

Health Select Committee Inquiry: Emergency services and emergency care inquiry

Written evidence from the Royal College of Surgeons

1. Introduction

- 1.1. This evidence sets out the Royal College of Surgeons' (RCS) view on the delivery of emergency care in England.
- 1.2. Patients requiring emergency surgical care are among the sickest in the NHS. These patients are often older and with significant medical problems; the risk of death or serious complication can be high. For this reason, managing emergency surgical patients in the safest and most efficient manner is vital.

2. Executive summary

- 2.1. Many of the most serious, life-threatening cases in A&E require surgical care so improving the provision of A&E, and emergency care more broadly, is crucial for the 1.2 million patients per year who require emergency surgical assessment or treatment.
- 2.2. There are a number of significant issues facing emergency surgery including: problems with care pathways for patients, waiting time targets and their impact on availability of hospital beds, provision of cover due to working time regulations, sufficient availability of generalist surgeons, and ensuring the payment system incentivises best practice.
- 2.3. Reconfiguration of emergency care is essential if patients are to be treated quickly and in the best setting. Consideration should be given to separating unplanned emergency and planned elective care in order to reduce cancellations and delays, achieve more predictable levels of work, and provide supervised training opportunities.
- 2.4. Where appropriate, major general surgical emergencies that require specialist treatment and facilities should be centralised, with patient assessment and less complex surgery delivered closer to patients' homes.
- 2.5. Commissioners and the Government need to urgently address the alternatives to A&E based within the community, in full consultation with patients and the local community.

3. Emergency surgical services in context

- 3.1. A&E attendances are rising. Comparing the first three quarters of 2012/13 to the same period in 2009/10, attendances have increased by 353,457 (+3.4%) in major ('type 1') A&E departments and by 829,995 (+5.3%) for all types of A&E departments.¹
- 3.2. Surgical assessment and treatment is an essential part of emergency care. The College of Emergency Medicine estimate that around 20% of A&E attendances require surgical opinion. Hospital Episode Statistics (HES) data on medical specialties

¹ <http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing>

for 2011/12 also shows that approximately a quarter² of surgical admissions are emergency cases. This equates to around 1.2 million admissions per year.

- 3.3. The most common reasons for an A&E attendance which leads to surgery or a surgical consultation are overwhelmingly for general surgery followed by orthopaedics. This is often for lower abdominal pain or injury to bones or joints.
- 3.4. General surgical emergency cases alone presently account for 14,000 admissions to intensive care – for conditions which are life-threatening and need constant monitoring and support – in England and Wales, this is estimated to cost approximately £88 million per year³. Emergency major gastrointestinal (GI) surgery (a form of general surgery) has one of the highest mortality rates due to the complexity of the surgery, which can reach over 50% in the over 80s.⁴ Better organisation of care should create an improvement in outcome for these patients.

4. The challenges facing emergency surgery

- 4.1. The ever growing pressure on A&E services has an impact on the whole hospital. The RCS is concerned that the current crisis in accident and emergency departments is directly hampering emergency surgical care, as patients who are inappropriately admitted to meet the A&E target are using hospital beds that are required by patients who require surgery in emergency theatres. Surgical patients who are admitted to any available bed can prevent consistent access to consultant-led care. It is only by tackling inappropriate emergency care admissions that the system will remain safe for patients and sustainable in the future.

The care pathway of patients

- 4.2. Services must be configured to help patients be seen by the most appropriate healthcare professional as quickly as possible following their initial contact with the health system. Studies show that mortality increases if patients have to wait longer.⁵ The current pathway of care for many surgical patients is not joined up between primary and secondary care, nor within the secondary care setting, with the potential for patients to be delayed in receiving necessary surgical consultation.
- 4.3. Triaging patients correctly in emergency and acute care is essential to ensure patients receive the right type of care as quickly as possible. At present, this process is variable across the country and we support guidance in this area by the College of Emergency Medicine⁶, which sets out how triage should work in practice.

² This is based on combining HES data on general surgery; urology; trauma and orthopaedics; ear, nose and throat; oral surgery; oral and maxillo facial surgery; neurosurgery; plastic surgery; cardiothoracic surgery; and paediatric surgery.

³ Intensive Care National Audit & Research Centre (ICNARC), London 2010. Data derived from Case Mix Programme Database based on 170,105 admissions to 185 adult, general critical care units in NHS hospitals across England, Wales and Northern Ireland.

⁴ Cullinane M, Gray AJ, Hargraves CM *et al.* The 2003 Report of the national Confidential Enquiry into Peri-Operative Deaths. London: NCEPOD; 2003.

⁵ http://www.acutemedicine.org.uk/index.php?option=com_content&view=article&id=110:as-waiting-times-increase-death-rates-rise&catid=76:press-releases&Itemid=83

⁶ College of Emergency Medicine. Triage position statement. April 2011.

Waiting time targets

- 4.4. The pressure on hospitals to meet waiting time targets for both A&E admissions and for elective surgery is in some hospitals delivering a chaotic system in which patients are unable to be treated in a timely manner or according to their clinical need. Time-limited targets that exist for treatment in A&E can result in inappropriate admissions to hospital. For example, some patients are being admitted to the nearest available bed to allow hospitals to say they have dealt with a patient within the target, even where this may not be clinically appropriate and may result in patients being sent to the wrong ward. This results in a lack of availability of beds for elective surgical patients and causes patients to be dispersed across the hospital leading to ineffective, inefficient and often, unsafe care. This view was recently echoed by the Royal College of Nursing⁷.

