SBAR Quantifying impact of complications of cosmetic procedures undertaken outwith NHS

Situation

Made aware of an increase in admissions in one week in October to one hospital in Scotland for postoperative complications following cosmetic procedures undertaken abroad.

There is no data field identifying an individual as having been admitted with complications following surgery abroad and therefore it is not possible to assess whether this is an unusual phenomenon or something more widespread. There is currently no knowledge of the numbers of Scottish people travelling abroad for surgical procedures, the procedures being undertaken, the drivers or the consequences and costs to individuals, families and the NHS.

Background

Scottish Government Public Health Adviser Informed by clinician of eleven admissions to [REDACTED] in a period of ten days with complications post cosmetic surgery undertaken abroad. [REDACTED] required ICU admission due to septicaemia. Nil assessed in UK for surgery. All had travelled abroad for procedures including bariatric surgery, chin lifts and breast implants. Returned to UK postoperative and subsequently presented with unusual microbiology and postoperative complications requiring admission and thereafter significant recovery periods (both as in- and out-patient – wound dressings) and can leave [REDACTED] with disfigurement.

There is anecdotal evidence suggesting that during the pandemic increasing numbers of people have been seeking cosmetic surgery abroad where the costs for non-essential surgery are lower and again anecdotally, the criteria for surgery are lower than in the case in Scotland (ie people are being accepted for surgery with major co-morbidities not managed).

Assessment

No one consistent location/country where individuals are returning from and presenting with post-operative complications. There is a predominance of Turkey in returning patients with problems but not only. This might reflect the ease of travel there and its own marketing.

There was a PQ on this topic in Westminster recently indicating this is an issue wider than [REDACTED] and wider than Scotland

[REDACTED] has asked ICU, plastics colleagues and bariatric surgeon colleagues if they are seeing increasing numbers of similar presentations. The remaining three plastics units across Scotland have not noted an increase in such presentations during that same time period. However, "all four units do report 'a steady trickle' of around one case per month on average. Most of these require surgical management, some require multiple theatre episodes, others a single episode". There has been, to date, [REDACTED] from Bariatric surgery in [REDACTED] who noted that they have been seeing a steady 3-4 cases every month of postoperative bariatric surgery patients presenting with postoperative complications and requiring surgical or medical intervention

Welsh BBC news published a media article on this topic on 24th October. Surgery: women regret overseas cut-price weight loss ops suggesting this is a widespread concern

Using codes to identify incidence is complicated. OPCS - There is no code for surgery undertaken abroad; there are complications codes (T81.3 and T81.4); SMR01 – admission reason is not a mandatory field and therefore is not consistently completed.

BAAPS (The British Association of Aesthetic Plastic Surgeons (baaps.org.uk)) are thought to be commencing a prospective database on patients returning from overseas with surgical complications Further information is being sought regarding this.

Options discussed:

1. Review of dehiscence code (2017-2022 inclusive) and then look for a recent previous admission (within 6 weeks for surgical procedure). If no previous surgery record found then assume likely that initial surgery was not performed in NHS
2. Short 3 month prospective surveillance of all patients admitted to ICU or plastics units in Scotland for postoperative complications
3. New code in emergency admission category (eg xxx which would then be translated to meaning complication of surgery undertaken outside UK)
4. Add a 5th digit

Recommendation

Set up a SLWG (SG, PHS, clinical input from both ICU and plastics, comms)

Identify a PH registrar and a surgical registrar to work together to support this project and take forward agreed options

Undertake a rapid literature review

Discuss with other three nations whether cosmetic tourism is creating a demand on NHS resource in the other three home nations and if so, then what they are doing to investigate/quantify size of problem

Take forward options 1 and 2 simultaneously thus using two different methodologies to quantify the size of the problem, understand which procedures are being undertaken and where and what the consequences are for patients, their families and the NHS. Explore the feasibility of option 3 and the cost-benefit of progressing (appendix 1).

Once the details are more clearly described over a set time period, work with communications teams at SG and PHS to develop a communications plan and consider qualitative analysis to understand the drivers to support PH messaging.

Appendix 1: Summary of discussions to date re. Option 3 – creating a new code in the emergency admission category

The terminology services team and the secondary care team have explored the feasibility of adding an additional code. The below is a summary of the discussions to date.

- It is technically feasible to create an additional option (e.g. Complication following surgery outside the UK) for the Emergency Admission Type on SMRs for the majority of Boards on the Intersystems Trakcare Patient Administration System (excluding non Trakcare sites D&G and Wester Isles which would need to be confirmed)
- The data for that field (in general) appears to be robust in terms of completeness for SMR01 for the year to March 2022
- Changes to national data would require a minimum of 6 months consultation period with HBs and suppliers via the agreed Change Control route. Any proposal shared with all Health Boards via a Data Change Notification is to allow a period of consultation as to the feasibility of the actual *application* of any new code. (It's possible that for reasons currently unforeseeable to us,

any proposed change to recording may cause a difficulty for Boards.) It may take some additional time to roll out changes across all the various sites.

- There may be additional resource requirements needed in order to make changes - these would need to be investigated in full if a national solution for SMR were to be considered rather than relying on local reporting by Health Boards.

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