Item 7: Interim Centralisation of High Risk and Emergency General Surgery at Kent and Canterbury Hospital

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 June 2014

Subject: Interim Centralisation of High Risk and Emergency General Surgery at Kent and Canterbury Hospital

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by East Kent Hospitals University NHS Foundation Trust.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) The Health Overview and Scrutiny Committee considered the development of East Kent Hospital University Foundation Trust's (EKHUFT) clinical strategy on three occasions. These were:

- 3 February 2012
- 12 October 2012
- 7 June 2013

(b) A number of 'key drivers for change' behind their clinical strategy review were identified by the Trust and this report provides additional information on Emergency Surgery Standards.

2. Emergency Surgery Standards

(a) In previous reports submitted to the HOSC, EKHUFT identified two publications as being key policy and service drivers underpinning the clinical strategy review.

(b) The first publication identified is a report by the Association of Surgeons for Great Britain and Ireland (ASGBI), *Emergency general Surgery: The Future.* This 'Consensus Statement' was produced as a result of a conference in February 2007. Some of the main points made in the conclusion are as follows:

- There is wide variation in the quality of emergency general surgery (EGS).
- EGS is one of the most common reasons for admission to a surgical bed in Britain.
- All Trusts which receive emergency general surgical admissions should have a named surgeon responsible for the clinical leadership of this service.

- Emergency admissions should have dedicated resources and senior surgical personnel readily available.
- There must be a clear and identifiable separation of delivery of emergency and elective care.
- Timely access to diagnostic services (particularly radiology), interventional radiology and emergency theatre time is necessary.
- The assessment, prioritisation and management of emergency general surgical patients should be the responsibility of accredited General Surgeons.
- The largest component of the emergency general surgical case-mix is gastrointestinal.
- ASGBI recognises the case for regional trauma centres.
- It is clear from trends within the specialty and training that separation of vascular surgery from general surgical practice in the UK is inevitable. Similar arguments apply to breast surgeons.

(c) In a later document, *Issues in Professional Practice, Emergency General Surgery*, the following explanation of the term 'general surgery' is provided:

"General surgery is a historical term, the spread of which currently includes gastro-intestinal surgery, endocrine surgery, torso trauma and hernia surgery. In some hospitals, breast, transplant and vascular surgeons still undertake some general surgery and may contribute to EGS, although these disciplines are increasingly separate. This separation has been driven by a desire for improved outcomes through specialisation, although neither the provision of specialist on-call cover nor the impact of withdrawal of manpower from EGS has been cleanly resolved."

(d) The other publication is the Royal College of Surgeons of England produced document *Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners*. This had the aim of providing information and standards on emergency surgical service provision for both adult and paediatric patients. This was published in February 2011.

(e) The report explains that an emergency surgical service is not one that simply operates out of hours. Instead, six elements are outlined:

1. Undertaking emergency operations at any time, day or night.

2. The provision of ongoing clinical care to post-operative patients and other inpatients being managed non-operatively, including emergency patients and elective patients who develop complications.

3. Undertaking further operations for patients who have recently undergone surgery (i.e. either planned procedures or unplanned 'returns to theatre').

4. The provision of assessment and advice for patients referred from other areas of the hospital (including the emergency department) and from general practitioners. For regional services this may include supporting other hospitals in the network.

5. Early, effective and continuous acute pain management.

6. Communication with patients and family members/others providing support.

(f) For most surgical specialties, providing emergency surgical care works out to around 40-50% of the workload. This varies according to the speciality; for example, in neurosurgery over half the admissions are non-elective and account for 70-80% of the workload.

(g) A number of reasons for changing the way emergency surgical care is delivered are given:

- "Patients requiring emergency surgery are among the sickest treated in the NHS.

- Outcome measurement in emergency surgery is currently poor and needs to be developed further.

- Current data show significant cause for concern – morbidity and mortality rates for England and Wales compare unfavourably with international results.

- It is estimated that around 80% of surgical mortality arises from unplanned/emergency surgical intervention.

- The NHS has to reduce its costs significantly over the coming years – savings can only be delivered sustainably through the provision of high quality and efficient services. The higher complication rate and poorly defined care pathways in emergency surgery (when compared to elective surgery) offer much greater scope for improvement in care and associated cost savings.

- The reduction in working hours for doctors and the focus on elective surgical care has changed the level of experience and expertise of trainees when dealing with acutely ill surgical patients.

- Patients expect consultants to be involved in their care throughout the patient pathway.

- Evidence from a survey of general surgeons indicated that only 55% felt that they were able to care well for their emergency patients.

- At least 40% of consultant general surgeons report poor access to theatre for emergency cases."

(h) The report is not prescriptive as to which model of care should be adopted, and the bulk of the report consists of describing the standards underpinning unscheduled surgical care applying to both paediatric and adult patients.

(i) A subsequent publication, *Emergency General Surgery* published by the Royal College of Surgeons (RCS) and the Association of Surgeons of Great Britain and Ireland (ASGBI) in August 2013 set out proposals to improve the care provided to emergency general surgery patients. The RCS and ASGBI recommend that:

- "NHS England should establish a strategic clinical network for emergency general surgery to oversee the delivery of safe and efficient care.

- Best practice tariffs should be developed to reward the delivery of high quality emergency general surgical services.

- Surgical treatment of acutely ill patients must take priority over planned, elective surgery when necessary.

- Services must be consultant-led and senior doctors must be involved throughout the patient's care. The seniority of the surgeon involved in the operation must match the clinical need of the patient.

- There should be a greater focus on the outcomes of care, with improved resources for audit and review of practice. Outcomes should be in the public domain".

3. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report from East Kent Hospitals NHS University Foundation Trust.

Background Documents

Agenda, Health Overview and Scrutiny Committee 3 February 2012, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3977&Ver=4

Agenda, Health Overview and Scrutiny Committee 12 October 2012, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3983&Ver=4

Agenda, Health Overview and Scrutiny Committee, 7 June 2013
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5073&Ver=4

Association of Surgeons of Great Britain and Ireland, *Emergency General Surgery: The Future*, February 2007
http://www.asgbi.org.uk/en/publications/consensus_statements.cfm

Association of Surgeons of Great Britain and Ireland, *Issues in Professional Practice, Emergency General Surgery*, May 2012
http://www.asgbi.org.uk/en/publications/issues_in_professional_practice.cfm

Royal College of Surgeons of England, *Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners*, February 2011,
http://www.rcseng.ac.uk/publications/docs/emergency-surgery-standards-for-unscheduled-care

Royal College of Surgeons and Association of Surgeons of Great Britain and Ireland, *Emergency General Surgery*, August 2013
http://www.rcseng.ac.uk/healthcare-bodies/docs/emergency_general_surgery.pdf

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