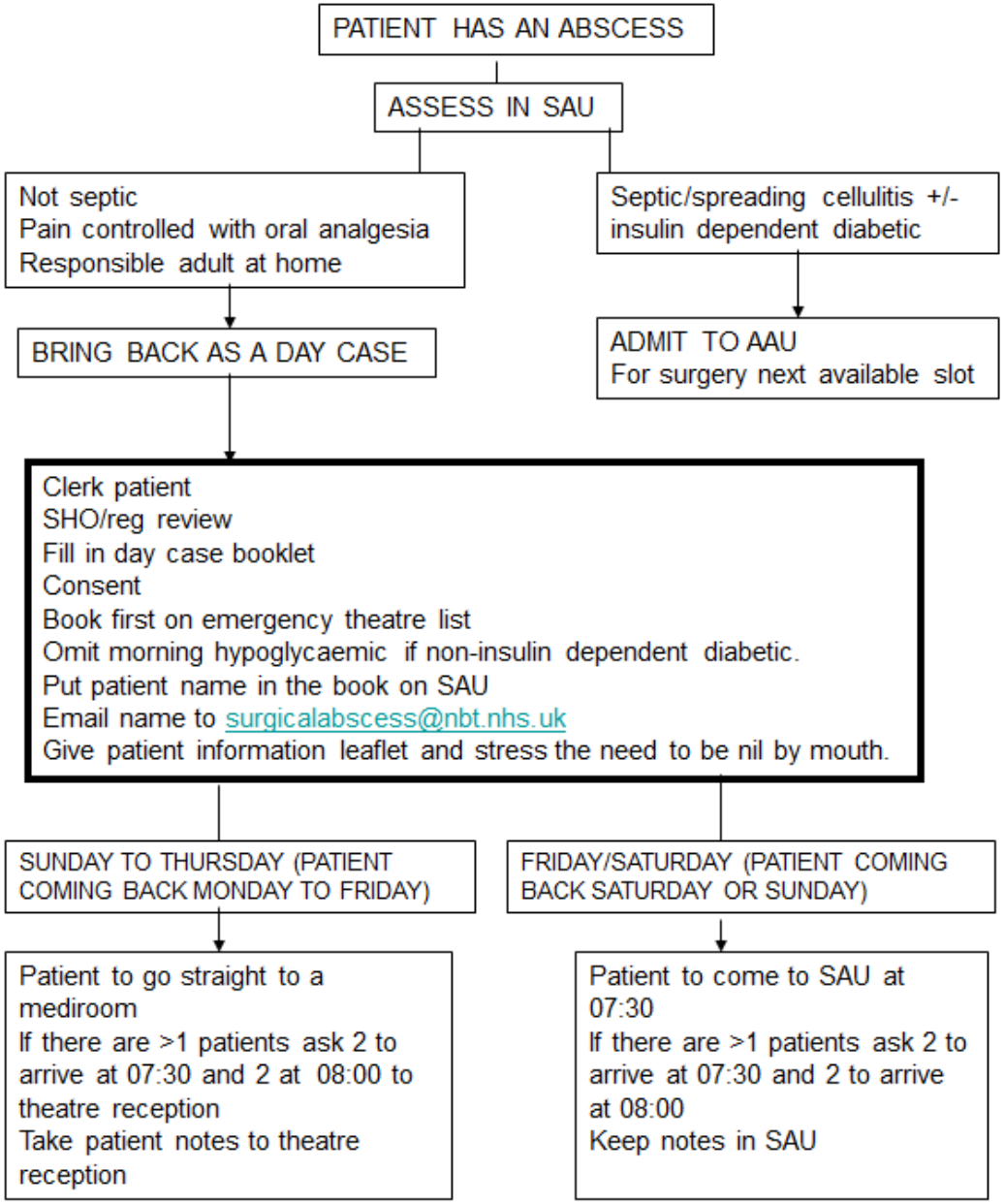


FinancialYear	TheMonth	Pre-List Brief %	Sign In %	Time Out %	Sign Out %	WHO Compliance %	WHO 2Of3 Compliance %	Safer Surgery Compliance %	Cases
2014/2015	Apr	82.1%	93.3%	97.1%	96.6%	92.2%	95.2%	77.5%	2577
	May	79.1%	93.5%	96.0%	94.1%	91.5%	93.7%	75.9%	1949
	Jun	90.5%	93.9%	96.8%	92.8%	91.1%	94.0%	86.6%	2180
	Jul	90.5%	94.3%	97.5%	94.2%	91.9%	94.1%	87.0%	2430
	Aug	91.7%	95.3%	97.2%	95.1%	93.4%	94.4%	88.9%	2268
	Sep	93.0%	96.6%	98.5%	96.7%	94.6%	95.1%	89.7%	2449
	Oct	93.7%	96.9%	98.8%	96.5%	94.5%	95.1%	89.8%	2527
	Nov	93.2%	96.7%	98.9%	98.0%	95.8%	96.0%	90.8%	2391
	Dec	92.1%	96.7%	98.3%	97.5%	95.7%	96.1%	90.2%	2338
	Jan	92.9%	97.2%	99.0%	97.9%	96.6%	96.9%	91.5%	2378
	Feb	92.8%	96.2%	98.3%	96.8%	94.8%	95.5%	90.3%	2269
	Mar	92.4%	96.4%	98.3%	96.6%	94.6%	96.2%	89.4%	2527
2014/2015 Total		**90.5%**	**95.6%**	**97.9%**	**96.1%**	**93.9%**	**95.2%**	**87.4%**	**28283**
2015/2016	Apr	95.6%	96.9%	98.6%	97.5%	95.5%	95.5%	92.5%	2096

ABSCESS PATHWAY



University Hospitals Bristol NHS

Setting: Adults, Trustwide
For use by: Medical and nursing staff

'Could This Be Sepsis?'

Sepsis Screening Tool

To be applied to all non-pregnant adults (16 and over) with fever symptoms, or who are unwell with any abnormal observations.

THE UK SEPSIS TRUST

Staff member completing form:
Date(DD/MM/YY):
Name(print):
Designation:
Signature:

Patient Details (affix label):
Trust No:
NHS No:
Surname:
Forename:
Gender:
DoB:

Important:
Is an end of life pathway in place? Yes ☐ Is escalation clinically inappropriate? Yes ☐ Initials ☐ Discontinue pathway

1. Is NEWS 5 or more or 3 in one parameter? Tick ☐
OR does patient look sick? ☐

