Royal College of Surgeons of England
IN NORTHERN IRELAND

THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

Our date 8 April 2023
Joint Royal College of Surgeons of England and Royal College of Surgeons of Edinburgh response to SWAH consultation with connected resources here.

Deadline for responses 10 April 2023

Summary: This document reflects the views of the Royal College of Surgeons of England and Royal College of Surgeons of Edinburgh. In the main our responses reiterate the benefits of centralised services, highlight the changing nature of surgery/surgeon profiles and the importance of patient safety within the context of a long term and realistic workforce plan that ensures the sustainability of several surgical services, both elective and emergency.

We also make a strong call for the development of managed clinical networks of care**,** as referenced within the Department of Health's 2022 Review of General Surgery, to ensure equitable access to high quality care both in emergency and elective settings.

These networks of surgical care are interconnected systems of service providers that allow for collaborative working, clear routes of communication, sharing of resources, and development of common standards of care across the network with agreed thresholds for patient transfer for elective and emergency surgery.

Such networks can help sustain the local delivery of safe services, as they support a whole-team approach in planning for the care of patients in emergencies. They can help with succession planning by providing CPD and refresher training, and support clinicians if unexpected circumstances require that they act beyond their practised competencies. The idea is that the networks should be underpinned by contractual agreements that specify service requirements and outcomes, and they should be appropriately resourced on an administrative and financial basis. There is research (Becher et al 2020) to support the reasons for the development of a strong and structured Emergency General Surgery (EGS) service not least around patient safety but also better outcomes where research by Nally et al 2019 found that patients undergoing Emergency Abdominal Surgery managed by high volume surgeons have better survival outcomes.

Finally we make a strong appeal to the Department of Health and those with policy responsibility for workforce planning to engage with the Royal Colleges and others to realise the strains affecting our current and future surgical workforce. The problems pertaining to recruitment of surgeons, professional trends or the difficulties in surgical training hasn't appeared in recent months or weeks. It has been building up for many years and not just in NI but across the UK. Those with policy remit for this area must recognise that this problem is more than just recruitment and retention: there is also a need to come up with more innovative solutions around succession planning and service configuration if we are to protect the continued availability of adequate emergency surgical services that are easily accessible to patients who need them.

Consultation Questions

1. Do you consider the temporary suspension of Emergency General Surgery Services a reasonable response to the patient safety concerns outlined in the document? (If not, please identify alternative proposals).
2. Do you consider these actions as reasonable, and do you believe they address some of the challenges faced by the service and will facilitate patients receiving treatment in a timely, suitable and safe environment based on their clinical need? If no, please provide any further or alternative actions that could be taken
3. Do you have any further views on the assessed [Equality Screening] impact of the proposals and any other potential impacts you feel we should consider?
4. Do you have any evidence to suggest that the actions taken by the Trust create a negative impact [regarding Rural Needs]?

Q1. Do you consider the temporary suspension of Emergency General Surgery Services a reasonable response to the patient safety concerns outlined in the document? (If not, please identify alternative proposals).

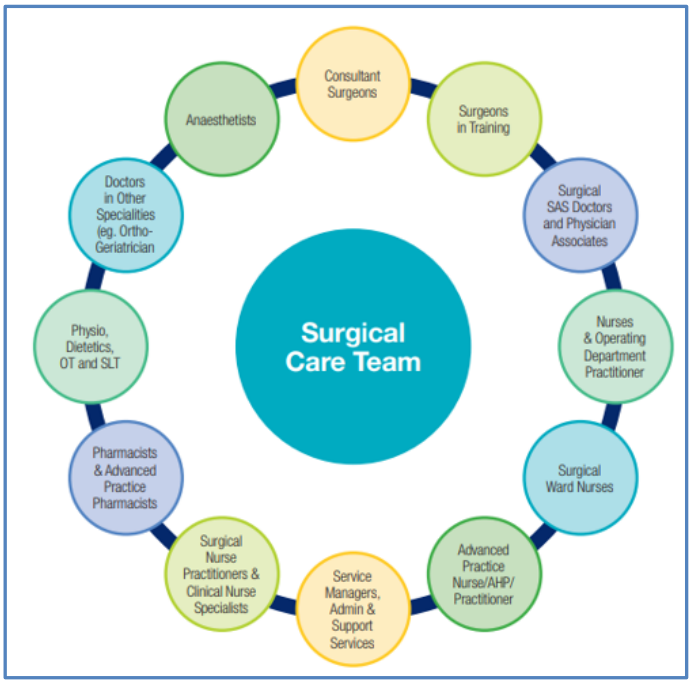
Yes the decision is an appropriate decision in light of SWAH being unable to meet two core areas of the clinical standards outlined by the Review of General Surgery – workforce (ie insufficient consultant General Surgeons to safely staff the out of hours rota) and also clinical interdependencies (ie radiology and endocrinology, bleeding rota and renal medicine). We also note the wider 6 standards for Emergency General Surgery (EGS) in the Review of General Surgery which points to 1. Model of Emergency Surgical Care 2. Clinical Infrastructure 3. Clinical Interdependencies 4. Workforce 5. Process and protocols 6. Quality Assurance

