September 2014

Royal College of Surgeons

Emergency surgery policy briefing

RCS ADVANCING SURGICAL STANDARDS

Emergency surgery

This briefing sets out the main challenges facing emergency surgery, and the high-level actions the Government and other policy-makers can take to support patients who require emergency surgical care.

What is emergency surgery?

Emergency surgery is carried out when a patient is at immediate risk of permanent disability or death. Patients with some of the most life-threatening illnesses and injuries rely on the immediate expertise of emergency surgical teams.

- 1.2 million patients require emergency surgical assessment or treatment each year[1]
- Approximately 25% of all surgical hospital admissions in 2012-13 were emergency admissions[2]
- The highest proportion of emergency surgical care is for general surgery (around 40%), followed by trauma and orthopaedic surgery (32%), then urological surgery (9%)[3]
- Advanced age and multiple conditions are common in patients requiring emergency surgery[4]
- Around 80% of all surgical mortality arises from emergency surgical intervention[5]
- The mortality rates for some emergency surgical patients are high with wide variations across the country and at different times of the week
- For emergency surgical patients, timely access to investigation, diagnosis and treatment is essential as delays can lead to increased mortality.

What are the problems facing emergency surgery?

Wide variation in mortality rates

Of the few audits that exist for emergency surgery, the findings suggest there is wide variation in mortality rates. The UK Emergency Laparotomy Network found that mortality following emergency laparotomies varied from 3.6% to 41.7% across 35 hospitals[6].

Clinical audits can play an important role in comparing clinical outcomes across services and driving up standards. In 2012 approximately 3,500 surgeons across nine surgical specialties achieved a world first by publishing their individual surgical results. However, the majority of outcomes measures used in the NHS have focused on elective rather than emergency care. Extending this focus to emergency care would enable units and hospitals to benchmark their performance against others in the region and the country.

There is also a need for more clinical and

commissioning standards for emergency surgery and emergency medicine more broadly, where the focus has also been on elective care.

Pressure on emergency services

Emergency surgical services are equally affected by the 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 an increasing number of frail older people being admitted to hospitals – who often need to stay longer in hospital. These issues have already been set out by other organisations including the College of Emergency Medicine.

In emergency surgery, prompt assessment, diagnosis and treatment are essential. Delays can result in increased mortality, complications, poor outcomes and negative experience for patients. This impact is felt beyond the emergency department; delays in emergency surgery can also affect patients undergoing planned surgery, for example, when planned operations are cancelled to free up medical staff for emergency work.

Admission and discharge

A&E departments have experienced a 3% annual increase in attendances.[7] The increased demand for emergency care has significant implications for emergency surgical services. A range of factors, including rising acuity, insufficient alternatives to admission, such as acute clinics or community nursing care, and a lack of consultants able to assess patients – whose experiences means they are less likely to admit patients who could be treated elsewhere – means that increasing numbers of patients are being admitted to hospital.

The rising number of hospital admissions, combined with insufficient bed capacity and insufficient access to operating theatres means that patients requiring emergency surgical care are forced to wait longer to be treated.

It is also important that patients are given all the information they need, in a format that they can understand, when they are discharged from hospital. This includes advice about self-care and the alternatives to A&E.

Readmission processes are unsatisfactory in some hospitals

Following emergency surgery, readmission processes in some hospitals are currently inadequate. Across emergency care, the emergency readmission rate (readmission to hospital within 28 days of discharge) was 11.45% in 2011/12, an increase of 27.1% since 2002/03.[8] No patient wants to have to return to hospital unnecessarily and more needs to be done to reduce this rate – largely through raising standards of care. When patients do need to be readmitted, they are not always able to return directly to the surgical team that treated them, and are forced to access help via emergency departments. This places additional pressure on emergency departments and does not make the most efficient use of resources.

Patients' needs are changing

Advanced age is common in patients requiring emergency surgery; older patients make up over 75% of trauma admissions. Older patients are also more likely to have additional personal or clinical needs in combination with their surgical needs, but in emergency situations there can be less time to take multiple conditions into account, which can significantly affect morbidity and mortality.[9]

Emergency surgical teams are therefore working increasingly in collaboration with other medical specialties and community-based health care services. It is a cause for celebration that patients are living longer, but the health service has not fully adapted to this demographic shift. Timely discharge of older patients is a particular challenge, due in part to insufficient community

and social care support.

Insufficient numbers of surgeons working in emergency surgery

Advances in surgery have encouraged the development of a workforce which is increasingly focused on delivering surgical care in specialist areas rather than the wider breadth of emergency surgery. Some specialisation is welcome – specialists who focus on particular procedures have helped to reduce mortality rates – but the NHS also needs more generalists who are able to deliver emergency surgical care.

