Delivering High-quality Surgical Services for the Future

A CONSULTATION DOCUMENT FROM THE ROYAL COLLEGE OF SURGEONS OF ENGLAND RECONFIGURATION WORKING PARTY

MARCH 2006

The Royal College *of* Surgeons *of* England

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The Royal College of Surgeons of England

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Contents

Note: The College gathered evidence from a number of individuals and organisations. Some of the evidence presented and views expressed have been included as case studies in this report. They are the opinion of the authors and do not necessarily reflect College policy.

Foreword

The Royal College of Surgeons of England believes that the patient must be the focus of healthcare provision and that services must be designed around patient needs. To achieve this, surgeons must work within multiprofessional teams and be forward looking and innovative.

Surgeons are not averse to change. They have been at the forefront of changes in healthcare – leading technological advances, developing new skills and innovative ways of working, and enhancing professional collaboration, demonstrated through, for example joint replacement, day-case surgery, keyhole surgery, and transplantation.

Health service policy and methods of healthcare delivery have changed dramatically over recent years – partly to drive improvements in patient access and reduce waiting times and partly to encourage competition and introduce external providers to the healthcare market. The health service environment is likely to change even further in the near future.

The College set up a working party to examine the issues affecting the configuration of surgical services in England and Wales, taking into account the various imperatives for change, the wider political climate and local planning arrangements. This is the initial report of the working party.

There is no 'one size fits all' solution to service configuration, and we do not pretend to have all the answers. The College has a responsibility for the care of patients, maintaining surgical standards and training future generations of surgeons. Therefore, the aim of this report is to identify areas where new government policy initiatives may produce tensions, to acknowledge and discuss these and to encourage debate to formulate constructive policy advice.

However, in its current deliberations and in all future areas of work, the principal priorities of the College are:

- the quality of care must be maintained or improved;
- government targets should not be allowed to distort patient care or to detract from surgical training; and
- each patient admitted to hospital or referred for surgical care is the responsibility of a named consultant.

This initial report of the working party is intended to outline our understanding of the current position of the NHS, the likely future direction of health policy and the integration of the NHS within such initiatives. When compiling this report, evidence was received from a variety of health policy leaders and from visiting a number of health systems.

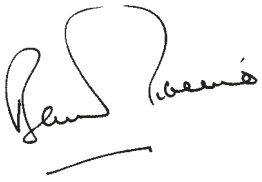
The College is keen to work with government and policy makers to deliver the highest quality surgical services and as an independent non-governmental body can bring objectivity to this process. It also wishes to play its part in ensuring that health service policy is implemented in such a way as to be in the best interests of patients.

Additionally, the report is also intended to act as a consultation document, by asking for the views of readers on potential future areas of work to be taken forward by the College in collaboration, where appropriate, with other organisations.

The College is well placed to analyse these issues and make recommendations to ensure patient safety.

We are delighted to present this report to you. It contains important messages from the College, surgeons, the health service, policy makers, and the public and patients. We hope this report will be used as a contribution to, and provide a foundation for, debate regarding any further work on the configuration of surgical services in the UK.

The full report can be downloaded from www.rcseng.ac.uk/publications/docs.



Bernard Ribeiro CBE
President, RCS

Dermot O'Riordan FRCS
Chairman, reconfiguration working party

Acknowledgements

On behalf of the College and the reconfiguration working party, Mr Dermot O'Riordan would like to thank Mrs Jo Cripps for her support in producing this report. He also wishes to extend his thanks to those individuals who shared their experiences and views with the working party, and to those who provided case studies.

The time and expertise of those organisations that hosted College visits and assisted the working party are also greatly appreciated.

Mr O'Riordan would like to acknowledge the help of his learning set on the Health Foundation Leadership Fellows scheme.

The working party wishes to acknowledge the very valuable contribution of Dr Paul Nicholson, the RCS patient liaison group representative, who sadly passed away during the writing of this report.

CHAPTER 1

Introduction

Policy background

The NHS in England

Since the election of the Labour government in 1997, the NHS in England has seen an unprecedented increase in funding. This has been coupled with the introduction of a challenging and controversial set of reforms. *The NHS Plan*, published in 2000, was the first in a series of policy directives aimed at improving the standard of care given to patients.[1] The plan set the pace for a raft of policy initiatives from the government.

