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

Mr Paul Eyers – Clinical Lead

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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

Start-up/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).
Standards

• 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.

• 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.

• All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI) 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.

• 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.
Standards

- 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.

- 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.

- All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker. Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated area.

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

- 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.
Standards

• All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented.

• 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.

• Handovers must be led by a competent senior decision maker 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.

• 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
Standards

- 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. In addition, there should be 7 day working day (0800-20.00,) access to ERCP locally or networked

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

- Sepsis bundle/pathway in emergency care.

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

- Emergency surgical services delivered via a network (e.g. vascular surgery, IR, etc.) 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.

- 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.
Standards

• As a minimum, a speciality trainee (ST3 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.

• Do you have clear protocols for senior speciality review of all general surgical in-patients to include: GI surgery (Colorectal, Upper GI, Hepato-biliary), Vascular, Breast & Urology every day, seven days a week.

• Do you have clear protocols, including a standard for timing, for senior medical (physician) speciality review of emergency general surgical admissions?
Methodology

Start-up/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 standards

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.


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

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
• 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

*Note - this represents ordinal, not interval data*
No. of standards met vs. hospital size (no. of beds)

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

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<th>Standard</th>
<th>Description</th>
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<th>Partially Met</th>
<th>Not Met</th>
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<td>1.</td>
<td>Two consultant led ward rounds of all acute admitted patients, 7 days...</td>
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<td>2.</td>
<td>Clearly agreed escalation policies based around an Early Warning...</td>
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<td>3.</td>
<td>All hospitals admitting surgical emergencies to have scheduled access...</td>
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<td>4.</td>
<td>All hospitals admitting surgical emergencies to have access to...</td>
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<td>5.</td>
<td>Rotas to be constructed to maximise continuity of care for all patients...</td>
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<td>6.</td>
<td>A unitary document to be in place, issued at the point of entry, which is...</td>
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<td>All acute surgical units have provision for formalised ambulatory...</td>
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<td>8.</td>
<td>Access to fully staffed emergency theatre, consultant surgeon and...</td>
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<td>All patients considered 'high risk' (predicted mortality greater than or...</td>
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<td>All emergency general surgical operations are discussed with the...</td>
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<td>Do you have clear protocols, including a standard for timing, for...</td>
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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.
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

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

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

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

- 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

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 than...

- 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.
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 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

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
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.
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.
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)
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.
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
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.
### Theatre Safety Performance

**WHO Safety Checklist and Safer Surgery Initiative**

**Data Refreshed:** 12/09/2016 11:50

#### Theatre Room Type

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<tr>
<th>Theatre Room Type</th>
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<tr>
<td>Theatre Room not completed</td>
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</table>

#### Theatre Room Code

- BRUNEL TH 01
- BRUNEL TH 02
- BRUNEL TH 03
- BRUNEL TH 04

#### Anaesthetic Type

- General Anæsthetic
- Local Anaesthetic

#### Financial Year and Month Performance

<table>
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<th>Financial Year</th>
<th>Month</th>
<th>Brief %</th>
<th>Sign In %</th>
<th>Time Out %</th>
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<td>95.5%</td>
<td>95.5%</td>
<td>92.5%</td>
<td>2096</td>
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</table>

**Directorate of Core**

- Critical Care
- Medicine

**Main Spec of Consultant**

- Accident and Emergency
ABSCESS PATHWAY

PATIENT HAS AN ABSCESS

ASSESS IN SAU

Not septic
Pain controlled with oral analgesia
Responsible adult at home

BRING BACK AS A DAY CASE

Clerk patient
SHO/reg review
Fill in day case booklet
Consent
Book first on emergency theatre list
Omit morning hypoglycaemic if non-insulin dependent diabetic.
Put patient name in the book on SAU
Email name to surgicalabscess@nbt.nhs.uk
Give patient information leaflet and stress the need to be nil by mouth.

SEPTIC/SPREADING CELLULITIS +/- IN SITU INSULIN DEPENDENT DIABETIC

ADMIT TO AAU
For surgery next available slot

SUNDAY TO THURSDAY (PATIENT COMING BACK MONDAY TO FRIDAY)

Patient to go straight to a mediroom
If there are >1 patients ask 2 to arrive at 07:30 and 2 at 08:00 to theatre reception
Take patient to ward on theatre day

FRIDAY/SATURDAY (PATIENT COMING BACK SATURDAY OR SUNDAY)

Patient to come to SAU at 07:30
If there are >1 patients ask 2 to arrive at 07:30 and 2 to arrive at 08:00
If urgent go to SAU
# Monthly ESAC Database Figures