The reduction in the number of consultants available to carry out unplanned surgical care has put increased pressure on trainee doctors who are working under less supervision. This, combined with the demanding on-call arrangements and pressures in emergency departments, has led to a negative perception of emergency surgery and emergency medicine more generally among trainees. For example, there were 135 higher trainee ST4 emergency medicine posts available in England during the second round of recruitment in 2012, of which only 25 posts (18.5%) were filled.[10]

We welcome the recent announcement that in 2014 the number of trainee doctors joining A&E departments has increased to its highest level ever, as a result of the increased funding and new initiatives that Health Education England and others have introduced to attract trainees to emergency work. In order to ensure that the NHS can continue to meet the needs of patients who require emergency surgery, sufficient numbers of trainee surgeons must be recruited to work in NHS trusts.

The implementation of the European Working Time Directive has also had negative consequences for the delivery of emergency surgical services and these have been set out by the College elsewhere.

There is also insufficient access to diagnostic and support services in hospital, seven days-a-week. These services are essential for facilitating rapid and appropriate decision-making, and avoiding delays in discharge.

Inappropriate system design and payment

The existing model of the district general hospital is not able to deal with all eventualities in emergency surgery. Many district general hospitals have limited resources and may not have the same access to diagnostic tests as specialist centres. The RCS, and others such as the King's Fund[11], have argued that emergency care needs to be reconfigured to help provide care in the most appropriate clinical setting to improve outcomes. Where possible, major general surgical emergencies that require specialist treatment and facilities should be centralised and patient assessment and less complex surgery delivered closer to home.

Evidence from our members and other organisations suggests hospitals are forced to cross-subsidise emergency work with payment received for elective care, due to the shortfall in tariff funding for emergency procedures. In part this is due to Monitor's 30% 'marginal tariff' which sets a baseline value for income from emergency admissions for each provider, based on 2008/09 admission levels. For emergencies above this baseline, providers receive 30% of the normal price and the remaining 70% is retained by clinical commissioning groups to help fund alternatives to A&E. However there is mixed evidence about whether investment in alternatives is actually happening in practice[12,13], and patients continue to turn to emergency departments.

Information sharing is often poor

In some hospitals, surgeons struggle to access all the information they need about patients requiring emergency surgery, for example, about multiple

conditions, personal wishes or communication needs. Effective and timely sharing of relevant clinical data is central to prompt diagnosis, treatment and discharge, but information sharing between GPs, primary care and hospital specialties, is currently insufficient.

There is particular scope for improvements to information sharing between surgical teams and GPs. NHS England has argued that more timely communication between specialists and GPs improves health outcomes and patient satisfaction.[14] Better information sharing between GPs and surgical teams can make surgeons aware of any additional needs patients in their care may have, and allows GPs to seek specialist advice once a patient has been discharged after surgery.

Recommendations for improving emergency surgery

In July 2014 the RCS, College of Emergency Medicine and other medical royal colleges published a report setting out 13 recommendations on how to build an urgent and emergency care system that is sustainable and resilient.[15] While action needs to be taken to improve urgent and emergency care more broadly, the recommendations below focus on the specific actions that the Government and other policy-makers can take to support emergency surgical patients.

Later in the year the College will be building on this policy briefing by carrying out an in-depth review, in collaboration with the relevant Surgical Specialty Associations, Joint Committee on Surgical Training and the Specialist Advisory Committees, on the sustainability of trauma services, and in particular on supporting the development of surgeons who will lead and develop major trauma services in England.

System design

- Through its work on urgent and emergency care, NHS England should encourage the separation of elective and emergency surgery work as far as possible. This can reduce delays to treatment and is already the case in trauma and orthopaedic surgery and neurosurgery. While emergency lists should be separated from elective lists, they should not be separated by geographical location unless patients undergoing both emergency and elective surgical care have access to a sufficiently trained workforce and diagnostic and support services. The Department of Health, NHS England and the devolved administrations should work with the RCS and the Surgical Specialty Associations to encourage all hospitals and specialties to adopt this approach.

- Specialist centres should work in operational networks to enable local providers to support collaboration, share common standards of care and operate good patient transfer arrangements according to clinical need. The RCS is pleased that in its review of urgent and emergency care services, NHS England has committed to developing emergency care networks, building on the success of trauma networks.