Staff availability

- 4.5. The Academy of Medical Royal Colleges recently published standards for seven day consultant care which stated that 'inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway'. We do not believe this is consistently happening at present. In emergency care, this consultant review should be more frequent. For example, in emergency general surgery the College believes there should be a consultant review at least every 12 hours. The presence of a senior decision maker who is able to treat or supervise the treatment of patients can lead to quick decision making and better patient care.
- 4.6. The cost and requirements of working time regulations have also had a detrimental impact on the delivery of emergency surgical services as a whole. Not only have the number (or tiers) of surgeons available to deal with emergencies been reduced as a direct result of the lack of flexibility in working hours, but also the ability to provide continuity of care to patients has been eroded. Where the impact of the regulations has not been properly managed, trainees are now less experienced in dealing with emergencies.
- 4.7. The NHS also needs to examine what more it can do to motivate and support medical staff to work in A&E as part of their career. Many junior doctors are initially keen to work in A&E but find the pressure and intensity of work understandably difficult. According to the College of Emergency Medicine there continues to be a considerable shortage in the number of senior training posts filled for emergency medicine⁸. The profession and the NHS needs to look at developing an attractive career structure which encompasses a sizeable emergency workload with sufficient and supported elective practice.

Rewarding best practice

- 4.8. Monitor and NHS England should develop payment systems for the NHS to reward the delivery of care which incentivises doctors to treat patients in the most appropriate clinical setting and in the most effective way. Designing appropriate payment systems has significantly changed emergency orthopaedic surgery,

⁷ <http://www.bbc.co.uk/news/health-22269688>

⁸ <http://secure.collemergencymed.ac.uk/code/document.asp?!D=7030>

including hip fractures where hospitals were rewarded for treating patients within 48 hours of the hip fracture as part of best practice standards.

- 4.9. There also needs to be more active engagement between commissioners and surgeons about how cost effective and efficient solutions can be delivered. The College and Surgical Specialty Associations have also created a suite of NICE-accredited commissioning guides to assist commissioners in this regard. Our recent submission to the Health Select Committee's inquiry on the implementation of the Health Act sets out our views on how to improve joint clinician and commissioner working.

Availability of generalist surgeons

- 4.10. Advances in surgery have, in recent years, encouraged the development of a workforce that is increasingly focussed on delivering surgical care in specialist areas rather than dealing with a wider breadth of emergency surgery. A major challenge for the profession in training the next generation of surgeons is to ensure that there are adequate numbers of surgeons able to deal with patients requiring emergency surgery, such as lower risk abdominal surgery in local hospitals. This is an issue that primarily affects general surgery. The profession is seeking to address this imbalance through the surgical curricula. The NHS also needs to support and recognise the importance of generalist surgical care.

5. Reconfiguring emergency care

- 5.1. The RCS believes that emergency care needs to be reshaped (or reconfigured) to help provide care to patients in the most appropriate clinical setting and to improve the delivery of emergency care.

Separating elective and emergency care

- 5.2. The College believes that, when carefully planned and adequately resourced, the separation of unplanned emergency and planned elective services will improve the quality and safety of care delivered to patients. In our 2007 publication *Separating emergency and elective surgical care: recommendations for practice* we outline the benefits of separation and ways to implement such change. In particular we highlight that the use of dedicated beds, theatres and staff for either elective or emergency surgery can reduce cancellations and delays, achieve more predictable levels of work, and provide supervised training opportunities.

Reconfiguring emergency surgical care

- 5.3. The College believes that where possible, major general surgical emergencies that require specialist treatment and facilities should be centralised with patient assessment and less complex surgery delivered closer to patients' homes. Specialist centres should work in operational networks of local providers to support collaboration, common standards of care and good patient transfer arrangements, according to clinical need. The network will enable the patient to be treated at the most appropriate hospital depending on the complexity of the case and the resources available to treat. The interdependencies with supporting services include emergency medicine, medical gastroenterology, acute medicine and care of the elderly services, need to be considered.

- 5.4. In remote and rural areas a different solution will be required given the difficulties in transferring patients who require emergency treatment to specialist centres. This will mean a wider range of skills will be required in the local workforce.

Alternatives to A&E

- 5.5. It is vital that reshaping secondary care services is aligned with improvements in access to primary care. There is now a growing consensus that access to primary out-of-hours care in particular is poor, with patients frustrated at being unable to attend GP services in the evenings and at the weekends. While improving access to primary care may not directly reduce A&E admissions for surgical care, this should result in quicker diagnoses and a reduction in A&E attendances for other non-emergency cases. The Department of Health and NHS England must urgently review how to improve access to primary care and this may include greater use of GP services present within hospitals to reduce pressures on acute services.
- 5.6. It is also important for the names and functions of primary care services to be clear to the public. Patients have traditionally not understood the myriad of alternatives to A&E, such as 'urgent care centres', 'walk-in centres', 'minor injury units', 'out-of-hours doctors services', 'primary care assessment services' and 'community hospitals' but A&E is a term the public do understand. Clarity over the functions of each of these services is vital, combined with clear and consistent communications from the Government, commissioners, and primary and secondary care clinicians to the public, to ensure these options are navigable.

Consulting on change

- 5.7. Too often reorganisations result in patients and their carers or families being pushed to one side of the debate, their questions ignored or their approach labelled as Luddite by the health service. The public needs to be at the centre of the decision-making process. Where there are problems, these need to be addressed with honesty and proper debate, informed by facts. It is imperative that patients must be fully involved in changes to their local services.
- 5.8. Furthermore, local and national politicians can have an important bearing on any reorganisation. It is often the case that a natural reaction of the local community is to protect their local services. As discussed in the College's recent publication *Reshaping Surgical Services*, politicians should engage with the clinical case for reshaping as much as public concerns, and support solutions that improve patient treatment and care. Once a decision has been made, it should be implemented quickly as delays can affect future planning of services.⁹

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⁹ Royal College of Surgeons. *Reshaping Surgical Services: Principles for change*. January 2013.