



Royal College
of Surgeons

ADVANCING SURGICAL CARE



The State of Surgery in Wales

Contents

Introduction	2
Summary of policy calls	2
About the Royal College of Surgeons in Wales	3
Professional Affairs Board	3
Background and context	3
Key challenges facing surgery in Wales	5
1. Access to services and waiting times in Wales	5
2. Service reconfiguration in Wales	9
3. Critical care bed capacity	12
4. Data and outcomes in Wales	13
5. Governance, regulation and inspection	14
6. Surgical education and training	15
7. Research and innovation	17

The State of Surgery in Wales

Introduction

This paper sets out the Royal College of Surgeons' view about the current state of surgery in Wales, with a focus on where improvements can be made. We outline the recommendations the next Welsh Government, working with others in the NHS, can take to address them.

Summary of policy calls

- » The next Welsh Government must make reducing waiting times a top priority and develop a strategy to achieve this. Political parties should set out how they will achieve this in advance of the Assembly elections.
- » Clinically necessary service changes have progressed too slowly. Health boards should be required to collaborate on their planning and provision of services. Political leaders need to spend as much time engaging with the clinical case for change as listening to public concerns. Emergency surgery is just one example of where service change is desperately needed to improve patient care.
- » Critical care bed capacity needs to increase. Action must be taken to tackle any inefficient use of existing critical care beds. Data showing the number of available and occupied critical care beds should be published on a monthly basis.
- » The publication of surgical unit outcomes data should be prioritised to drive forward improvements in care.
- » Working with royal colleges in Wales, the Welsh Government should review the existing provision of services at night and at weekends. This would be with a view to drafting a strategy to improve 24/7 support for urgent and emergency patients.
- » Data on cancelled operations, with reasons for that cancellation, should be published monthly.
- » There needs to be greater collaboration between clinical and managerial leaders in NHS Wales. The professional and clinical agenda needs to be elevated in the decision-making process in Health Boards. Royal colleges and specialty associations should have a stronger role in this process.
- » Lay representation should be included at all levels of the NHS, especially at Local Health Boards.
- » There needs to be a much clearer system of inspection and external challenge in the health service in Wales. This should continue to include specialist clinical leads in inspection teams, and should incorporate third party intelligence and data. Consideration should also be given to appointing a Hospital's Inspectorate within HIW to support the wider work of HIW.
- » The Welsh Government should look to commission a review to look at what more the NHS can do to support the uptake of innovation and new techniques.

About the Royal College of Surgeons in Wales

The Royal College of Surgeons (RCS) is a professional body that sets the highest standards for surgical practice and training in order to deliver safe and high quality patient care. Our expertise, authority and independence allow us to act in the best interests of patients and support those who provide surgical care. We aim to work alongside Welsh Government, the Welsh NHS, and all political parties as a constructive partner to continue to drive up standards for patients.

Professional Affairs Board

The RCS' Professional Affairs Board in Wales enables surgeons at the front line to share information, bring concerns to local decision-makers and look for solutions to improve patient outcomes.

Members of the Professional Affairs Board represent each of the ten surgical specialties in Wales. The Board is chaired by the College's Director of Professional Affairs in Wales.

Background and context

There is much to celebrate about the Welsh NHS. The NHS in Wales is treating more patients than ever before,¹ more people are living longer as a result of the care they receive² and the recently published National Survey for Wales shows people have a high level of satisfaction with the NHS.³ Wales has also made strong attempts to integrate health and social care. Furthermore, there has been a reduction in the length of stay for emergency inpatients, an increase in the number of elective inpatient episodes performed as day cases, and a reduction in the level of non-elective admissions per annum.⁴

Many of the challenges facing the NHS in Wales are common to many health systems across the world: a growing and ageing population, rising hospital admissions for people with chronic disease, and increases in the cost of providing health care. The number of finished consultant episodes of care in Welsh hospitals has risen by over 15 per cent since 2005/2006,⁵ and

1 Welsh Government press release, 'Welsh NHS is treating more people than ever', 18 June 2014, <http://www.wales.nhs.uk/news/32916>.

2 Welsh Government press release, 'Welsh NHS is treating more people than ever', 18 June 2014, <http://www.wales.nhs.uk/news/32916>.

3 National Survey for Wales: Headline results, April 2014 – March 2015, National Statistics, 11 June 2015, <http://gov.wales/docs/statistics/2015/150611-national-survey-wales-2014-15-headline-results-en.pdf>.

4 A. Roberts and A. Charlesworth, 'A decade of austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26', Research report, The Nuffield Trust, page 6: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140617_decade_of_austerity_wales.pdf.

5 C. Baker, 'NHS Wales Statistics', House of Commons Library Research Briefing, 30th December 2014, p.g.7: <http://researchbriefings.files.parliament.uk/documents/SN06994/SN06994.pdf>.

was 972,846 in 2013/14.⁶ In 2012/13, surgery represented 31 per cent⁷ of total hospital episodes, consistent with data in England.

