Surgery in safe hands: a manifesto for surgery

The current parliament will expire in 2010 and there will be a general election by June at the very latest. The UK is therefore set for a long and possibly increasingly bitter election campaign with health care prominent in the wrangling. Politicians of all parties are seeking to stake a claim with the electorate to be the best defenders of the NHS. With massive public spending cuts almost certain and likely budget restrictions for many years to come it is crucial to each of the party's chances how well they convince the public that health care is safe in their hands.

Against this backdrop the Royal College of Surgeons feels that now, when the political parties are setting out their stalls, is the appropriate moment to offer its own manifesto to improve standards of surgical care in UK hospitals. *Surgery in Safe Hands* lists twelve clear areas of policy priority (Royal College of Surgeons of England, 2009). The document will form the basis of the College's conversations with ministers, opposition politicians and the Department of Health regardless of who wins the election and forms the next government. Each of these policies has been debated in the College Council, and they reflect extensive soundings on the views of the working surgeons who constitute the College's membership.

The manifesto covers three broad themes – delivering for patients, supporting and developing surgical staff, and building for the future.

Delivering for patients

It will come as no surprise to those who have noticed the College appearances in the media of late that the most urgent concern for surgery right now is the corrosive effect the European Working Time Directive is having upon patient safety and surgical training in the UK. The attempts to introduce 48-hour working have removed substantial amounts of doctors' time from NHS hospitals with no risk assessment of what effect that would have on institutions having to look after sick patients 24 hours a day.

In the past a junior doctor would be on duty out of hours as part of a team, able to rely on the support of colleagues and obtaining good training by caring for patients throughout the hospital admission. Now juniors find themselves covering multiple wards on their own, often in areas of medicine very different from their specialty and in which they have very little expertise. What time they are allowed to spend in the hospital is devoted in large proportion to out of hours work, with little or even no time left for attending the elective sessions where surgeons are trained.

Trainee surgeons are made to work shifts, starting at unpredictable and variable times of day and night, and are telling the College that this makes them more tired than traditional on call-rotas. A statement by the Association of Surgeons in Training (2009) and the British Orthopaedic Trainee Association cited 15 separate pieces of research that found that shift working led to more errors than 24 hours on-call.

With so few doctors in the hospital at the same time there is little time to share opinions and pass on expertise. Handover of patients with complex problems has become more frequent, and every handover is an opportunity for error. The National Confidential Enquiry into Patient Outcome and Death (2009) report, *Deaths in Acute Hospitals: Caring to the End?*, highlighted the resultant dangers at a time 3 years ago when hours reductions were not enforced so rigorously as they are now. The situation is now demonstrably worse.

The College backs the call from the Association of Surgeons in Training and the British Orthopaedic Trainee Association for the flexibility of working an on-call system of up to 65 hours a week which provides properly staffed surgical teams to ensure cover for patients is continuous and safe and allows optimum training.

The publication of the cardiac surgery database (Society for Cardiothoracic Surgery in Great Britain and Ireland, 2009) showed dramatic reductions in surgical mortality across the board, even as risk factors such as co-morbidity and age of patients treated increased. This demonstrated clearly that, with solid, reliable, risk-adjusted data in the hands of surgeons, standards across the board improved. The College wants to see surgeons leading on the development of clinical audits and surgical outcome measurement as this will not only provide the public with the facts, but put the power to improve health care in the hands of doctors rather than via targets set from Whitehall.

Another area where improved data are needed is in hospital-acquired infections. The Department of Health have claimed success in driving down meticillin-resistant *Staphylococcus aureus* and *Clostridium difficile* infection rates through their *Towards cleaner hospitals* programme (Department of Health, 2004) and the College supports this approach (Royal College of Surgeons of England, 2008). But while the focus thus far has been on cleanliness there remain important matters of hospital organization which the NHS has thus far shied away from addressing, in particular the influence of low staff–patient ratios and bed occupancy rates, and availability of isolation rooms. Properly measuring these is an important next step to further reductions in infection rates.

Supporting surgical staff

One of the most regrettable trends in NHS reorganization in recent years has been the erosion of team working not only within the acute sector but also across the whole referral system. The tendency by policy makers has been to try to cut hospital waiting lists by bringing in the ideas of industrial mass-production efficiency. This has without doubt helped speed up access to treatments but has also affected adversely the patient experience.

