July 2015

Royal College of Surgeons

Briefing

RCS ADVANCING SURGICAL STANDARDS

Priorities for a New Government

How we can support high quality surgical care

In our drive to improve surgical care the Royal College of Surgeons broadly supports the vision set out in the NHS Five Year Forward View. Its delivery and focus on preventing ill-health must remain a priority in this Parliament as set out in the Government's first Queen's Speech. It is right that the Secretary of State has made his top priority improving primary and community care, alongside moves towards seven-day NHS care.

However, reform in the community needs to happen in conjunction with reform to hospital care to benefit those patients that will always require treatment in acute settings. Ongoing attention must be given to the NHS' workforce and training needs; along with a focus on research, which is fundamental to improving surgical outcomes through innovation and demonstrating the evidence base for treatment. Numerous studies show reform is best driven from within the health service.[1] Nevertheless, there are a number of actions a new Government can take to support surgical care which we outline below.

As a College, we also support international surgical care through education, training, standard setting, and research. Five billion people[2] around the world are unable to access safe surgery when needed, and we urge the Government to support us to promote global surgical care.

1. Implement sustainable seven-day care in the NHS

The issue: Mortality and complication rates are significantly higher for patients admitted on Fridays and at the weekend. A number of studies have shown that people are less likely to receive prompt treatment and more likely to die if they are admitted to a hospital at the weekend. We welcome the Prime Minister's indication this will be an early priority for the new Government.

The NHS must deliver the same standards of care, seven days a week. Seven-day hospital care must also be consultant-led to ensure timely intervention and better outcomes for acutely unwell patients. We stress this is not about making staff in the NHS work seven days a week, but rather changing the way they work across the week by, for example, altering rotas and shift patterns. There are a number of

[1] See *The King's Fund* (2014) *Reforming the NHS from within*

[2] http://www.surgeons.org/news/surgical-colleges-support-the-lancet-commission-on-global-surgery/

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barriers preventing this from happening, particularly contractual negotiations and cost.

Given the current and likely future financial environment, the NHS will need to rationalise services to ensure there is sufficient senior, trained staff cover and ensure the maximum use of scarce resources. This will require some services to reconfigure. We must also ensure there is seven-day access to key services and facilities in hospitals – like pharmacy, radiology, physiotherapy, and community support for the next steps in a patient's treatment. Any cost savings associated with seven-day care (such as fewer complications and quicker discharge) will inevitably be balanced by a financial impact for providing the same quality of care every day of the week.

Recommendations:

- To aid NHS planning, the Government or NHS England should commission in-depth financial modelling of the anticipated cost of seven-day services and skills shortages.
- Politicians should not oppose any service changes which are evidence based, have been consulted on, and are required to support seven-day services.
- The Government with NHS Employers should continue to review how NHS staff contracts can be improved to support equality of care over the week.

2. Prioritise improvements to urgent and emergency care

The issue: The few audits existing for emergency surgery suggest there is wide variation in mortality rates. The UK Emergency Laparatomy Network found that mortality following emergency laparotomies varied from 3.6% to 41.7% across 35 hospitals[3]. Emergency surgical services are being affected by pressures experienced across the rest of emergency care such as increasing numbers of people attending emergency departments, increasing admissions, inpatient bed availability, staffing pressures, and the increasing number of older people with frailty being admitted to hospitals who have prolonged lengths of stay.

Monitor and NHS England have been slow to reform the tariff for urgent and emergency care. Evidence from the College's members and other organisations suggests hospitals are currently cross-subsidising emergency work with payment received for elective care.

Recommendations:

- The Government should support NHS England's ongoing review of urgent and emergency care. In its first mandate, the Government should be clear that improving the urgent and emergency care system should be a top priority for the NHS. As part of this, NHS England and Monitor should be asked to hasten their review of the tariff for urgent and emergency care.
- The Department of Health, through its national audit programme, should urgently review the audits that exist in emergency care with a view to commissioning new audits to support transparency in outcomes.
- Health Education England (HEE) should be asked to continue to prioritise the design and implementation of an attractive training

[3] D. I. Saunders et al. (2012) Variations in mortality after emergency laparotomy: the first report of the UK Emergency Laparotomy Network. British Journal of Anaesthesia 109 (3): 368–75.

structure for emergency medicine and surgery with career development opportunities. We would be pleased to continue working with HEE on this issue.