The current Welsh Government has devised its response to these challenges in the form of Prudent Healthcare, a key plank of the Welsh Government's vision for the NHS in Wales. Prudent Healthcare is part of the growing international campaign of 'Choosing Wisely'.⁸ It seeks to meet the twin challenges of rising cost and increasing demand while improving the quality and value of care.⁹

Some challenges are more unique to Wales. Many parts of Wales are rural which creates problems for accessing health services and attracting staff. The Welsh population also has a higher rate of morbidity compared with many other Western countries. On average, the Welsh population is more elderly, and has poorer health and higher rates of deprivation than the English population.¹⁰ Public health is a key focus for the current Welsh Government¹¹ and should remain so. A number of these public health challenges were highlighted by the recently published Welsh Health Survey 2015.¹² Adults in Wales self-reported against a range of measures which found:

Health-related lifestyle

- » 20 per cent smoked.
- » 40 per cent drank alcohol above the guidelines on at least one day in the past week; 24 per cent drank more than twice the daily guidelines.
- » 31 per cent were physically active on five or more days in the past week; 34 per cent on no days.
- » 58 per cent were classified as overweight or obese; 22 per cent were obese.

Health status, illnesses and other conditions

- » 50 per cent were being treated for an illness: 20 per cent for high blood pressure, 13 per cent for a respiratory illness, 12 per cent for arthritis, 12 per cent for a mental illness, 9 per cent for a heart condition and 7 per cent for diabetes.

6 Patient Episode Database for Wales (2014). Treatment Speciality by LHB of Residence, Welsh Residents, 2013/14. This data needs to be treated with caution as there appears to be a 100,000 reduction in the number of surgical procedures since 2012/13 for reasons that are unclear and are very likely due to data quality.

7 Patient Episode Database for Wales (2014). Treatment Speciality by LHB of Residence, Welsh Residents, 2012/13 – Revised.

8 BMJ Quality & Safety Online First, 31 December 2014 as 10.1136/bmjqs-2014-003821.

9 Welsh Government Written Statement, 'Delivering Prudent Healthcare in Wales', 11 July 2014, <http://gov.wales/about/cabinet/cabinetstatements/2014/prudenthealthcare/?lang=en>.

10 C. Baker, 'NHS Wales Statistics', House of Commons Library Research Briefing, 30th December 2014, p.g.2: <http://researchbriefings.files.parliament.uk/documents/SN06994/SN06994.pdf>.

11 The National Assembly for Wales's Health and Social Care Committee is currently consulting on the Welsh Government's Public Health (Wales) Bill. Further information on the Government's proposed legislation can be found at: <http://gov.wales/consultations/healthsocialcare/white-paper/?lang=en>.

12 Welsh Health Survey 2014: Health-related lifestyle results, National Statistics, 03 June 2015, available at: <http://gov.wales/docs/statistics/2015/150603-welsh-health-survey-2014-initial-headline-results-en.pdf>.

- » 33 per cent said their day-to-day activities were limited because of a health problem/ disability, including 15 per cent who were limited a lot.

Yet there are also areas where the Welsh health system is struggling¹³ and without better data and transparency it can be difficult to examine the quality of care provided. One of the biggest challenges facing surgery in Wales is waiting times. Statistics highlight the 26- and 36-week planned surgery targets are not being met. The number of patients waiting longer than 36 weeks for treatment continues to increase according to the most recent figures available. This report sets out more detail on those challenges and recommendations for action.

In many areas, Wales is leading the way in ground-breaking advances and championing surgical excellence. Case studies are provided throughout the document illustrating pioneering surgery.

Key challenges facing surgery in Wales

This section details some of the specific issues facing surgery in Wales, along with some recommendations to address them.

1. Access to services and waiting times in Wales

Timely access to healthcare is an important aspect of quality in any health system¹⁴ and this is one of the biggest challenges facing surgical services in Wales. The longer a patient waits for treatment, the longer they are in pain and the worse their outcomes from surgery. In some cases such as cardiac or emergency surgery, long waits can mean the patient may die before receiving treatment.

The current Welsh Government target is for at least 95 per cent of patients to have waited less than 26 weeks from referral to treatment, with 100 per cent treated within 36 weeks. Progress against these targets is measured and reported each month.¹⁵

The current data show that many surgical patients are waiting too long for treatment. As of August 2015 there are almost 450,000 people waiting to start treatment in Wales, with 28,500 waiting more than 36 weeks.¹⁶ Neither target is currently being met although, following previous concerns raised by the RCS, waiting times for cardiothoracic surgery are now significantly lower with only six patients waiting longer than 36 weeks August 2015. This was previously as high as 205 patients in January 2014. The table overleaf illustrates the waiting times for different specialities.

Waiting time targets are an imperfect tool. In some circumstances they might encourage

¹³ C. Baker, 'NHS Wales Statistics', House of Commons Library Research Briefing, 30th December 2014, pages 3–10, <http://researchbriefings.files.parliament.uk/documents/SN06994/SN06994.pdf>.