N → Low risk of sepsis. Use standard protocols, review if deteriorates. ☐

Y ↓

2. Could this be due to an infection? Tick

- Yes, but source unclear at present ☐
- Pneumonia ☐
- Urinary Tract Infection ☐
- Abdominal pain or distension ☐
- Cellulitis/ septic arthritis/ infected wound ☐
- Device-related infection ☐
- Meningitis ☐
- Other (specify: .....) ☐

N → **4. Any Amber Flag criteria?** Tick

- Relatives concerned about mental status ☐
- Acute deterioration in functional ability ☐
- Immunosuppressed ☐
- Trauma/ surgery/ procedure in last 6 weeks ☐
- Respiratory Rate 21-24 or breathing hard ☐
- Heart Rate 91-130 or new arrhythmia ☐
- Systolic BP 91-100 mmHg ☐
- Not passed urine in last 12-18 hours ☐
- Temperature < 36°C ☐
- Clinical signs of wound, device or skin infection ☐

Y ↓

3. Is ONE Red Flag present? Tick

- Responds only to voice or pain/ unresponsive ☐
- Systolic B.P ≤ 90 mmHg (or drop >40 from normal) ☐
- Heart rate > 130 per minute ☐
- Respiratory rate ≥ 25 per minute ☐
- New need for Oxygen to keep SpO₂ ≥ 92% ☐
- Non-blanching rash, mottled/ ashen/ cyanotic ☐
- Not passed urine in last 18 hours ☐
- Urine output less than 0.5 ml/kg/hr ☐
- Lactate ≥2 mmol/l ☐
- Recent chemotherapy ☐

N → Send bloods *if 2 criteria present, consider if 1* (To include FBC, U&Es, CRP, LFTs, clotting) — Time complete ☐ Initials ☐
Contact Doctor to review *USE SBAR. Must review results within 1 hour* — ☐ ☐
Time clinician attended — ☐ ☐

Is AKI present? (tick) YES ☐ NO ☐

Y → Clinician to make antimicrobial Prescribing decision within 1h — Time complete ☐ Initials ☐

Y ↓

Red Flag Sepsis!! Start Sepsis 6 pathway NOW (see overleaf)

This is time critical, immediate action is required.