The situation of unplanned collapse is deeply regrettable in any hospital and highlights the importance of building, training, planning and protecting the workforce to meet the needs of patients. An appropriate workforce strategy that lists what skills we need in our health service in the short term and long term, mapped against population needs is at a critical point. The Department of Health's current workforce plan, which aims to outline what an optimum workforce looks like by 2026 is most welcome in this regard.

Presently vacancy rates across all staff grades and categories are concerning. There are over 8,300 vacancies across the HSC including 229 surgeons/SAS doctors with the highest level of consultant vacancies in the Western Trust.

The traditional profile of a General Surgeon who was trained in all aspects of General Surgery is slipping away. The current aspiration pertains to subspecialisation with colleagues providing expert care in one part of General Surgery. Such subspecialisation has brought about the necessity to consider new ways of working (e.g. separating emergencies of an upper GI nature from emergencies of a lower GI nature). Similarly, modern emergency general surgery has much more dependency on the use of interventional radiology and other disciplines. The current organisation of elective services into sub-specialty units and the loss of the role of the 'General Surgeon' is another important aspect causing recruitment ripple effects in smaller units especially in rural settings.

The delivery of safe surgery requires extensive perioperative care involving multiple team members with differing skills across an intensive period of time. The below graphic illustrates the spread. For those teams working in surgical hubs the best practice guidelines via GIRFT are here and for EGS the details are here.



Additionally, Health inequalities in NI are deepening with preventable mortality rates increasing in the most deprived areas resulting in the inequality gap widening with the rate in the most deprived areas now treble that in the least deprived areas. These statistics are stark when we consider the rise of a two-tier health system evolving in NI where those individuals with access to the requisite financial resources are turning to the private sector because they feel they have no alternative.

Q2 Do you consider these actions as reasonable, and do you believe they address some of the challenges faced by the service and will facilitate patients receiving treatment in a timely, suitable and safe environment based on their clinical need? If no, please provide any further or alternative actions that could be taken

These actions are reasonable. The General Surgery service commissioned at SWAH has funding for 6.5 consultants, but this staffing has not been sustained at any time in recent years despite repeated rounds of recruitment. The Trust initiated a project in September 2021 in order to work towards a sustainable emergency general surgery service. This was in response to challenges to the delivery of a safe and sustainable general surgery service and to address the particular challenges in maintaining 24/7 rotas to meet professionally mandated standards of care.

It was expected at the conclusion of the Trust review, the Trust would proceed to consult on a planned change to the provision of Emergency General Surgery across the Western Trust area. This position changed at the beginning of October 2022 when the Trust experienced a number of critical staffing changes, which meant that the 24/7 rota for Emergency General Surgery at SWAH could not be sustained after 18th December 2022. This resulted in an unplanned and temporary change to Emergency General Surgery services at the South West Acute Hospital from 5th December 2022. The Trust has developed a contingency plan with pathways in place to provide safe emergency treatment of general surgery patients at Altnagelvin Hospital, Craigavon Hospital and Sligo General Hospital.

The Western Trust in their consultation document state that when preparing for the change to their EGS service at SWAH they estimated approximately 5 patients per day could be affected by the temporary suspension. They explain that a total of 72 patients from 5 December 2022 to 6 January 2023 were admitted to Altnagelvin hospital with a surgical presentation, who may have previously been admitted to a surgical ward at SWAH.

In relation to the above, we note Strand One from the Review of General Surgery clinical standards document which states: "When a hospital has a functioning Emergency Department and an acute inpatient medical service but does not have an emergency surgery inpatient service, there must be clear pathways for access to the off-site emergency general surgical team for advice, assessment and agreed protocols for ambulance bypass and / or transfer of patients as required, to a surgical inpatient facility."