¹⁴ T. Garner, 'Are People Waiting Longer for Health Care?' The Health Foundation, March 2015, <http://www.health.org.uk/publication/are-people-waiting-longer-health-care>.

¹⁵ N. Barwise, 'NHS Referral to Treatment Waiting Times', National Assembly for Wales Research Service, June 2015, [http://www.assembly.wales/Research per cent20Documents/15-011 per cent20- per cent20NHS per cent20June/RN15-011.pdf](http://www.assembly.wales/Research%20Documents/15-011%20per%20NHS%20per%20June/RN15-011.pdf).

¹⁶ Stats Wales, patients waiting to start treatment by month and grouped weeks, <https://stats.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment/patientswaitingtostarttreatment-by-month-groupedweeks>.

hospitals to prioritise treating those about to breach the target above those in greater clinical need. However, they should remain in place to help the NHS to monitor access to surgery and other services. As of September 2015, almost 17,000 patients were also waiting more than the Welsh Government's target of eight weeks for diagnostic tests.¹⁷

It is disappointing that more progress has not been made in reducing waiting times for access to some surgical services in Wales. We recognise the huge challenges in improving access – such as increased demand, funding pressures, and the current configuration of services – will not be overcome overnight. However, ahead of the Assembly elections, all political parties must treat access to services as a priority and set out how they will improve timely access to both planned and emergency surgery.

Why are waiting times not improving in Wales?

In some areas, waiting times are consistently shorter, such as for maxillofacial surgery. In others, such as waiting times for cardiac and oral surgery, the figures are slowly moving in the right direction. However, in surgical specialties such as general surgery, urology and trauma and orthopaedics, there has been a marked deterioration in waiting times, with no clear explanation.

Certainly, the NHS in Wales is facing increasing demand and is treating more people than ever before. In 2000/01, 275,000 elective inpatient and day cases and a total of 586,000 inpatient and day cases were seen. In 2011/12, 362,000 elective inpatient and day cases and a total of 723,000 inpatient and day cases were seen.¹⁸ Furthermore, there are increasing hospital admissions for people with chronic disease who may require more complex treatment and longer stays in hospital.

A recent report by the Wales Audit Office into waiting times for elective treatment found that: 'financial pressures have been a contributing factor to the decline in performance against waiting times targets'.¹⁹ Such monetary pressures likely result in lower staffing and consultant levels in Wales with comparable parts of the UK. The report also highlights increasing bed occupancy rates.²⁰

As a way of managing winter surges in demand for emergency care, many Local Health Boards may restrict elective surgery for some surgical specialties, increasing waiting times. Operations may also be cancelled because there are no beds available for patients after their operation. In addition to a shortfall in critical care bed capacity, Wales lost nearly half of its beds between 1989/1990 and 2013/14.²¹

17 NHS Wales Diagnostic & Therapy Services Waiting Times: At end September 2015 <http://gov.wales/docs/statistics/2015/151112-nhs-diagnostic-therapy-services-waiting-times-september-2015-en.pdf>

18 Welsh Government press release, 'Welsh NHS is treating more people than ever', 18 June 2014, <http://gov.wales/newsroom/healthandsocialcare/2014/8859626nhs-performance/?lang=en>.

19 NHS Waiting Times for Elective Care in Wales, Wales Audit Office, 27 January 2015, page 44, http://www.audit.wales/system/files/publications/nhs_waiting_times_technical_report_english.pdf.

20 NHS Waiting Times for Elective Care in Wales, Wales Audit Office, 27 January 2015, page 51, http://www.audit.wales/system/files/publications/nhs_waiting_times_technical_report_english.pdf.

21 Stats Wales, NHS beds summary data by year, <https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/NHSBedsSummaryData-by-Year>.

Table: Number of patients waiting over 26 weeks for treatment by surgical specialty²²

	Sep-11	Aug-15	% increase or decrease
Cardiothoracic surgery	188	49	-73.9%
Ear, nose and throat	2,548	6,805	167.1%
General surgery	3,385	9,251	173.3%
Neurosurgery	260	165	-36.5%
Oral surgery	1,471	2,248	52.8%
Paediatric surgery	33	347	951.5%
Plastic surgery	582	530	-8.9%
Trauma and orthopaedics	13,576	17,013	25.3%
Urology	1,644	3,962	141.0%

Note: Vascular surgery and oral and maxillofacial surgery statistics are not recorded separately.

Waiting times for knee replacements

As a result of severe winter pressures, some health boards in Wales temporarily suspended planned surgery in early 2014/2015 and Christmas 2014. This has partly resulted in some patients reportedly waiting over 70 weeks for knee replacement surgery at the Princess of Wales hospital in Bridgend,²³ which faced severe pressures. However, it is clearly unacceptable for patients to wait over 70 weeks for a knee operation. Delaying treatment can impact on the outcomes of surgery, decreasing patients' mobility and causing increased pain. The College has urged the hospital and the Health Board to take urgent action to reduce waiting times as soon as possible.