3. Reform training and education

The issue: The independent Shape of Training review, (October 2013) made 19 recommendations for changes in medical training to help meet the needs of patients, society and the NHS in the future. In particular it recommended a longer period of more generalised medical training after medical school. This provides an opportunity to focus and improve the quality of medical education and training to meet the needs of patients.

Recommendations:

- As part of the Shape of Training review, we are keen to work with the Government and relevant agencies to review the role of the wider surgical and medical team.
- The Government and Health Education England should avoid a 'one size fits all' approach to medical training. Medical and surgical specialties should be allowed to tailor the way they implement the review's recommendations and the medical professions must be fully engaged with leading development and implementation of any proposals for change.
- Any design of postgraduate training must address the availability of time for training by reducing the reliance on trainees to deliver service and by looking at the role of the wider surgical team.
- Changes to training will need to attract more doctors to careers in emergency and trauma surgery, and to encourage more women to develop sustainable careers in those specialties where they are currently grossly underrepresented. They will also need to allow time for training in research to facilitate high-quality innovation in the NHS.
- The changes should do more to support doctors who wish to develop more specialised competencies ('credentials'), in particular specialist practice, and link these to the needs of the service and patients.
- The Government should introduce a national undergraduate curriculum and national examination in undergraduate training. This must include more focused delivery of surgical teaching.

4. Improve data and transparency

The issue: The College believes improving transparency of outcomes will help to drive improvements in surgery.

Better collection and sharing of patient data is important for improving quality in the health service. A survey of RCS members conducted in 2014 found that improvements in communication and information sharing between medical professionals and different services were key in helping to improve the co-ordination of patient care.

Recommendations:

- Electronic patient records should be rolled out across England as soon as possible, providing relevant concerns about confidentiality are addressed. Patients should also be given the right to access their records. This will help NHS staff to be aware of a patient's history and their preferences for care.
- The Department of Health and NHS England should commission more audits in

emergency surgery with associated quality improvement programmes.

- The Government should continue to support the publication of surgeons' outcomes data. There needs to be greater focus on improving the existing collection of data with more relevant indicators and unit data. This initiative must be led by the profession rather than central Government to provide public and professional confidence in any published data.

- The Government and NHS England should mandate the collection of data of surgeons and anaesthetists involved in an operation to reflect the role of the broader team in delivering surgical care. At present only data for the admitting surgeon is collected in Hospital Episodes Statistics.

5. Promote innovation and research

The issue: Clinical research and the development of new operative techniques extends the frontiers of surgery and directly improves patient care. Funding for surgical research has increased in recent years and should continue. Our report *From Innovation to Adoption* showed a need for government to facilitate research and innovation in the NHS.

Recommendations:

- In its first mandate to NHS England, the Government should ask the body to work in partnership with NICE and other stakeholders including the RCS to develop a horizon-scanning process. This must identify and review promising new surgical procedures and its evidence to support widespread use in the NHS.

- In order to promote a research-active culture in the NHS, Government should maintain investment in the National Institute for Health Research (NIHR), and ensure that funds are made available for research infrastructure and overhead costs.

- The Government should ask Monitor and NHS England to examine how else the tariff can support development training and education for new surgical procedures.

- The College would not support reintroducing the Medical Innovation Bill into Parliament based on its wording in the 2014/15 Parliament.

6. Support joint working between the NHS and social care – particularly for older people

Integrated care is important for surgical patients, especially for frail older patients with multiple conditions. For example, effective transfer from hospital to other services requires good relationships between hospitals and primary, community, and social care. It is right that the *Five Year Forward View* is focused on blurring the old boundaries between different services. Patients need different services to work together for their care so they are treated in the right place.

As part of this drive, the Government has announced it intends to devolve decision-making on health and social care to Manchester and potentially other cities. This is set to include greater joint working and potentially a merged budget for health and social care. Many decisions are best taken at a local level, but it is important that any new bodies do not ignore wider national plans including around education and training, national reconfigurations, and research.

Recommendations:

In the College's view, devolving powers to cities should adhere to a number of principles:

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- Set out the role health professionals could play. We believe clinical commissioning groups (CCGs) have benefited from clinical involvement in commissioning decisions and this should be maintained. Clinical involvement also improves public confidence in commissioning decisions – polling by Ipsos MORI has shown that 88% of the public trust doctors to 'tell the truth'.

- Maintain support for research (including appropriate funding) and education and training of health professionals.

