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Editorial

Safe emergency general surgery—ASGBI statement

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The provision of safe emergency general surgical (EGS) care is a global issue[1] with changing population demographics, incidence of surgical disease and post-pandemic recovery all impacting the delivery of EGS services. Emergency admissions have risen exponentially over the past decade, with ~750 000 emergency general surgical admissions per year in England alone[2,3].

In 2014, the National Emergency Laparotomy Audit reported considerable variation in the organization and delivery of care for emergency laparotomy patients with subsequent recommendations to standardize high-quality care in emergency laparotomy[4–6].

Here, we present results from a unique census of EGS activity defining current practice and variation and a series of further recommendations for adult EGS provision.

The EGS Steering Group of the Association of Surgeons of Great Britain and Ireland (ASGBI) designed a prospective cross-sectional snapshot survey using a modified Delphi method to cover four areas: hospital infrastructure, EGS workload, surgical workforce and resource availability. Data collection took place between September 2022 and May 2023 with ASGBI members and EGS conference delegates invited to participate via email. Responses were received from 177 NHS Trusts, with a response rate of 88% (*Fig. 1*).

Respondents reported the average number of EGS patient episodes in a 24-hour period, defined as a new patient assessed by the EGS team, irrespective of whether admitted, with activity classified as low (0–10 patient episodes), medium (11–25), high (26–50), and very high (51–75). The majority of sites (86%) reported medium or high activity (*Table 1*).

Eighty per cent of hospital sites had a dedicated surgical assessment unit, 77% provided an ambulatory service, often incorporating a consultant-led 'hot clinic', and 33% had a dedicated primary care advice line. Although more than 90% of sites reported 24/7 access to an emergency theatre list, less than half of sites had a dedicated EGS theatre, especially those with low and medium EGS activity. All except one site reported 24/7 access to CT yet only 10% of sites had 24/7 access to ultrasonography and only ~50% centres had 24/7 access to interventional radiology.

Consultant surgeons generally worked separate day/night shifts or a continuous on-call period for either three or four days as a split week. Dedicated EGS surgeons had been appointed in 28% of hospitals, with high- and medium-activity centres reporting the highest proportion (33% and 31% of sites respectively).

Sites reported a median of 11 consultants to cover EGS activity (i.q.r. 8–14) with rotas staffed predominantly by colorectal (47%), upper gastrointestinal (33%), and hepatobiliary surgeons (7%). Specialized emergency general surgeons accounted for 6% of the rota, with breast, vascular, and endocrine surgeons the remaining 8%. In most sites the on-call consultant was responsible for an unselected emergency take with subspecialty on-call availability limited in low-activity sites. The EGS consultant covered paediatric general surgical emergencies in 73% of hospital sites.

Recommendations for safe and efficient EGS care

Safe staffing levels are essential, defined by EGS admissions and inpatient volume, not hospital size. Patient pathways for all stages of the EGS patient journey should be universally incorporated, especially for the early identification and management of sepsis and the delivery of optimal care for emergency laparotomy patients.

EGS services should be available and contracted 24/7, including for both consultant surgeons and anaesthetists, with access to fully staffed operating theatres. EGS cases should receive appropriate prioritization and without competition with elective care. 24/7 access to cross-sectional imaging and interventional radiology should be available alongside critical care with outreach to deliver protocol-triggered reviews and escalation.

There should be a lead clinician for EGS with allocated contracted time, and training in EGS should ensure required competencies are acquired for completion of training.

Daily input from geriatricians for older patients, irrespective of procedure, should be available, with regular multidisciplinary reviews of processes and patient outcomes for all EGS patients.

ASGBI EGS collaborative group

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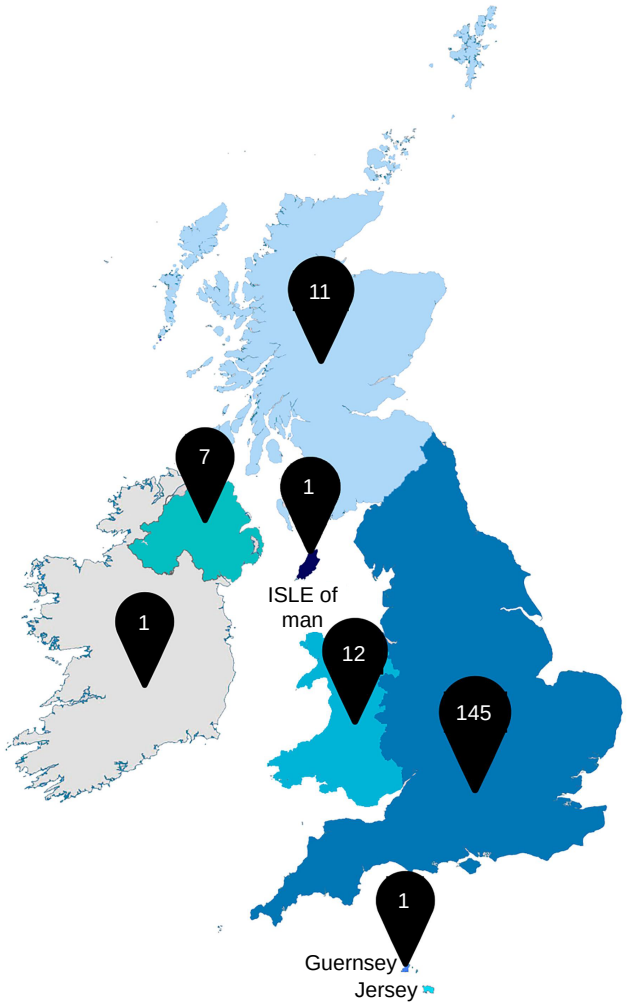

Fig. 1 Distribution of responses across the regions of the United Kingdom and Republic of Ireland.

Table 1 Distribution of emergency general surgery patient episodes in 24 hours

Number of emergency general surgery patient episodes	Number of hospital sites	Proportion of total sites included (%)
Low activity	16	9
Medium activity	85	48
High activity	68	38.4
Very high activity	8	4.5

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Data availability

The data underlying this article will be shared on reasonable request to the corresponding author.

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H.J.E., S.L. and G.T. contributed equally to the conception, writing and revision of this editorial.

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