November 2013

Royal College of Surgeons

House of Lords briefing

Briefing for short debate on what plans the Government has for the future of A&E units

Tuesday 26 November 2013

This briefing sets out the Royal College of Surgeons' eight recommendations on how to improve A&E services. Many of the most serious life-threatening cases in A&E require surgical care so improving emergency care is crucial for the 1.2m people a year who require emergency surgical assessment or treatment.

1. Make A&E training compulsory for surgical and many medical trainees

A&E units are understaffed by around 10% and as high as 43% in Barking, Havering and Redbridge University Hospitals NHS trust[1]. This is a serious issue. The NHS needs to examine what more it can do to motivate and support medical staff to work in A&E as part of their career.

As part of this, the RCS would like A&E training to become compulsory for all trainee surgeons, and for medical trainees if there is broad support for applying this beyond surgery. This could augment staff numbers in hospitals and encourage trainees to work in A&E at other stages of their career. We are reviewing how this would work in practice and recommend that the GMC review this proposal as a matter of urgency.

2. Reconfigure emergency care

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. We believe this would help to improve outcomes and the experience of care.

We therefore support NHS England's recent review of urgent and emergency services. Changing the shape of services is inevitable; what matters is not where, but how you are treated. The surgical profession will do all it can to help solve this overwhelming problem.

[1] http://www.bbc.co.uk/news/health-23971709

For further information on any of the issues in this briefing please contact Patrick Leahy, Head of Public Affairs, on 020 7869 6041 or pleahy@rcseng.ac.uk

3. Separate elective and emergency care

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. 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. This happens in some trusts already, but is not universal across the NHS.

4. Surgeons need to help out in A&E this winter

While NHS England's review is welcome, many of its recommendations will take time to implement. To help tackle immediate pressures, the RCS has asked its members to contact their medical or clinical directors to ask what more they can do in A&E this winter. We will also speak with other national organisations to look at how we can support surgeons to help out in emergency units.

5. Support more generalist surgeons

Advances in surgery have encouraged the development of a workforce that is increasingly focused on delivering surgical care in specialist areas rather than dealing with a wider breadth of emergency surgery. However, there need to be adequate numbers of surgeons able to deal with patients requiring emergency surgery such as lower risk abdominal surgery in local hospitals. The profession is seeking to address this imbalance through the surgical curricula.

6. Improve the alternatives to A&E

We agree with NHS England that we need to do more to support alternatives to A&E. NHS England's review should prompt a broader strategy about how to improve primary care. 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.

It is also important for the names and functions of primary care services to be clear to the public. According to NHS England, there are 27 different names for urgent care centres. These need to be standardised.

7. Increase the frequency of consultant review of patients, seven days-a-week

The Academy of Medical Royal Colleges recently published standards for seven-day consultant care (chaired by our President) which stated that 'inpatients should be reviewed by an on-site consultant at least one every 24 hours seven days a week unless it has been determined it will not affect the patients pathway'. This is not 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. This can improve patient care and free up capacity in a hospital.

8. Reward best practice

The tariff in the NHS (a list of prices trusts receive for procedures and treatment) currently rewards elective care but does not fully reimburse the costs of emergency care. This needs to be reviewed by NHS England and Monitor to better incentivise emergency care.