

EXECUTIVE SUMMARY

One of the recommendations of the 1997 NCEPOD report entitled ‘Who Operates When?’ (WOW I) was that the study should be repeated in five years’ time. This report is the result of that recommendation. It shows how the practice of anaesthetic and surgical theatre work has changed as a result of the Calman reforms, the introduction of shorter working hours for junior doctors and an increase in the number of consultants. It also shows where recommendations made in the WOW I report are still relevant today.

NCEPOD asked Trusts to provide data on all operations performed in a seven day period in 2002. Only 34% of Trusts were able to provide this data in an electronic format. There were problems with inaccurate or missing information for data that were important to this report and that must be vitally necessary for Trusts trying to manage their surgical services. In too many cases the NCEPOD classification of the operation was incorrect, the ASA status was not recorded, or the theatre information system did not record the grade of surgeon or anaesthetist.

Many findings in this report are encouraging. There has been an increase in the number of consultants and other career grade staff in posts in the NHS, although the amount varies between specialties. Over 50% of elective surgical patients in NHS Trusts are treated as day cases, and elective surgery as a whole is largely performed by career grade anaesthetists and surgeons. In general, appropriate elective operations were selected to be carried

out during evenings or at weekends and the work appears to have been properly resourced. Very few of the operations performed in independent hospitals were not elective operations.

The management of emergency patients requires special consideration. This report shows that many Trusts do not have the facilities to care for emergency patients properly, either because they do not have sufficient resources for emergency operating to take place in the daytime alongside elective operating, or because they do not have the staffing in place to provide the same quality of care out of hours as in hours. There is much greater involvement of consultant staff in the care of emergency patients than in the WOW I report, which is commendable, but emergency work out of hours is still the province of trainees.

The data were reviewed by a large multidisciplinary group of advisors. The group discussed the cases done out of hours, which operations truly needed to be done out of hours on clinical grounds, and which could be managed during the day time with better organisation.

The report raises issues which require a wider debate. Does the NCEPOD classification of the urgency of an operation need revision? Which staff should anaesthetise and operate on day cases? Now that junior doctors are working shorter hours, is it acceptable for non-essential surgery to be done out of hours? These and the other issues raised by this report need to be discussed and resolved by clinicians and managers.

PRINCIPAL RECOMMENDATIONS

- Revise NCEPOD classification to include more specific definitions and guidelines, which are relevant across surgical specialties (NCEPOD responsibility).
- Provide adequate information systems to record and review anaesthetic and surgical activity.
- Ensure that Strategic Health Authorities, together with NHS Trusts, collaborate to guarantee that all emergency patients have prompt access to theatres, critical care facilities and appropriately trained staff, 24 hours per day every day of the year.
- Ensure that all essential services (including emergency operating rooms, recovery rooms, high dependency units and intensive care units) are provided on a single site wherever emergency/acute surgical care is delivered.
- Debate whether, in the light of changes to the pattern of junior doctors' working, non-essential surgery can take place during extended hours.

KEY POINTS AND RECOMMENDATIONS OF RELEVANCE TO CLINICIANS

(See full report for all recommendations and key points)

STUDY PROTOCOL

Recommendations

Revise NCEPOD classification to include more specific definitions and guidelines, which are relevant across surgical specialties (NCEPOD responsibility).

Ensure the correct ASA status is collected, as it is an essential part of the patient assessment and record keeping.

Key points

- The ASA status was missing in 33% of cases and the ASA was incorrectly assigned in a number of cases.
- NCEPOD classifications are not consistently recorded.

FACILITIES

Recommendations

Nominate an arbitrator, who would decide the relative priority of theatre cases in order to avoid queuing for theatre spaces.

Ensure that systematic clinical audit includes the pattern of work in operating theatres.

MEDICAL WORKFORCE IN THE NHS

Recommendation

Assess the competency of staff grade and Trust doctors and take this into account when allocating anaesthetic and surgical sessions.

Key points

- The numbers of staff in post increased between 1996 and 2001 for all grades. The biggest increase, of 124%, was in the number of staff grade doctors.
- The title of a doctor's post may not be sufficient to judge whether the doctor has the skills to care for a particular patient.