We would support this position and plans, referenced in same report (p41), that "The NI Ambulance Service (NIAS) and GPs will also play a key role in the reconfiguration of services to ensure appropriate access arrangements, protocols, bypass and transfer arrangements are in place."

Further details on safe transfer with Northern Ireland Ambulance Service (NIAS), private ambulance transfer and the Hospital Emergency Medical Service (HEMS Helicopter) HEMS team will provide transfer from SWAH ED to Royal Victoria Hospital ED as the major trauma centre are contained within the Trust's consultation document and are welcome.

3. **Do you have any further views on the assessed [Equality Screening] impact of the proposals and any other potential impacts you feel we should consider?**

We do not have any reason to believe there will a differential impact on any protected characteristic group.

4. **Do you have any evidence to suggest that the actions taken by the Trust create a negative impact [regarding Rural Needs]?**

The withdrawal of emergency surgery services at SWAH will, inevitably, have an impact on rural needs by increasing journey times for ambulances to get a patient to a suitable emergency general surgery facility. However, as above, whilst it does have a negative impact the withdrawal of emergency surgery at SWAH is, we believe, reasonable as a greater risk would ensue from attempting to continue to provide an emergency surgical service at the current staffing level.

It has increasingly been the case that smaller rural hospitals across the board, in the UK and worldwide, have failed to recruit consultant general surgeons. It is important to note that this is not because of a lack of effort, nor is it a reflection on SWAH, the Trust or other hospitals or the local areas in question. Fundamentally, modern medicine requires increasing subspecialisation to be at the highest standard and this inevitably requires centralisation of key services in centres of excellence. These are predominantly located in urban conurbations with a large enough catchment area that the population base supports increased specialisation.

It is also important to note that keeping an emergency general surgery unit at SWAH would also require higher levels of staffing of multiple roles across the surgical and perioperative team, including theatre nurses, anaesthetists, blood bank staff, radiology, endoscopy and other diagnostic services, as well as Intensive Treatment Unit (ITU) provision, all on a 24/7 rota basis. It is not therefore the case that the addition of a given number of consultant general

surgeons would allow the service to return. Increased specialisation is a fact across the entire surgical team, not just the surgeons themselves, leading to the same issues of recruitment into rural settings across these roles, not just for surgical consultants.

This issue of staffing of the entire surgical and perioperative team means that an attempt to maintain surgery at SWAH would result in a second-class service at the hospital when compared to the provision given at the alternative units at Altnagelvin Hospital and Craigavon Hospital. The issue of transfer and ambulance times therefore needs to be balanced against the risk to patients of a potentially sub-standard offering at SWAH. The judgement of the Royal Colleges is that the latter is the greater risk to patient safety.

The Royal College of Surgeons of Edinburgh report *Standards informing delivery of care in rural surgery* (2015) drew on evidence from the experiences of Scottish Remote/Rural General Hospitals (RGHs) comparable to SWAH. Emergency general surgery has been lost at similar units such as Golspie, Arran, Stranraer and Broadford on Skye. There have been similar situations in England and Wales. The report was commissioned by RCSEd to provide a guide to delivery of surgery in rural areas without compromising standards or patient safety,

When it came to emergency surgery, the report commented that *"Major trauma presenting to RGHs is perhaps the least contentious issue. There is broad agreement that such patients should be cared for in major trauma centres even within urban settings, and so may bypass geographically closer hospitals even for initial management."* Provision for emergency care at trauma centres at Altnagelvin Hospital, Craigavon Hospital and potentially Sligo General Hospital allow for this to take place.

The report also states that to maintain standards *"transfer should occur between units that are in regular contact and with clear lines of communication".* The issue of safe transfer of patients requiring emergency surgery is key. The details of safe transfer management provided by NIAS in the consultation documents are therefore welcome.

Scottish RGHs have long-standing arrangements with one or more District General Hospital (DGH) or teaching hospital. These are primarily to provide advice, specialist care, and visiting services and have been termed 'obligate networks' (Scottish Government, 2007). The main linked hospital for Stornoway (Western Isles), Wick and Fort William is Raigmore Hospital in Inverness, whereas Lerwick (Shetland Isles) and Kirkwall (Orkney Islands) refer patients to Aberdeen Royal Infirmary. Oban has links with Glasgow and Inverness. These relationships allow for clear lines of communication in a systemic manner. The mirroring of such arrangements for SWAH to be linked to Altnagelvin Hospital and Craigavon Hospital allows for "*clear pathways for access to the off-site emergency general surgical team for advice, assessment and agreed protocols for ambulance bypass and / or transfer of patients as required*" as called for in the Review of General Surgery in Northern Ireland (2022).