Version 1.0 07/16 Jeremy Bewley (ICU Consultant), Caroline Horrobin & Naomi Hryb (Patient Safety Nurses) THQ0119 Page1

Adapted from the Sepsis Trust Pathway

University Hospitals Bristol NHS

Sepsis Six Pathway

To be applied to all Adults over 16 years of age with suspected or confirmed Red Flag Sepsis

THE UK SEPSIS TRUST

Make a treatment escalation plan and decide on CPR status
Inform Consultant *(use SBAR)* patient has Red Flag Sepsis — Time zero ☐ Consultant informed? (tick) ☐ Initials ☐

Action (complete ALL within 1 hour) — Reason not done/variance

South West Clinical Senate

Monthly ESAC Database Figures

Month of: September 2016

Total number of patients attending ESAC (inc electives)	156
DNA's	8
Number of patients admitted from ESAC clinic	16
Number of patients seen in nurse-led clinic	20
Estimated number of bed days saved through nurse-led clinic	22
Patients admitted via Red Board	11
Days in escalation (reduced clinic/trolleys)	2
Percentage of days in escalation (reduced clinic/trolleys)	9.5%
Estimated number of bed days saved	163
Number of patients seen through weekend abscess pathway	7

NBT Review of Evidence

Standard 1
Couldn't really work out what was going on in the job plans. There seems to be a split of the on-call sessions, with someone else doing on-call after 5pm. They run on-call from 5pm to 5pm, doing a single day at a time with 3 day weekends.

Suggestion in 'Junior Doctors handbook' that they run overlapping on-call between on-call team and post-on-call team, with post take team managing cases for a further 24 hours before care handed onto elective teams or swapped to alternate speciality. Seems interesting process - what if the post-take team has been up all night? *Not sure, will need to ask on the day.* Similarly not clear about continuity or freedom from elective and private practice activities. There is a document '1_7 AAU process' - I am not sure if this is what happens or what they are aspiring towards. In this there is a twice daily consultant round with some evidence for continuity of care and of appropriate transfer.

Standard 2
Interesting escalation - for less than 5 calls- go up chain, eventually to the consultant. However, for more sick calls go to SpR, and if he/she is not available, then to 'crash call'. What if the issue is entirely surgical and patient needs to return to theatre asap? '2222' team seldom have surgical experience to know this. Surprised that the consultant is not part of escalation.

Standard 3
Seems to be availability of Plain X-ray, CT, 24/7. May also be able to get U/S and MRI, but I suspect MRI will be spinal and neuro only. AAU tips suggest ultrasound 8-8 each weekday with 3 hours of slots at weekend (Sat and Sun). Radiology '3 IP' seems to suggest that critical (also emergency) requests are reported within 75 mins - this would be too long for the standard and seems at odds with most other places so far. 'Brunel imaging matrix' suggests that cases in AAU would have a 'target time' for CT of 2 hours, with less time for ambulatory or hot clinic patients - this seems the wrong way around; admitted patient likely to be sicker. Also, the work on the NELA CT pathway has produced a marginal improvement in time to scan and reporting for septic cases, but a massive increase in the time for emergency laparotomy 'non-septic' cases.

Standard 4
Appears to be a 24/7 IR service

Standard 5
The overlapping on-call system allows admitting team to manage cases for 48 hours, whereupon, if they haven't been discharged they are under care of appropriate elective team - with option to swap/exchange cases between UGI and Colorectal. Not sure which consultant they are under once they are under elective teams care - is it same as admitting surgeon? Patients admitted to acute unit - Ward 26b, with a plan to move them if they exceed the 48 hours period (I presume, but not sure what happens if 26b fills up too much or gets filled with medical cases). Issue would be with sick patients admitted and still sick after 48 hours, but then on the elective wards - not sure of who takes active role in managing this emergency case.