In surgery the loss of the traditional surgical firm has been much lamented. Patients can now no longer rely on being treated by the same consultant-led team of clinicians throughout their hospital episode. Continuity of care has been seriously impaired. The fracturing of close working relationships across the grades in a craft specialty like surgery also removes the ability of trainees to gain understanding by seeing through whole care episodes. Doctors also need a commitment by all NHS trusts to see training as being in the best interests of service and patients by recognizing protected training time in consultant trainer contracts.

The Royal College of Surgeons believes that a commitment to a consultant-delivered service represents the best quality for patients, and part of making that happen is proper long-term planning of the UK work force. Consultant numbers must meet future needs and that only comes about by stable planning of training numbers.

Building for the future

The spread of innovation in surgery has traditionally been slow and surgeons, with their technical load, perhaps have fewer opportunities than colleagues in other specialties to undertake medical research. The kind of observational studies required for surgical interventions are more difficult to organize, and government funding for surgical studies has lagged behind other areas of medicine. The research base and scientific regulatory structure that exists for pharmaceutical innovation is in many ways lacking for surgical areas. The College is looking into ways to improve this.

In addition to developing better surgical techniques, there are organizational changes that could be undertaken within the NHS that would improve conditions for patients. For example, the separation of elective and emergency surgery where appropriate may improve predictability and outcome for patients.

There are also difficult decisions to be made about the centralization of certain surgical services where it has been shown that high volumes improve outcomes. In an increasingly sub-specialized field it is no longer possible or economical to provide the highest standards for every procedure within every district general hospital. Decisions must be evidence based, with quality for patients as the driver. The process can be made far more credible if objective external advice from the Royal colleges is at the heart of the decision-making process.

Many challenges lie ahead for the NHS over the coming years, as expectations will remain high while funding in real terms falls. As the country enters an extended period of electioneering, the College will continue to challenge politicians on the issues which are vital to raising surgical standards. The written manifesto for the election campaign will serve as the College's banner. BJHM

John Black
President
Royal College of Surgeons
London WC2A 3PN

KEY POINTS

- As a craft specialty with a variable 24-hour workload the 48-hour working restrictions currently applied are of severe detriment to training the next generation of surgeons and patient safety.
- A sector opt-out to work flexibly up to 65 hours (including on-call commitments) is the solution that trainees would find acceptable to maintain work–life balance, provide quality of continuous care for patients and enable learning.
- In order to further reduce hospital-acquired infection rates hospitals need to look beyond health professionals' behaviour and cleaning and address structural issues like bed occupancy rates.
- Patients will be best served by restoring teams of doctors and being assigned a named consultant responsible for seeing through their whole episode of care.

Association of Surgeons in Training (2009) *Optimising Working Hours to provide quality in training an patient safety; A position statement by the Association of Surgeons in Training.* Association of Surgeons in Training, London (www.asit.org/assets/documents/ASiT_EWTD_Position_Statement.pdf accessed 26 November 2009)

Department of Health (2004) *Towards cleaner hospitals and lower rates of infection: A summary of action.* www.dh.gov.uk/en/Publichealth/Healthprotection/Healthcareacquiredinfection/Healthcareacquiredgeneralinformation/index.htm (accessed 18 November 2009)

National Confidential Enquiry into Patient Outcome and Death (2009) *Deaths in Acute Hospitals: Caring to the End?* National Confidential Enquiry into Patient Outcome and Death, London (www.ncepod.org.uk/2009dah.htm accessed 26 November 2009)

Royal College of Surgeons of England (2008) *Healthcare acquired infections policy position.* Royal College of Surgeons of England, London

Royal College of Surgeons of England (2009) *Surgery in safe hands: priorities and policies 2010.* Royal College of Surgeons of England, London (www.rcseng.ac.uk/publications/docs/surgery-in-safe-hands-priorities-and-policies-2010 accessed 26 November 2009)

Society for Cardiothoracic Surgery in Great Britain and Ireland (2009) *Sixth National Adult Cardiac Database Report 2008.* Society for Cardiothoracic Surgery in Great Britain and Ireland, London

Correspondence

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Dr Jack Tinker
Editor-in-Chief, BJHM
c/o Rebecca Linssen, MA Healthcare
St Jude's Church
Dulwich Road
London SE24 0PB
email: bjhm@markallengroup.com
fax: 020 7978 8316