SWSenate
SOUTH WEST CLINICAL SENATE

NHS

Recommendations from SW Clinical Senate Meeting
16 October 2014, The Bristol Hotel, Bristol

***'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 South West Clinical Senate recommends that

1. All Providers should participate in national audits relating to the care of patients who undergo emergency surgery.
2. 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.
3. 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.
4. A clinical lead should be identified in each unit
5. 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.
6. 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).
7. A CQUIN is agreed for 2015-16 focusing on a reduction in mortality following emergency surgery.
8. Future commissioning decisions in this area should take account of outcome data including morbidity as well as mortality and patient experience.
9. CCGs are encouraged to take account of existing service and patient flow data, including making use of geographical information software.
10. 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.
11. 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
12. Providers should work towards separating facilities for emergency and elective case-load.