- NHS England's urgent and emergency care review should prompt a broader strategy about how to improve primary and community care. While improving access to primary care may not directly reduce A&E admissions for surgical care, it should result in quicker diagnoses and a reduction in A&E attendances for other non-emergency cases. Outpatient services can relieve some of the strain on A&E departments. In some hospitals, consultants are able to refer patients to appointments at outpatient clinics, where they can be treated along the most clinically appropriate pathway. It is also important for the names and functions of primary and community care services to be standardised and clear to the public.

- Monitor and NHS England need to accelerate their review of the tariff for urgent and emergency care. The 30% marginal rate should

be abolished.

Workforce

- Health Education England needs to continue to work with the relevant royal colleges and professional bodies to review how to create an attractive career structure for emergency medicine including emergency surgery.

- A&E training for all trainee surgeons, and potentially other medical professionals, should be reintroduced. The Joint Committee on Surgical Training should review where this best sits in the surgical curriculum. The present Shape of Training review should consider this recommendation as part of its ongoing work.

- The recommendations of the Taskforce on the European Working Time Directive need to be implemented as quickly as possible.

- While emergency surgery is already provided seven days a week in the NHS, this needs to apply across all services necessary to support urgent and emergency surgical treatment. Ahead of the 2015 general election, all political parties should commit to pursuing seven-day services in the NHS.

Data, standards and guidance

- NHS England and the surgical community should publish further audit data for emergency surgical procedures to monitor and improve mortality rates. Outcomes data need to factor in the complexity of surgery, the nature of team working, and the time, resources and critical interdependencies required to deliver the service.

- There is a need for more clinical (NICE) and commissioning standards for emergency surgery and emergency medicine more broadly. NHS England and NICE should prioritise publishing clinical standards and commissioning guidance for emergency care. The RCS and the Association of Surgeons of Great Britain and Ireland (ASGBI) have developed a commissioning guide for emergency general surgery through our national surgical commissioning centre, which was published in April 2014. This should be implemented by commissioners and providers. As part of our future work in this area we will review whether best care pathways should be developed for common emergency surgical conditions, in collaboration with the Surgical Speciality Associations.

Delivering patient-centred, coordinated treatment and care

- It is essential that every patient is provided with information about which consultant is responsible for their care, and how they can be contacted. Emergency surgical services should have a system in place for communicating the name of the responsible consultant to patients, both on admission and at every change of consultant responsibility.

- On discharge, all patients should receive a copy of their discharge summary and a rehabilitation prescription, which should document therapy requirements, follow up arrangements and information about how to contact the treating team if problems arise. Patient who need to be readmitted following surgery should be able to rapidly return to the surgical unit where they were treated, rather than go through emergency services first.

- Enhanced recovery programmes for elective and emergency surgery should be rolled out through financial incentives, such as Commissioning for Quality and Innovation (CQUIN) payments. We believe NHS England, working with the RCS, should take the lead on promoting this.

- There is considerable scope for improved communication between surgical specialists and GPs. Some hospitals operate their own

email accounts or phone numbers, via which GPs can contact them directly should they have concerns or questions about a patient who has recently received surgical treatment.

- Emergency surgical care for older people should be improved through the use of Comprehensive Geriatric Assessments carried out by multi-disciplinary teams to ensure additional needs are fed into a person's discharge planning. Joint care pathways shared between surgical teams and physicians specialising in care of the elderly can facilitate general medical care, rehabilitation and social care in the community.

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[1] Based on combining 2012-13 Hospital Episode Statistics data on general surgery; urology; trauma and orthopaedics; ear, nose and throat; oral and maxillo facial surgery; neurosurgery; plastic surgery; cardiothoracic surgery;
[2] Ibid.
[3] HC Deb, 6 January 2014, c152W.
[4] Emergency Surgery: Standards for Unscheduled Care, Royal College of Surgeons. 2011.
[5] Ibid.
[6] 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.
[7] Emergency Care and Emergency Services 2013 View from the frontline. Foundation Trust Network. 2013.
[8] Hospital Episode Statistics, emergency readmissions to hospital within 28 days of discharge – Financial year 2011/12, published 05 December 2013.
[9] 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.
[10] HC Deb, 26 November 2013, c273W.
[11] Transforming the delivery of health and social care, The case for fundamental change. The King's Fund. 2012.
[12] Urgent and Emergency Services. House of Commons Health Select Committee. 2013.
[13] Monitor and NHS England's review of the marginal rate rule. Monitor and NHS England. October 2013.
[14] Transforming urgent and emergency care services in England Urgent and Emergency Review End of Phase 1 Report: High quality care for all, for now and for future generations. NHS England. November 2013.
[15] Acute and emergency care – prescribing the remedy. College of Emergency Medicine, Royal College of Physicians, Royal College of Paediatrics and Child Health and Royal College of Surgeons. July 2014.