Standard 6
Don't know - no evidence, and in fact some pathway specific documentation suggesting not a unitary document. Need to ask on day.

Standard 7
Hot clinic in place, with clear allocated slots of which half are linked to U/S slots. The referrals go here from the 'hub' referral set-up, which is run by nurses. Not sure if the clinical team can also book into the hot clinic, but assume they probably can.

Ambulatory pathway for daycase management of abscesses and for ambulatory care of rectal bleeding. Not sure how cases get onto day lists or who does them.

Standard 8
There appears to be a 24/7 CEPOD theatre, but only has planned 2 sessions per day - whereas most 24/7 CEPOD lists run to 22.00, i.e., a 3-4 session day, followed by OOH availability.

Standard 9
P-possum - to understand on day.
NELA consultant surgeon/anaesthetist in theatre 75% of time when risk of death >5%/

Standard 10
Don't know - no evidence presented.

Standard 11
They have a WHO and safety check list. Not sure about timing of operations with respect to booking time. WHO checklist data doesn't seperate CEPOD list, and has tailed off a bit in last few months.
The audit of the CEPOD list suggest only 45% of case performed in CEPOD theatre (? on day booked) with 19% done elsewhere and 11% postponed 14% cases were not documented and 9% were cancelled.

Standard 12
Daily handover at 0800 and 20.30. Not clear who decision makers are. Not sure of link between on-call and post-on call team. Good inclusion of theatres, anaesthetic and other specialties at 0800 handover - how do they keep them there when discussing non-operative cases!?
Good ward handover sheet. Does this apply to 26b to other ward handover or does it include medical team transfers, i.e., between teams but on same ward?

Standard 13
Audit of last 5 CT doesn't cover clinical importance and so is difficult to gauge department response, although note the OOH ones seem to take longer than in hours cases and the former are more likely to be the urgent ones. Also audit of new admission proforma. Audit of new NELA 'time to CT and report' pathway seems to be better for septic cases, but worse for non-septic ones.

Readmission audit. Good audit of CEPOD theatre function identifying delays and issues with process. Audit of appendix pathway, acute pancreatitis and time to treatment of pancreatitis due to gallstones disease, plus interesting review of frailty and dementia in emergency admission

Clear involvement in NELA, ELC plus Multicentre appendicectomy audit.

Patient experience data for SAU through F&F - but only 17 responses

Standard 14
No 24/7 ERCP. Endoscopy SOP doesn't seem to have page about emergency cases and OOH work. Seems to be an on-call endoscopist.

Emergency General Surgery: Review site visits
Focus group with key staff

Focus group information
The site has been advised to convene a group of key staff involved in acute care to be available for the focus group session, including junior doctors on the emergency rota, ward sisters and senior nurses and therapists.

The session with the focus group should be semi-structured covering awareness of the RCS Emergency Services standards, policy and escalation.

The group focus session should last approximately 1hr.

Focus group questions – to guide discussions

- Do you know about the Royal College of Surgeons 2011 Standards for Unscheduled Surgical Care and their aim? What do you do well, what could be better?
- What is the Hospital's policy for the first consultant assessment? If there is no policy, who decides on timing of consultant review and how? What are the timings of the on-call consultant ward rounds?
- Are all patients seen each day by a consultant? If not, who reviews the patients each day?
- Do the juniors doctors have trouble accessing support - either from the surgical team or from other services?
- Is there a speciality trainee (ST3 or above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status), available at all times within 30 minutes? Are they able to easily escalate concerns to a consultant?
- Are there delays in starting the CEPOD list? If so, why?
- Do you physiologically score your emergency general surgical cases? If so what system do you use?
- What is the escalation policy/protocol for a high risk patient? At what point would you seek consultant input?
- What is the process for dealing with children/where do they go?
- How does the handover process work here? Is there dedicated time for this? Is it the same at the weekend? Do you have an electronic template/system? Does the on-call team have a handover of existing ward patients from all the other teams at/for the weekend?