- To reduce waiting lists by introducing independent sector treatment centres (ISTCs) to increase healthcare capacity, which would be in addition to existing NHS services.[2]
- To introduce the payment-by-results initiative – restructuring methods of payment for treatment within the NHS to ensure that each provider is paid a set tariff per procedure.[2]
- To introduce incentives for healthcare providers to treat and manage patients efficiently.[2]
- To provide guidance on service change and modernisation in order to deliver sustainable solutions to keep services local.[3]
- To introduce choice by providing patients with the option of receiving care in a number of locations.[4]
- To create a patient-led NHS, identifying the need for cultural change within the NHS to increase and support patient choice and create a more holistic approach to healthcare, including health promotion and IT solutions to help patients manage their healthcare needs.[5]
- To provide services which are locally accessible to patients by increasing provisions within primary care settings.[5a]

The NHS is a rapidly changing organisation. Public sector reforms are at the heart of government policy. The fast pace of change and the way in which the NHS is conceptualised in the political arena means that the almost constant reprioritisation of health policy is particularly difficult to deal with. Clearly, there has been an ideological shift from the NHS as the sole *provider* of healthcare, free at the point of delivery, to the NHS as the *guarantor* of such healthcare, coordinating the provision of services throughout both public and private organisations via commissioning bodies.

The recent thrust of government policy has been to introduce a plurality of service providers and to promote contestability and competition within the health service. Government attempts to improve efficiency by setting challenging targets,[6] coupled with its aim to devolve power from the centre and make the NHS more accountable locally[7] have caused confusion within the public sector. Central policy has also been established against a backdrop of clinical guidelines from other professional healthcare bodies that have further confounded the delivery of safe and effective patient care.

Throughout these policy changes and reforms the government has made a continuing commitment to retain the guiding principles of the NHS:

- care is provided free at the point of delivery regardless of ability to pay; and
- the NHS is paid for by general taxation.

It is unlikely that the increases in the level of investment seen over recent years will be sustained after 2008, by when funding of the NHS is expected to match the European average proportion of GDP. Therefore, while the principle of the NHS still remains, many NHS Trusts are now entering a phase of financial vulnerability. When this is combined with the introduction of payment-by-results, patient choice and contestability, the next few years could be difficult in terms of sustaining local services.

Northern Ireland and Wales

The health systems in Northern Ireland and Wales have vital differences when compared with that of England.

Neither Northern Ireland nor Wales have Foundation Trusts.

Funding mechanisms in Wales are based on traditional block payments and there are no immediate plans to introduce a 'payment by results'-style system. There are no plans to introduce competition and contestability to healthcare provision in Wales.

In May 2005 the Welsh Assembly Government published a 10-year health strategy document, *Designed for Life*. It sets out a vision of health and social care services based on a strategic shift of health services away from the acute care sector and into the local community.

Northern Ireland's funding mechanisms are also currently based on traditional block payments but consideration is being given to whether a version of the payments-by-results system could be introduced.

As part of a wider reform of elective care, Northern Ireland has recently signalled its intention to increase plurality of service provision by making increased use of the independent sector, in particular to reduce waiting times. This will be introduced in parallel with appropriate increases in health service capacity.

There is, however, an urgent need for both the Northern Irish and Welsh NHS to examine the configuration of services to improve the provision of safe services for the peoples of Northern Ireland and Wales, and to maintain the training and education of surgeons. Regional planning is required in order to facilitate this, and network approaches to service provision will need to be implemented. Therefore, while much of the policy described in this report does not currently affect Northern Ireland or Wales, the underlying principles of reconfiguration, planning and networking are readily applicable. The College is keen to work with the Northern Ireland Office and the Welsh Assembly Government in designing appropriate service models and ensuring the continuation of high-quality training for surgeons.

Reconfiguration

The College's prime responsibility is the improvement of surgical standards to support high-quality patient care. In addition, it needs to protect the training of the next generation of surgeons. As a consequence it has a legitimate voice on how best to organise the care of surgical patients.

Consideration by healthcare providers on how to provide the best services possible has led some Trusts to examine critically the ways in which they provide services and how such services are organised.

Within both the government and the Department of Health (DH), there has been recognition that the current methods employed to configure health services are unsustainable. The National Leadership Network (www.nationalleadershipnetwork.org) has commissioned a project to create a framework for future service models in local acute hospitals in support of the aim to create a patient-led NHS.

The reconfiguration of hospital services is highly sensitive. At a local level, patients, members of the community, local media and MPs often vigorously contest plans to reconfigure services. An example of this occurred in Kidderminster, where health authority plans to downgrade services at the local hospital provoked a sustained attack from local residents, resulting in a consultant from the Trust being elected as an independent MP on this issue. There is also reluctance within central government to make decisions about locally-delivered healthcare, even when professional logic on the grounds of patient safety and cost has been clearly demonstrated. This reluctance has led to many examples of difficulties in sustaining services and the poor management of hospital mergers and site rationalisation.