THE PATTERN OF WORK IN INDEPENDENT HOSPITALS AND COMPARISON WITH THE NHS

Key points

- Patients in independent hospitals had a different distribution of age and ASA status than NHS patients.
- There were very few non-elective operations in independent hospitals.
- Independent hospitals worked a more extended week for elective patients than NHS hospitals.

DAY CASE SURGERY

Recommendations

Review guidance on which staff should anaesthetise and operate on day case patients.

Review the level of supervision of trainee anaesthetists working on their own in dedicated day case units.

Key points

- Only 40% of NHS day case patients were treated in a dedicated day case facility.
- Non-consultant staff cared for more than 40% of day case patients.
- Trainee doctors were involved in anaesthetising patients of poor health, apparently unsupervised.
- There was a low level of supervision of trainee anaesthetists.

ELECTIVE SURGERY IN THE NHS

Key points

- Elective surgery was largely performed by career grade staff between the hours of 08.00 and 18.00 on weekdays.
- 4.5% of elective operations were performed at the weekend.
- Consultant anaesthetists and surgeons were the most senior clinician present for two-thirds of cases at weekends.

NON-ELECTIVE SURGERY IN THE NHS

Recommendation

Debate whether, in the light of changes to the pattern of junior doctors' working, non-essential surgery can take place during extended hours.

Key point

- The involvement of senior staff has markedly increased since WOW I.

INVESTIGATION OF OUT OF HOURS CASES IN THE NHS

Key points

- Many consultants do not regard their work outside the hours of 08.00 to 18.00 as "out of hours".
- Many operations were performed out of hours because of inadequate scheduled sessions for non-elective surgery.

KEY POINTS AND RECOMMENDATIONS OF RELEVANCE TO MANAGERS

(See full report for all recommendations and key points)

STUDY PROTOCOL

Recommendations

Provide adequate information systems to record and review anaesthetic and surgical activity.

Ensure that the information about hospital facilities is accurate in order to ensure that acute services are efficiently and safely managed.

Key point

- NCEPOD classifications are not consistently recorded.

FACILITIES

Recommendations

Ensure that Strategic Health Authorities, together with NHS Trusts, collaborate to guarantee that all emergency patients have prompt access to theatres, critical care facilities and appropriately trained staff, 24 hours per day every day of the year.

Ensure that all operating theatres have sufficient numbers of trained recovery staff available whenever those theatres are in use.

Provide regular resuscitation training for all clinical staff, which is in line with Resuscitation Council guidelines.

Ensure that all recovery bays have both a pulse oximeter and ECG monitor available. This applies whether patients are having local or general anaesthesia or sedation. The equipment used in recovery areas should be universally interchangeable and able to provide a printable record.

MEDICAL WORKFORCE IN THE NHS

Key points

- The numbers of staff in post increased between 1996 and 2001 for all grades. The biggest increase, of 124%, was in the number of staff grade doctors.
- The title of a doctor's post may not be sufficient to judge whether the doctor has the skills to care for a particular patient.

THE PATTERN OF WORK IN INDEPENDENT HOSPITALS AND COMPARISON WITH THE NHS

Key point

- Independent hospitals worked a more extended week for elective patients than NHS hospitals.

DAY CASE SURGERY

Key point

- Only 40% of NHS day case patients were treated in a dedicated day case facility.

ELECTIVE SURGERY IN THE NHS

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NON-ELECTIVE SURGERY IN THE NHS

Recommendation

Ensure that all essential services (including emergency operating rooms, recovery rooms, high dependency units and intensive care units) are provided on a single site wherever emergency/acute surgical care is delivered.

Key points

- There were large differences between specialties in the proportion of the total specialty workload made up of non-elective cases.
- The involvement of senior staff has markedly increased since WOW I.

INVESTIGATION OF OUT OF HOURS CASES IN THE NHS

Key points

- Many consultants do not regard their work outside the hours of 08.00 to 18.00 as “out of hours”.
- Many operations were performed out of hours because of inadequate scheduled sessions for non-elective surgery.