Cases where a patient will be so badly injured or unwell that the difference in ambulance times will be relevant are thankfully rare. We note that Air Ambulance Northern Ireland does cover the area and that in relevant cases this will allow for significantly reduced times for safe transfer. It is also inconceivable that a patient presenting in such a state to SWAH would not be seen by elective surgical teams who are on site and stabilised prior to transfer.

The actions taken by the Trust to ensure an elective surgical presence (the Elective Overnight Stay Centre) remains at SWAH is welcome.

To conclude, as sub-specialisation across the surgical and perioperative team has increased the provision of emergency care to smaller communities spread across a wider geographical area has become more problematic. The issue at SWAH has been that the consultant general surgeon staffing level at the hospital has now reached a point where it is no longer possible to service the community with emergency surgery at a safe and appropriate standard. The decisions taken are thus reasonable, and appropriate measures have been taken to, so far as possible, mitigate the negative impact on the rural communities of County Fermanagh.

Any other comments

Emergency General Surgery (EGS) relates to the treatment of patients presenting with acute abdominal pain, infections, bleeding and trauma. In children, the most frequently performed emergency surgeries are appendectomy and testicular conditions. The main objective of this consultation is to find out if an alternative viable means of delivering EGS can be identified. It is quite clear that NI's health care needs and pressures on hospital services are rising year on year. There are over 122,000 people waiting for surgery either as an inpatient or day case on our waiting lists presently.

Two thirds of these patients require day case surgery and underlines again the Royal College of Surgeons of England's approach, also supported by the Royal College of Surgeons of Edinburgh to dedicated elective sites called surgical hubs.

These are protected sites that facilitate and protect planned surgeries away from the pressures of emergency care. We made this call in our Action Plan for the recovery of surgical services in NI and the College's surgical 2022 manifesto. As a college we consistently have raised our concerns about NI's waiting lists and how the pandemic negatively impacted planned elective surgery.

We have long lobbied relevant political and civic stakeholders to ensure patients are not further disadvantaged and are able to access their planned elective surgery in a timely fashion.

At the same time the need for transformation of the NI health service is undeniable. There are specific issues relating to the requirement to maintain 24/7 rotas for emergency general surgery across multiple sites and the difficulties this creates in terms of staffing and meeting professionally mandated standards of care.

Notwithstanding this it is important to note that precedence already exists with the development of a regional primary percutaneous coronary intervention (primary PCI) for patients with acute ST elevation myocardial infarction (heart attack).

The Review of General Surgery report, ordered by the then Health Minister Robin Swann and published in 2022 is helpful in that it sets out a series of standards that hospitals will be required to meet in order to continue providing emergency and planned (elective) general surgery.

The reason for the report was "in response to challenges to the delivery of a safe and sustainable general surgery service for the population of Northern Ireland".

In that report Minister Swann stated: "*Currently we are not providing the best possible care for our patients. Whilst surgeons and wider multi-disciplinary team do outstanding work, our systems are not providing them with the tools to do the best they can. This has led to people not receiving the care I would expect – something we must change going forward. There is therefore an unassailable need for a new approach to ensure that general surgery, both emergency and elective, can be provided safely and sustainably*."

Patient safety is clearly a core driver of the report when it states that the standards must be in place in "hospitals receiving emergency general and paediatric surgery patients to ensure safe outcomes for patients through the delivery of high quality, sustainable and equitable care for the people of Northern Ireland wherever they live."

The report also sets out the benefits of an elective/emergency split and shows that the current emergency general surgery service delivery model is not efficient with around 40% of patients not going on to have surgery.

The evidence base for the Review of General Surgery was established with reference to guidance from the Royal Colleges, Association of Surgeons of Great Britain and Ireland (ASGBI), CEPOD, Nuffield Trust and NHS organisations including Getting It Right First Time (GIRFT), regulatory bodies and benchmarking programmes.

The evidence based standards for both emergency and elective general surgery were developed and refined with input from all general surgeons in Northern Ireland, other clinicians, HSC Trusts, managers and service users.

The report also paved the way for **Elective Overnight Stay Centres or surgical hubs** to facilitate planned procedures for high volume, intermediate complexity cases where at least one night in hospital is required.

We welcome news that the SWAH is NI's latest Regional Elective Overnight Stay Centre. This positive development will increase the number of patients in SWAH whilst also providing a support to clinical colleagues. It secures its future surgical capacity that we would like to see sustained long into the future.