²² Stats Wales, Patients waiting to start treatment by month and grouped weeks, <https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment/patientswaitingtostarttreatment-by-month-groupedweeks>.

²³ M. Smith, 'Health board promises "significant investment" as surgery waits rise to one year four months', Western Mail, 17 June 2015, <http://www.walesonline.co.uk/news/health/health-board-promises-significant-investment-9474277>.

Cardiac waiting times in South Wales

The College has been active in raising concerns about waiting times for cardiothoracic surgery in Wales. The Welsh NHS has since taken successful action to markedly improve these waiting times.

In July 2013, the College raised concerns with Healthcare Inspectorate Wales regarding a high number of patients dying while awaiting elective cardiac surgery in South Wales. Our analysis of NHS data highlighted that waiting times were longer than clinically appropriate. We reiterated these concerns in February 2014, and that month the Welsh Government announced that 80 of those patients deemed most in need of cardiac surgery would be transferred to England to receive cardiac surgery. At the same time additional funding to upgrade cardiac theatres at the University Hospital of Wales in Cardiff was also announced. The College has welcomed these developments. It has also worked with the Welsh Health Specialised Services Committee and Health Inspectorate Wales regarding plans for configuration of cardiac surgery.

The latest figures show an improvement in waiting times, with six patients waiting more than 36 weeks to start treatment at August 2015 (down from a high of 205 in January 2014) and 43 waiting over 26 weeks (down from a high of 167 in May 2013). There are now 454 patients waiting to start treatment (down from a high of 950 in December 2013).

The College remains committed to working with the NHS in Wales to deliver high quality care to patients where and when they need it.

Recommendations:

We are under no illusions about the challenges in improving access to healthcare in Wales. Nevertheless it is disappointing that more progress has not been made in reducing waiting times and we have made a number of recommendations:

- The next Welsh Government and all political parties must prioritise reducing waiting times.
- The next Welsh Government should devise a specific strategy to improve planned and emergency surgery waiting times and access to services in Wales. The College would be happy to contribute to this work.
- Any push to reduce waiting times must take due account of clinical need when considering which patients to prioritise.

2. Service reconfiguration in Wales

In February 2012, the Welsh Government published *Together for Health: A Five Year Vision for the NHS in Wales*, which outlines the challenges facing the health service and the actions necessary to ensure it is capable of world-class performance.²⁴

Since the publication of *Together for Health*, local health boards across Wales have been drawing up reconfiguration proposals designed to put the NHS on a safe and sustainable footing. The Welsh Government and a number of stakeholders have taken a consistent position that service reconfiguration is necessary.

In support of their position, the Government cite a report by health economist Professor Longley which sets out the case for change.²⁵ Professor Longley's report highlights convincing evidence that hospital services in Wales are 'not always configured optimally', that patient care may suffer, and that some key staff groups are unsustainable, 'with the risk of imminent service collapse'.²⁶

RCS position on service reconfiguration

The College supports the reshaping of services where it is based on clinical evidence and will benefit patients. Centralising complex services can save lives and make services more sustainable by concentrating expertise onto fewer sites. As former Health Minister Lord Darzi has said:

'It was for these reasons that when I was in office, I recommended consolidating London's 32 stroke units into 8 specialist ones in my report *A Framework for Action* published in 2007. That led to a 17 per cent reduction in mortality and a 7 per cent reduction in patient length of stay.'²⁷

There is a clear need for reconfiguration of services in Wales based on clinical need, as Professor Marcus Longley has recognised,²⁸ particularly to address the sustainability of the current pattern of acute hospitals. This need is well recognised by Welsh Government. However, progress on service changes has been too slow; often hindered by a lack of local will and politicians campaigning against clinically necessary service changes. Political leaders need to spend as much time engaging with the clinical case for change as listening to public concerns. In some cases, there has not been enough joined-up working between different health boards. Boards should be required to collaborate on their planning and cooperate on the provision of services across health board boundaries.

²⁴ 'Together for Health: A Five Year Vision for the NHS in Wales', Welsh Government, February 2012 <http://www.wales.nhs.uk/sitesplus/documents/829/togetherforhealth.pdf>.

²⁵ M. Longley, 'The Best Configuration of Hospital Services for Wales: A Review of the Evidence', Welsh Institute of Health and Social Care, University of Glamorgan, April 2012, http://news.glam.ac.uk/media/files/documents/2012-05-09/WIHSC_report_summary.pdf.

²⁶ M. Longley, 'The Best Configuration of Hospital Services for Wales: A Review of the Evidence', Welsh Institute of Health and Social Care, University of Glamorgan, April 2012, page 3, http://news.glam.ac.uk/media/files/documents/2012-05-09/WIHSC_report_summary.pdf.