- New commissioning arrangements must be collaborative; not just between health and social care, but across the patient pathway between specialist and generalist care.

- New decision-making processes should be transparent, particularly to avoid politicised decisions where there is greater involvement of local politicians.

- Any plans to merge health and social care budgets must set out how spending on health will be maintained.

While integrating care is important for older people, there is also evidence that older people have varied access to surgery. Our report *Access all Ages* found wide variation in rates of surgery among older people across England. This suggests some older people are being counselled against or denied surgery despite potentially being healthy enough to undergo an operation. Cancer Research UK is also concerned about older people's access to cancer surgery following similar findings they published last year. We therefore recommend:

- Through the mandate to NHS England, the Government should ask CCGs to review whether older people are getting sufficient access to surgical services in their area and to set out how they will take any action to address concerns identified.

7. Revise restricted hours working (EWTD and regulations in the "New Deal")

The issue: A wide range of stakeholders have recognised the impact the European Working Time Directive (EWTD) imposed, on top of the New Deal, on the NHS. In 2014, the independent EWTD Taskforce (which included professional bodies, patients, trainee doctors, and the British Medical Association) argued that while there have been benefits including a reduction in fatigue, the Directive as applied in the UK has had an adverse impact on the training of certain medical specialties including surgery. The rules, along with the associated court judgments stipulating when rest periods must be taken, have introduced an inflexibility into working patterns on wards which has impacted on the quality of training for some doctors, and continuity of patient care.

Recommendations:

- The European Commission is currently reviewing whether to amend the EWTD, and is due to publish proposals in 2016. As part of its discussions with the Commission and its European counterparts, at a minimum we would like the UK Government to support greater flexibility in the EWTD rules by addressing the impact of SiMAP/Jaeger judgements. We support maintaining individuals' right to opt out of the EWTD.

- Following the EWTD Taskforce, HEE has set up a working group to examine the challenges set by the taskforce around the definitions of work and training. In its first mandate to HEE, the Government should ask the body to continue this work.

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- The rest requirements and pay banding supplements in the New Deal should be relaxed in future contractual arrangements.

8. Reform professional regulation and protect people undergoing cosmetic surgery[4]

The issue: The surgical and dental professions continue to be regulated under the provisions of legislation (primarily the Medical Act 1983 and the Dentists' Act 1984) which has failed to keep pace with the significant changes that have affected healthcare in recent decades.

Nowhere is this more evident than in the case of cosmetic surgery, a multi-million pound industry in the UK. Any doctor (including non-surgeons) can currently practise cosmetic surgery without having a surgical qualification. We believe this poses patient quality and safety risks. The College is setting training standards, as well as improving information available to patients, aiming to ensure only those with the appropriate skills and experience undertake cosmetic surgery. In addition, politicians and the public will be well aware of the PIP breast implant failures, with ruptured implants causing scar tissue and pain and inflammation. This was a failure of manufacturing regulation and post implantation surveillance compounded by unregulated professional practice.

To avoid public confusion the College would also like to see the protection of the title 'surgeon' and other relevant dental titles. The College's Patient Liaison Group commissioned an opinion poll in June 2012. This indicated that 95% of the public believed someone using the title 'surgeon' would have a medical degree, and 92% thought that use of the job title 'surgeon' should be restricted by law. However, existing legal provisions in the Medical Act 1983 on the title 'surgeon' have been difficult to enforce and need to be more clearly worded.

Recommendations:

- The Government should introduce primary legislation to update the regulation of healthcare professionals especially to protect people undergoing cosmetic surgery. This will require significant Parliamentary time but as this is a current patient quality and safety issue it should be included in the next Queen's Speech.
- In 2014 the Law Commissions' published their review of professional regulation and drafted legislation which we broadly support. This provides template legislation, the aims of which should be to:
    - Give the GMC and General Dental Council (GDC) the power to annotate their register to indicate specialisms and other qualifications on the registers, including recognising RCS-approved qualifications in cosmetic surgery. In the summer the GMC will also consult on whether a certificate of practice in cosmetic surgery should be mandatory and the outcome of this consultation should be borne in mind by legislators.
    - Clarify and strengthen the protection of surgical and dental professional titles for the protection of the public.

[4] Cosmetic surgery is where a person chooses to undergo an operation, or invasive medical procedure, to alter their physical appearance for aesthetic rather than medical reasons.

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