Month of: September 2016

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<td>Total number of patients attending ESAC (incl. electives)</td>
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<tr>
<td>DNA’s</td>
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<tr>
<td>Number of patients admitted from ESAC clinic</td>
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<td>Number of patients seen in nurse-led clinic</td>
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<td>Estimated number of bed days saved through nurse-led clinic</td>
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<td>Days in escalation (reduced clinic/trolleys)</td>
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<td>Percentage of days in escalation (reduced clinic/trolleys)</td>
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</tr>
<tr>
<td>Estimated number of bed days saved</td>
<td>163</td>
</tr>
<tr>
<td>Number of patients seen through weekend abscess pathway</td>
<td>7</td>
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</table>
NBT Review of Evidence

Standard 1

Standard 1. Could not really work out what was going on in the job applications. There seems to be a lack of the overall structure, with someone doing on-call after 3pm. They run on call from 3pm to 3pm, doing 24 hour shifts at a time with 4 days off.

Suggestion in Junior Doctors handbook that the on call on call team and post on call team, with post team taking calls for another 24 hours before case handover with different teams or shifted to another specialty. Seems interesting process - what if the post team has been up all night? Not sure if it will be seen on the ward. Similarly not clear about continuity of care from effective and dedicated practice activities.

There is a document, "AIAA process", which is not clear if this is what happens or if they are applying to work. In this there is a daily consultant round with some evidence to continue care and appropriate transfers.

Standard 2

The existing structure - for less than 5 caller-go-a-way teams, eventually to the consultant team. More team calls go to split, if the site is not available. The role of the site is to return the call in 24 hours. This would be a good system.

Standard 3

Seems to be availability of Fish X-ray, CT, 24/7. May also be able to get US and MRI, but suspect MRI will be optimal and only for selected cases. AIAA has suggested ultrasound 6 hourly with 3 hours of site availability (8am to 8pm). Radiology, MRI, CT site appears to suggest that team is not available and a routine CT of 2 hours, with longer hours for emergency or urgent cases - this seems the wrong way around, admitted patient likely to be a case. Also, it is not clear if there is a protocol for CT or MRI, but longer hours for emergency or urgent cases - this seems the wrong way around, admitted patient likely to be a case. Also, it is not clear if there is a protocol for CT or MRI, but longer hours for emergency or urgent cases.

Standard 4

Appears to be a 24/7 MRI service

Standard 5

The decision making system about admitting team to manage cases for 24 hours, where appropriate. If they have not been discharged they are under the admitting team care - it seems to be admitting team care - it is unclear if the consultant is aware? Patients admitted at acute unit - Ward 200, with a plan to move them if they exceed the 24 hour period (8am to 8pm). Not sure what happens if they remain or are more or less or additional beds are needed. Audit of move to CT and report, seems to be better for acute cases, but worse for non-acute cases.

Responsibility audits. Good audit of CT/MRI theatre function indicating delays and issues with protocol 4 hour delay for appendectomy Pearce, acute appendicitis and 4 hour delay for preoperative assessment, plus interesting review of patients and emergency consult in emergency admission.

Clear involvement in NBLA, SIC plus Multicentre appendectomy audit.

Patient experience data for SIC through NBT, but only 17 responses.

N.B.: The document does not seem to have any evidence about emergency cases and SIC work data.

Standard 7

Notclear where, with poor allocation of staff and lack to CoH assessment. The response go from the "right" department, which is run by nurses. It is not clear if the consultant team can also do the "right" thing, but assume they probably can.

Ambulatory pathway for daycases, management of observations, and for ambulatory cases of staff and consultation.

Standard 8

There appears to be 24/7 CPICD theatre, but only planned 13000 day cases in 2017. Whereas most 24/7 CPICD beds are run in 2200, e.g. 5-6 day cases, followed by CoH availability.

Standard 9

Regular update on regular basis.

Standard 10

Don't know - no evidence presented.

Standard 11

They have a WSH and safety check list. Not sure about timing of operations with respect to booking time. 2000 beds are needed for operations. CPICD beds are usually taken on 2200. 1000 beds are needed for operations. 5000 beds are needed for operations. 5000 beds are needed for operations. 5000 beds are needed for operations. 5000 beds are needed for operations. 5000 beds are needed for operations. 5000 beds are needed for operations. 5000 beds are needed for operations. 5000 beds are needed for operations. 5000 beds are needed for operations.

Standard 12

Daily handover at 0900 and 20.30. Not sure who decides on that.

Standard 13

Audit of 1 acute CT does not cover clinical importance and is very difficult to prove department response, although note the CoH once cases are longer than in days cases. The former are more likely to be urgent cases. Audits of CoH come in CoH and report, seems to be better for acute cases, but worse for non-acute cases.