²⁷ Lord Darzi on surgery and the future of the NHS, Royal College of Surgeons, 5 June 2015, <https://www.rcseng.ac.uk/blog/lord-darzi-on-surgery-and-the-future-of-the-nhs>.

²⁸ M. Longley, 'Prudent Progress in the Welsh NHS', Nuffield Trust, 29 July 2015, <http://www.nuffieldtrust.org.uk/blog/prudent-progress-welsh-nhs>.

Emergency Surgery: a clear case for service reconfiguration

We estimate that around a quarter of surgical hospital admissions each year are emergencies. Yet the NHS has deprioritised improvements to emergency care in recent years, in the face of other challenges such as financial problems and waiting time targets for planned care.

However, as the National Emergency Laparotomy Audit (NELA) data show, there is wide variation in mortality and complication rates for emergency surgery patients. For example, mortality following emergency laparotomies varied between 3.6 and 41.7 per cent across 35 hospitals in the UK.²⁹

In Wales, there is a wide variation in the volume of emergency activity. According to the South Wales Health Collaborative, most hospitals' emergency activity in South Wales is too low to meet doctors' training needs and they are unable to provide full clinical services required to support emergency surgery.³⁰ There is therefore a clear need to prioritise the centralisation of emergency surgery in order to improve patient outcomes and the sustainability of services.

The RCS is currently undertaking work to better understand why some emergency surgical services have better outcomes than others.

Vascular surgery: unequal reconfiguration process

To further improve patient outcomes, Wales needs to continue to make progress to deliver vascular and endovascular surgery in a co-ordinated manner. The Vascular Society's *Provision of Services for Patients With Vascular Disease 2012 and 2014* give clear guidance on the centralisation of arterial surgery based on population size, throughput and outcome. A modern service for Wales would be based on three centres, in the South East, South West and the North of Wales.

The main constraints for patients are lack of hybrid theatres (currently being discussed in ABMU and Cardiff & Vale) and the inability to provide an interventional radiology on call service (under discussion at Wales Imaging Board).

There is consensus within the vascular community in Wales on the importance of the above measures. However, there is justifiable concern in Wales that progress across the principality has been unequal with some South Wales health boards successfully moving towards this model and others less so. Concerns have been raised as to the level of management support for these changes.

Welsh Government support is needed to fund the Hybrid Theatre development and encourage health boards to hasten progress.

²⁹ D.I. Saunders et. al. (2-12) 'Variations in mortality after emergency laparotomy: the first report of the UK Emergency Laparotomy Network', *British Journal of Anaesthesia* 109 (3): 368–78.

³⁰ <https://www.rcseng.ac.uk/surgeons/supporting-surgeons/regional/events/documents/emergency-surgery-presentation-hamish-laing> Accessed 25 September 2015.

Reconfiguration working: Upper GI cancer services in South Wales

Authors: David S.Y. Chan, Tim Havard and Wyn G. Lewis

Upper gastrointestinal (UGI) cancer is one of the most prevalent cancers in the UK but its prognosis remains poor. UGI cancer service reconfiguration and centralisation consistent and compliant with the guidelines for commissioning cancer services, strongly supported and largely achieved in England, has received less resource and support in Wales.

UGI surgery has, by tradition, been within the domain of the general surgeon and historically, a notional district general surgeon might expect to deal with fewer than 25 people with oesophageal cancer and 40 with gastric cancer per year. The last decade, however, has witnessed significant changes in practice in general surgery and sub-specialisation for major oncological work is now the accepted routine, in keeping with NHS guidance recommending the establishment of specialist teams serving populations over one million.

An agreement was reached in December 2009 to reconfigure and centralise the Upper GI surgical service on a single site at the University Hospital of Wales, Cardiff, with an agreed start date of 1 August 2010. The new model was based on five specialist UGI surgeons performing all of the resectional surgery; three of the surgeons were based at the surgical centre, whilst the other two were to operate on an in-reach basis, with a facility for joint consultant operating, where necessary.

Following centralisation, the rate of curative treatment intent increased from 21 to 36 per cent, length of hospital stay after surgery decreased from 16 to 13 days and median survival increased by 24 per cent. These outcomes confirm the patient safety, quality of care, and survival improvements achievable by compliance with NHS Improving Outcomes Guidance.

The need for sustainable seven day care

Mortality and complication rates in Wales are significantly higher for patients admitted on Fridays and at the weekend.³¹ As with services in England, a number of studies have shown that people are less likely to receive prompt treatment and more likely to die if they are admitted to a hospital at the weekend.

The Welsh NHS needs to improve outcomes for patients admitted at the weekend. Given the potential impact on resources, the RCS believes this should initially be focused on emergency and urgent care, and the care of patients already in hospital. Seven-day hospital care must be consultant-led to ensure timely intervention and better outcomes for acutely unwell patients. Many consultants already work at the weekends although studies show this varies by service and hospital. This is not about making staff in the NHS work seven days a week, but rather changing the way they work across the week by, for example, altering rotas and shift patterns.