The Mater and Daisy Hill hospitals have also been named as overnight centres and adds to NI's surgical hub community of staff and services already working at Lagan Valley and Omagh.

The review also calls for the creation of a **general surgical network** to ensure that no matter where one lives in Northern Ireland they will have equal access to high quality care both in the emergency setting and in the elective setting.

In the RGS report, the authors state that in the development of the standards, their work "flagged the need for the HSC to join the National Emergency Laparotomy Audit (NELA). This is a data gathering audit that collects data on compliance with standards, and provides trusts with benchmarked reports on their compliance and performance. The findings of this audit therefore drive patient safety and quality. This has now been taken forward and regional membership of NELA is being progressed."

NELA membership means Quality Assurance and subject to funding, all Trusts' emergency surgical care teams will submit data and also audit practice against a range of local indicators such as:

- Activity
- Return to theatre
- Emergency surgery inpatient length of stay parameters
- Readmission rates (7 day & 28 day)
- Patient Experience

To conclude the matter of removing EGS from SWAH has undoubtedly caused a substantial response in the local area. It is entirely reasonable to understand local fears about how

emergency general surgery services will operate in the future, if the temporary decision remains and how a Western Trust service will continue to support patients in times of deep distress.

And whilst it is clear there are undeniable challenges for Trust management, patients, staff and DOH to consider, there are some areas from research, undertaken from across the globe points to some areas that require local investigation.

For example research in Scotland (Wohlgemut et al 2022) has flagged the importance of looking into early identification and prognostication of patients at high risk of requiring transfer to higher levels of care from rural and distant populations.

The 20 year study involved 1,572,196 EGS admissions and concluded by stating: “Several clinical decision support tools that predict mortality and need for intensive care have been developed. Trauma systems have widely adopted trauma field triage decision tools to decide whether to bypass smaller trauma units and convey to large trauma centres. An analogous system devised for EGS patients who may require transfer to centres with specialist surgical services or ICUs, may improve care for rural and distant populations**.”**

Another piece of research (Salih et al 2020) using data from the National Emergency Laparotomy Audit in 171 National Health Service hospitals in England and Wales with 22,772 adult patients undergoing emergency surgery on the gastrointestinal tract between 2013 and 2016 found “in the UK NHS, estimated travel time between home and hospital was not a primary determinant of short-term mortality following emergency gastrointestinal surgery.

Becher et al 2020 also found that a strong and structured EGS service was key. Other research by Nally et al 2019 found that patients undergoing Emergency Abdominal Surgery managed by high volume surgeons have better survival outcomes.

For any queries about this jointly submitted Royal College document please contact Áine Magee Policy and Public Affairs Manager Northern Ireland, Royal College of Surgeons of England as a first point of reference via email amagee@rcseng.ac.uk

References

Becher, R. D., et al. (2020). "Regionalization of emergency general surgery operations: A simulation study." *Journal of Trauma and Acute Care Surgery* 88(3).

Department of Health Northern Ireland Health Inequalities Annual Report 2023 Accessed online 29 March 2023 https://www.health-ni.gov.uk/topics/dhssps-statistics-and-research/health-inequalities-statistics

Department of Health Northern Ireland Review of General Surgery 2022 https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-review-general-surgery.PDF Accessed 21 March 2023

Herity N, Corrigan D, McNeill A. Transformation of Heart Attack Care: A Primary Percutaneous Coronary Intervention Service for Northern Ireland. Ulster Med J. 2019 Jan;88(1):36-40. Epub 2019 Jan 22. PMID: 30675077; PMCID: PMC6342036. Accessed online 29 March 2023 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6342036/

Nally, D. M., et al. (2019). "Volume and in-hospital mortality after emergency abdominal surgery: a national population-based study." *BMJ Open* 9(11): e032183

National Emergency Laparotomy Audit (NELA) https://www.nela.org.uk/

Royal College of Surgeons of Edinburgh (2016) *Standards informing delivery of care in rural surgery; Report of the Short-Life Working Group on Rural Surgery*. rural-surgery-report-march-2016.pdf (rcsed.ac.uk)

Salih, T., et al. (2020) "Distance travelled to hospital for emergency laparotomy and the effect of travel time on mortality: cohort study." *BMJ Quality & Safety* 23: 23.

Wohlgemut J.M et al (2022) Emergency general surgery: impact of distance and rurality on mortality, *BJS Open*, Vol 6, Issue 2, https://doi.org/10.1093/bjsopen/zrac032