Standard 14

No 24/7 CPICD, ambulatory surgery. CPICD doesn't seem to have any evidence about emergency cases and SIC work data.
Emergency General Surgery: Review
Focus group with key staff

Focus group information
The site has been advised to convene a group of key staff including doctors, nurses, and therapists.

The session with the focus group should be semi-structured to explore 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 2009 Unscheduled Surgical Care and their aim? What do you think could be done better?
- What is the Hospital’s policy for the first consultant attendance for an on-call patient? What is the policy, who decides on timing of consultant review and who is responsible for the on-call consultant ward rounds?
- Are all patients seen each day by a consultant? If not, why not?
- Do the juniors doctors have trouble accessing support or advice from the on-call consultant team or from other services?
- Is there a standard trainee (ST3 or above) or a Trust approved Trust appointed (i.e., MRCS, with ATLS provider status), available at all times?
- 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 surgery patients on a regular basis? If not, why not?
- What is the escalation policy/protocol for a high risk patient? When would you seek consultant input?
- What is the process for dealing with children/where do they go when they have an emergency?
- How does the handover process work here? Is there anything different at the weekend? Do you have an electronic system? Does the on-call team have a handover of existing ward teams for the weekend?
<table>
<thead>
<tr>
<th>Emergency department</th>
<th>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?</th>
</tr>
</thead>
</table>
| 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?  
Do we audit this for quality? |
| Critical Care        | 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?
Multiple pathways (inpatient, outpatient, ED, urgent care) through which patients enter the system
Everybody admitted for an overnight stay
Double counting – been and admitted get coded twice

What constitutes a referral?
GP referrals?
Everybody seen in SAU
We don’t have an SAU

We can define
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.

Each trust needs to investigate current system of measurement to see what it is counting
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
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
From focus group with F1’s:
Handover - “They’ll go between 3 different teams. Monday to Thursday 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.

Self-Assessment
Nurse focus group:
We have a patient that comes in for example with cholecystitis and it’s 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 there’s 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

<table>
<thead>
<tr>
<th>Standard</th>
<th>% of Trusts</th>
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<tbody>
<tr>
<td>1. Two consultant led ward rounds of all acute admitted patients, 7 days...</td>
<td>25 Met, 57 Partially Met, 18 Not Met</td>
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<tr>
<td>2. Clearly agreed escalation policies based around an Early Warning...</td>
<td>93 Met, 7 Partially Met, 0 Not Met</td>
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<tr>
<td>3. All hospitals admitting surgical emergencies to have scheduled access...</td>
<td>100 Met, 0 Partially Met, 0 Not Met</td>
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<tr>
<td>4. All hospitals admitting surgical emergencies to have access to...</td>
<td>50 Met, 7 Partially Met, 43 Not Met</td>
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<tr>
<td>5. Rotas to be constructed to maximise continuity of care for all patients...</td>
<td>43 Met, 50 Partially Met, 7 Not Met</td>
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<tr>
<td>6. A unitary document to be in place, issued at the point of entry...</td>
<td>21 Met, 64 Partially Met, 14 Not Met</td>
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<tr>
<td>7. All acute surgical units have provision for formalised ambulatory...</td>
<td>43 Met, 36 Partially Met, 21 Not Met</td>
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<tr>
<td>8. Access to fully staffed emergency theatre, consultant surgeon...</td>
<td>64 Met, 7 Partially Met, 29 Not Met</td>
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<td>9. All patients considered 'high risk' (predicted mortality greater than or...</td>
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<td>10. All emergency general surgical operations are discussed with the...</td>
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<td>11. The majority of emergency general surgery to be done on planned...</td>
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<td>12. Handovers must be led by a competent senior decision maker...</td>
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<td>13. Patient experience data to be captured, recorded and routinely...</td>
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<td>14. Hospitals admitting emergency patients have access to...</td>
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<td>15. Training is delivered in a supportive environment with appropriate...</td>
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<td>16. Sepsis bundle, pathway in emergency care</td>
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<td>17. There is a policy for review of all Emergency general surgery patients...</td>
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<td>18. Emergency surgical services delivered via a network (e.g. vascular)...</td>
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<td>19. For emergency surgical conditions not requiring immediate...</td>
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<td>20. As a minimum, a speciality trainee (ST3 or above) or a trust doctor...</td>
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<td>21a. Do you have clear protocols for consultant review of all general...</td>
<td>21 Met, 89 Partially Met, 7 Not Met</td>
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<td>21b. Do you have clear protocols for registrar review of all general...</td>
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<td>22. Do you have clear protocols, including a standard for timing...</td>
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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.*