We must also ensure there is seven-day access to key services and facilities in hospitals – like pharmacy, radiology, physiotherapy, and community support for the next steps in a patient's

³¹ M. Longley, 'The Best Configuration of Hospital Services for Wales: A Review of the Evidence', Welsh Institute of Health and Social Care, University of Glamorgan, April 2012, page 12, http://news.glam.ac.uk/media/files/documents/2012-05-09/WIHSC_report_summary.pdf.

treatment. Any cost savings associated with seven-day care (such as fewer complications and quicker discharge) will inevitably be balanced by the financial impact of providing the same quality of care every day of the week. Given the current and likely future financial environment, the NHS may need to rationalise services to ensure there are sufficient senior, trained staff cover across the week and ensure the maximum use of scarce resources. This will require some services to reconfigure.

Recommendations:

- There is a clear need for reconfiguration of services in Wales based on clinical need, particularly to address the sustainability of the current pattern of acute hospitals.
- Progress of clinically necessary service reconfiguration has been too slow. Health boards should be required to collaborate on their planning and provision of services. Political leaders need to spend as much time engaging with the clinical case for change as listening to public concerns.
- Working with royal colleges in Wales, the Welsh Government should review the existing provision of services at night and at weekends. This would be with a view to drafting a strategy to improve support for urgent and emergency patients regardless of the hour of the day, or day of the week that they need care.

3. Critical care bed capacity

Intensive care units (ICUs) and high dependency units (HDUs) are specialist hospital wards that provide intensive care, treatment and monitoring for people in a critically ill or unstable condition.³² They are also known as critical care units or intensive therapy departments. An HDU is one level down from intensive care.

ICUs and HDUs have critical care beds that provide specialised monitoring equipment, a high degree of medical expertise and a higher nurse to patient ratio. Surgical patients may be admitted to an ICU/HDU to stabilise their condition after emergency surgery, or as a planned measure following complex elective surgery where close monitoring is required.

A recent report for Welsh Government shows that Wales has the lowest number of critical care beds in Europe. The analysis shows that Wales has 3.2 critical care beds per 100,000 people, compared with four in England and the European average of 11.³³ The report also identifies that the number of critical care beds has fallen by four across Wales since 1999, with most units routinely operating above the recommended 75 per cent occupancy rate.³⁴ Another factor is the inappropriate use of critical care beds as a result of delayed discharge, inappropriate admission or a shortage of staff.³⁵

³² <http://www.nhs.uk/conditions/intensive-care/pages/introduction.aspx>.

³³ 'An assessment of unmet need for critical care in Wales', All-Wales Implementation Group Delivery Plan for the Critically Ill, NHS Wales, June 2014, page 4, <http://gov.wales/about/cabinet/cabinetstatements/2014/criticalcare/?lang=en>.

³⁴ <http://www.bbc.co.uk/news/uk-wales-politics-28419601>.

³⁵ 'An assessment of unmet need for critical care in Wales', All-Wales Implementation Group Delivery Plan for the Critically Ill, NHS Wales, June 2014, page 5, <http://gov.wales/about/cabinet/cabinetstatements/2014/criticalcare/?lang=en>.

Delayed access to and premature discharge from critical care have been identified as important risk factors for postoperative death, as has delayed admission to critical care.³⁶ Routine admission to critical care after high risk surgery reduces complication rates and subsequent admissions to intensive care. This ultimately saves money through shortened hospital stay and reduced use of ICUs, which currently cost the NHS around £88 million per year.³⁷

If surgeons are to operate on high risk patients then it is essential that they receive the right level of care after surgery. There must be an appropriate number of critical care beds to manage high risk patients in the most cost effective and efficient way. Demand for critical care is expected to grow at a rate of 5 per cent per annum largely due to an increasing number of elderly people with multiple chronic illnesses that make them more likely to need critical care.³⁸

There is not just a shortage of critical care beds, but hospital beds more generally in Wales. Data show a 44 per cent reduction in the average number of daily available beds, from 19,855 in 1989/1990 to 11,241 in 2013/14.³⁹ This may be a factor behind the increasing waiting times.

We believe bed capacity, particularly critical care bed capacity, needs urgent consideration and we would urge Welsh Government and all political parties to consider how to increase bed capacity and use existing capacity more effectively.

In England, the number of available and occupied critical care beds is published publicly on a monthly basis. We would like to see similar data published in Wales.

Recommendations:

- The next Welsh Government and all political parties should consider how to increase critical care bed capacity in Wales and tackle any inefficient use of existing critical care beds.
- Critical care bed capacity data showing the number of available and occupied critical care beds should be published on a monthly basis.

4. Data and outcomes in Wales

Greater transparency in the health service in Wales would improve governance and drive up performance and allow us to make judgements about the quality of patient care in Wales.

As with many parts of the NHS across the UK, data collection in Wales has been historically poor, particularly for outcomes data. There are a variety of reasons for this, but in Wales

³⁶ P. McQuillan, et al. 'Confidential inquiry into quality of care before admission to intensive care', *BMJ*. 1998; 316(7148): 1853–9.