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- Is access to radiology at the weekend comparable to access during the week? What is your access to interventional radiology out of hours or at the weekend? What are the access times for emergency ultrasound and CT scanning out of hours and at the weekend? Are they a problem/Do they delay surgery?
- What do you feel works well here and what could be done better?
- Do you collect any patient experience data on emergency admissions? Is there any review/audit/process to communication with family and friends of patient? What do you think we should audit?
- What will you take from this Trust to your next Trust?
- Would you want to be admitted to this hospital as an emergency at the weekend? Why/Why not?

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Emergency department	How well does the emergency department interface with the acute surgical unit and the emergency general surgical team? Do you have set protocols and pathways? What, if any, are the problems?	
Radiology	Who reports on images overnight and at the weekend? - If response is a registrar, ask how soon after does the consultant review the reporting and are discrepancy rates audited routinely. If response is a 'remote out of hours reporting service', ask how soon after does the consultant review the reporting and are discrepancy rates audited routinely. Interventional radiology - Is there a regular network meeting to discuss latest issues/governance? Have you got clear pathways/a clear SLA?	
Critical Care	Do we audit this for quality? Who staffs Critical Care? Is it consultant led? Is it shared with physicians? Do you have a policy around access according to risk predictors? Do you have an outreach team...Is it 24hrs?	

Lack of consistent and robust data - Workload

What constitutes an admission?

What constitutes a referral?

multiple pathways (inpatient, outpatient, ED, urgent care) through which patients enter the system

Everybody admitted for an overnight stay

GP referrals?

Everybody seen in SAU

Double counting – seen and admitted get coded twice

We don't have an SAU

<u>We can define</u>

A referral will be anyone seen by the emergency general surgery team.

An admission will be an unplanned admission to general surgery

Ambulatory will be a hot clinical attendance or unplanned 0 length of stay admission.

<u>Each trust needs to investigate current system of measurement to see what it is counting</u>

Workforce

Yeovil - 4/3 split

North Devon – 4/3 split 8am – 8.30pm, Mon-Thurs

Cheltenham – 4/3

Taunton – 4/3

UHB – 4/3 split

Cornwall - 4/3

Plymouth – 4/3. Mon-Thurs, 2 consultants alt. btw on-call & CEPOD operating. Friday-Sunday, single consultant.

NBT – 5/2. Mon-Fri, 2 consultants alt. btw on-call & CEPOD operating. Saturday/Sunday, single consultant.

Gloucestershire – 7 days (8am-5pm) Second colleague covering nights except at weekends

Weston – 7 days/nights. Essentially covering the entire week apart from Tue, Wed and Thurs nights from 1700-0830. Over these three nights another consultant is on call.

South Devon – 7 days/nights (alternating upper/lower GI weekly) Essentially covering the entire week apart from Tue, Wed and Thur nights from 1700-0830. Over these three nights another consultant is on call.

RD&E – 36hr on-call

Great Western – Single day working

Bath – Single day working

Self-Assessment

General Surgery Consultant On-Call Rota

2016

Column1	Colu	Colu	Mon	Tue	Wed	Thu	Fri	Sat	Sun
					LEGEND				
04/01/2016	2	B	PMM	PMM	PMM	PMM	TJE	TJE	TJE
11/01/2016	1	C	CRW	CRW	CRW	CRW	PMM/ES	ES	ES
18/01/2016	2	D	TJE	TJE	TJE	TJE	ES/PMM	PMM	PMM
25/01/2016	1	E	ES	ES	ES	ES	HN	HN	HN
01/02/2016	2	F	LEH	LEH	LEH	LEH	CJV	CJV	CJV

From focus group with F1's:

Handover - "They'll go btw 3 different teams. Mon-Thurs team. Then Friday the temporary colorectal or upper GI team. Then Saturday a new take team. There's a couple of handovers there- that's probably an area of weakness"

From walk around:

The weekends usually pretty good cause because the one consultant that's on-call just takes all of the patients and manages them all for the weekend with that active daily review. But then it's the following week that's difficult when you've got emergency patients under your name and you're all over the place.

Nurse focus group:

We have a patient that comes in for example with cholecystitis and its the lower GI team that are on call that week, then they obviously need to get a handover to the upper GI team. But if the upper GI team don't come and assess them on the Monday, we'll get in touch with the take team. If they still haven't handed them over, sometimes theres a delay where they say, we have handed them over and yet we get, well no they haven't.