³⁷ 'Address variations in care now for "forgotten" patients, surgeons tell Trusts', Royal College of Surgeons, 29 September 2011, <http://www.rcseng.ac.uk/news/address-variations-in-care-now-for-forgotten-patients-surgeons-tell-trusts#.VYI55LVwblU>.

³⁸ 'An assessment of unmet need for critical care in Wales', All-Wales Implementation Group Delivery Plan for the Critically Ill, NHS Wales, June 2014, page 6, <http://gov.wales/about/cabinet/cabinetstatements/2014/criticalcare/?lang=en>.

³⁹ Stats Wales, NHS beds summary data by year, <https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/NHSBedsSummaryData-by-Year>.

outcomes and recording activity in particular have historically not been well resourced. This is recognised by the Welsh Government. The current structures in Wales mean there is not the same imperative for organisations to collect data as there has been in England where 'payment by results' and tariffs for procedures require hospitals to record their activity in order to be paid. While this might not necessarily be the right approach in Wales, we would like to see greater focus on the collection and management of data in Wales in order to focus the NHS on improving outcomes for patients.

Recent improvements in data collection in Wales have been driven by the national clinical data registries such as the Cardiac Surgery Registry, the National Joint Registry and National Bowel Cancer Audit Project. These registries have now published organisational data alongside the NHS collected data (Hospital Episode Statistics and Patient Episode Database for Wales) and this has improved data quality. Financial investment has been important in these cases for ensuring data collection.

Data collection in practice: oesophagogastric cancer network

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The South East Wales regional oesophagogastric cancer network has compared its data with that of English units to analyse the relative accuracy of unit-based reporting compared with surgeon-specific reporting. The median number of resections performed by an individual oesophagogastric surgeon in South East Wales per year was 10 (range 5–25), although 14 when joint cases were included. The median surgeon-specific annual mortality rate was 0%, but varied from 0 to 9.09% year to year. The median unit mortality rate was 1.8% (range 0–3.7%). The unit mortality rates are equivalent to English unit data, and demonstrate less annual variability compared with surgeon-specific mortality rates.

We strongly supported the announcement by Welsh Government in July 2013 that they would work to publish surgical outcomes data in Wales at a unit level with consideration given to individual outcome data at a later date.⁴⁰ It is disappointing that more progress has not been made since this announcement, as the publication of unit outcomes data will drive forward improvements in care. We urge the Welsh Government to make this an urgent priority, and we have already expressed our willingness to work closely with Government on this.

In Wales there is no routine publication of data on how many operations are cancelled and whether the cancellation is for a clinical or non-clinical reason. Having access to this data would help to clarify why operations are being cancelled and where there are pressures in the system which might be contributing to high waiting times for some types of surgery.

⁴⁰ [http://www.assembly.wales/Written%20Questions%20Documents/Answers%20to%20the%20Written%20Assembly%20Questions%20for%20answer%20on%208%20per%20July%202013%20\(Written%20doc,%20per%2088KB\)-08072013-250692/waq20130708-English.doc](http://www.assembly.wales/Written%20Questions%20Documents/Answers%20to%20the%20Written%20Assembly%20Questions%20for%20answer%20on%208%20per%20July%202013%20(Written%20doc,%20per%2088KB)-08072013-250692/waq20130708-English.doc)

Recommendations:

- Publication and collection of data should be more adequately resourced by local health boards.
- We urge the next Welsh Government and all political parties to progress with the publication of surgical unit outcomes data as a matter of priority to drive forward improvements in care.
- We would also like to see data on cancelled operations, with reasons for that cancellation, published publicly in Wales on a monthly basis.

5. Governance, regulation and inspection

Those on the frontline of the NHS ultimately drive up the quality of surgical care. Nevertheless, regulation can help to ensure minimum standards of care are met.

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales. Carrying out its functions on behalf of Welsh ministers, HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and healthcare providers, that services are safe and good quality. Services are reviewed against a range of published standards, policies, guidance and regulations.⁴¹

There has been some criticism of HIW and the Welsh Government is consulting on draft legislation which will be brought forward in the 2016–2021 Assembly term to strengthen the regulatory remit and independence of HIW. We support this.

We believe there needs to be a much clearer system of inspection and external challenge in the health service in Wales. This should continue to include specialist clinical leads in inspection teams and the need to incorporate third party intelligence and data.

While HIW already carries out some proactive reviews, more regular reviews should occur. Routine inspection is mostly related to specific areas of concern and issues such as cleanliness. Consideration should also be given to appointing a Hospital's Inspectorate within HIW as in England to support the wider work of HIW. Changes to HIW need to happen quickly as considerable anxiety remains about the standards of care in hospitals in Wales. To provide public reassurance we believe that there is merit in reviewing all hospitals in Wales through an enhanced inspection regime by HIW.

⁴¹ <http://www.hiw.org.uk/learn-more-about-us-1>.

NHS trust board representation

We believe there needs to be greater collaboration between clinical and managerial leaders in the NHS in Wales. There has been an historical culture of financial priority in decision-making within health boards although the move to a three-year financial planning cycle should help to mitigate against this. As well as financial prudence to balance the books, local health boards should ensure a patient-centred approach to service development.

At present, with the exception of the medical director, there is no medical staff representation on board or executive roles in health boards in Wales. There is therefore a need to elevate the professional and clinical agenda within the decision-making process in health boards.

We believe lay or patient representation should also be sought at all levels of the NHS, especially on NHS trust boards, specifically in developing standards. This would help the patient voice to be heard at the highest levels in the NHS, to ensure the focus of decision-makers is on improving patient care.

Recommendations:

- There needs to be a much clearer system of inspection and external challenge in the health service in Wales. This should continue to include specialist clinical leads in inspection teams, and the need to incorporate intelligence and data collected by other third party organisations.
- Health Inspectorate Wales should carry out more regular proactive reviews.
- Consideration should also be given to appointing a Hospitals' Inspectorate within HIW to support the wider work of HIW.
- There is merit in reviewing all hospitals in Wales through an enhanced inspection regime by HIW.
- All Health Boards should ensure greater collaboration between clinical and managerial leaders in the NHS in Wales.
- To help ensure that the patient voice is heard at the highest levels in the NHS, lay or patient representation should also be included or sought at all levels of the NHS – especially on NHS trust boards.

6. Surgical education and training

The education and training of healthcare professionals is fundamental to the delivery of high quality care and patient safety. The shift away from hospital-based training and development to embrace a community setting will result in a greater emphasis on generalist care provision.

However, it is also important to recognise that to treat an ageing population with multiple conditions and to protect access to specialist services patients need a balance of both generalist and specialist doctors. Patients with complex surgical problems still want and require specialised surgeons who have better outcomes due to their greater experience and expertise.

Following the recent *Shape of Training* review, major changes to the provision of postgraduate medical education and training are under consideration. The Welsh Government has established a Shape of Training Wales group which will help inform the national workforce plan for Wales. The College is working proactively with Health Education England (HEE) to consider the feasibility of different models of surgical care and would welcome the opportunity to extend these conversations in Wales.

Recruitment and retention

In Wales, there has been concern about the ability of the health service to recruit doctors in medical specialties such as paediatrics and general medicine.

These problems are not replicated in surgery. Training posts in all surgical specialties are well subscribed and for a number of years now recruitment into all ten surgical specialties has seen 100% fill rates. Similarly, at consultant level recruitment level has been strong in specialties such as neurosurgery.

Nevertheless, on occasions there are issues with individual senior posts at some hospitals, especially smaller hospitals and those in more rural areas. Prevarication on service reconfiguration has also harmed recruitment at some hospitals. More should also be done to attract more women into surgery through visible role models and making the training pathways more flexible.

The Welsh NHS is increasingly spending more on agency staff (not just for surgery). This increased from £40m in 2011/2012 to more than £71m in 2014/2015.⁴² The Welsh Government should find ways of reducing the reliance on agency staff.

It should be noted that the recommendations of the Health Professional Education Investment review, and the proposal for a single body for workforce planning, development and commissioning of education and training in Wales,⁴³ could have had far reaching implications for the role and structure of the postgraduate deanery in Wales. However, we understand the review's implementation has stalled after criticism of its evidence base.

7. Research and innovation

Embedding research throughout the NHS is essential for improving the evidence base for medicine, helping to tackle ill health and improve the quality and outcomes of patient care. Furthermore, reducing research bureaucracy can encourage medical professionals to take part in research.

⁴² 'Not enough nurses being trained, says Welsh RCN chief', BBC Wales online, 31 July 2015, <http://www.bbc.co.uk/news/uk-wales-33726026>.

⁴³ Health Professional Education Investment Review, Welsh Government, 3 August 2015, <http://gov.wales/topics/health/publications/health/reports/education-investment-review/?lang=en>.

There are no academic professor of surgery posts in Wales funded by universities, although some posts are funded by the NHS. We believe the Welsh Government should give further consideration to support for academic medicine and surgery in Wales. Surgical trainees should not be disadvantaged in comparison with their colleagues in other parts of the UK.

There are several examples where the Welsh Government has centrally funded specific innovations and these are welcome. For example, in September 2015 the Government announced £773,000 funding for pioneering lymphoedema 'super microsurgery' at Neath Port Talbot Hospital.⁴⁴ Wales is only the second place in the UK to provide this life-changing operation alongside the Royal Marsden. Alongside such investment, the Welsh Government should look to commission a review to look at what more the NHS can do to support the uptake of innovation and new techniques.

⁴⁴ <http://gov.wales/newsroom/healthandsocialcare/2015/micro-surgery/?lang=en>, Accessed 24 Sept 2015.

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