Percentage of Trusts that meet, partially meet or don't meet each individual standard

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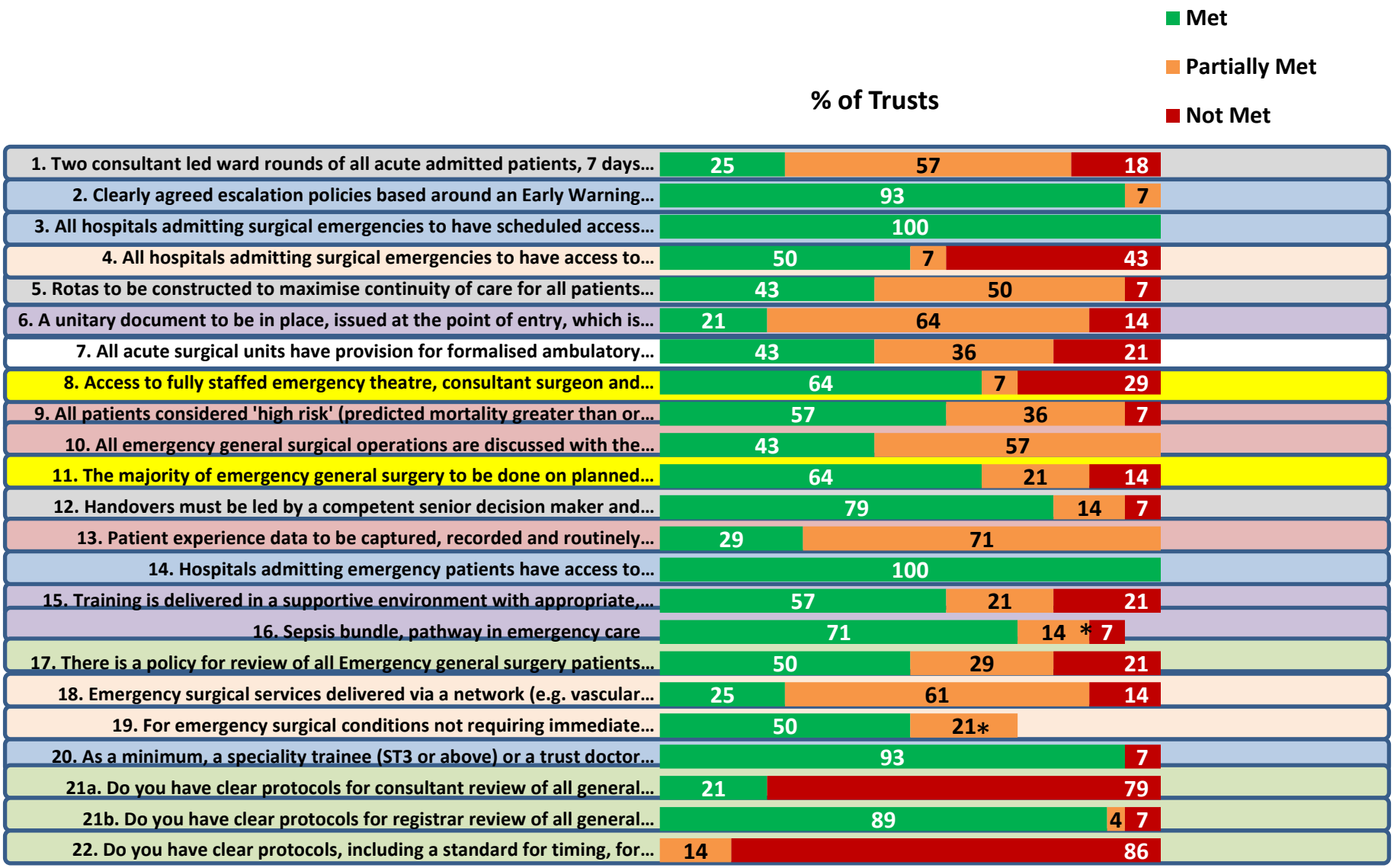

*Note: Standard 16, Sepsis Data not supplied for South Devon

Standard 19, Four trusts n/a due to bypass transfer arrangement for children.