The need for the reconfiguration of hospital services can be seen as threefold:

- Reconfiguration driven by clinical need – the requirement to provide safe services for patients as locally as possible, while still ensuring patient safety and the best use of clinical staff, facilities and resources.
- Reconfiguration made necessary by the introduction of contestability and competition within the health service – where NHS units may be priced out of the market for providing certain health services.

- Reconfiguration driven by cost – the need for Trusts to assess the viability of providing services where the cost of their provision is more expensive than the income they will gain under payment-by-results.

These aspects will be considered further in Chapter 4.

Within this context the College has identified the need to look at issues of reconfiguration both in emergency and elective surgical service provision, and to examine other requirements and pressures, for example patient safety and clinical outcomes, the provision of appropriate training opportunities for junior surgeons, the European Working Time Directive (EWTD), the proposal to streamline specialist training under the Modernising Medical Careers (MMC) initiative, cost effectiveness, quality of care and equity of access for patients.

CHAPTER 2

The NHS

Key Messages

- The NHS now acts as the guarantor of healthcare free at the point of delivery, with such healthcare being offered by a plurality of providers.
- Care must be provided locally wherever possible.
- Models of service delivery must be appropriately resourced.
- Patient safety must be assured.
- The rapid pace of change and the raft of policy initiatives within the NHS is confusing for patients, clinicians and managers alike.
- Service pressures are many and varied.
- An ageing population will place additional pressures on the health service.
- Service delivery in remote and rural areas is of particular concern.
- The NHS has enjoyed unprecedented levels of investment, but the financial arrangements for some units remain fragile. The introduction of contestability will destabilise some NHS units and provision must be made to protect essential local services.
- The uncertainty about the levels of funding of the NHS after 2008 is a cause for concern.
- Foundation Trusts must ensure equity of access and the protection of core services.
- Private finance initiatives are costly and inflexible. Investment in large secondary care facilities may not be suited to the healthcare needs of future generations.

Introduction

The NHS was created with the founding principle of providing health services for all, free at the point of delivery regardless of ability to pay. These principles have underpinned the provision of NHS services for over fifty years. However, there has been significant change to the NHS over that time. Successive governments have imposed their own ideological policy mix on the NHS resulting in the frequent reorganisation and reprioritisation of the service.

Equity of access to services for all patients is a challenging task for the NHS. The generally accepted principle of equity is one that offers local access to services while protecting the quality of services and ensuring the safety of the patient. Thus, patients expect to be treated for accident and emergencies within their locality.[3] Patients are willing to travel for expert services for which the quality of care and the expected outcome would be better than if treated locally where there may not be the appropriate resources or expertise to deal with the situation.

Ensuring patient needs are met

Predicting need in healthcare, in general, and in the NHS, in particular, is notoriously difficult. Demand for services can be mapped to some extent by matching disease prevalence data with population demographics. However, technological and pharmaceutical advancements will have an impact upon surgical needs. A prime example of this is cardiothoracic surgery where the advent of stenting and interventional radiology for routine cases has resulted in surgery being reserved for the more complex cases, thus creating unexpected and sudden variations in the predicted demand for surgical intervention.[8]

There is a need to be able to anticipate demand to a certain degree in order that Trusts can design and offer the services that their catchment population requires. However, the constraints imposed upon the NHS in terms of financial pressures, local accountability and workforce supply mean that it lacks the ability to expand and contract its workforce, facilities and resources in a sufficiently flexible manner to be able to meet the changing needs of patients and the market. This will be explored further in Chapter 8.

Demographics

The proportion of the population aged over 65 has increased from 13% in 1971 to 16% in 2003.[9] This has profound effects on healthcare demand – the majority of acute surgical admissions are the elderly in whom the burden of co-morbidity is high.

In addition, the average number of people per square km is 380 in England, but actual numbers range from 25 per square km in some remote areas, to over 13,000 per square km in some inner-city areas.[10] This has difficult implications for healthcare planning, with inner-city areas often boasting several large hospitals, which duplicate services, and the more remote areas being served by perhaps one hospital, which may not provide a full range of services, or be fully and easily accessible to patients. Health policy has historically focused on urban areas, thus creating a greater divide between urban and rural healthcare.

Resources and capacity

There is evidence to suggest that resources within the NHS are not always adequately utilised. The drive to increase productivity in the NHS may be a flawed one. For example, an increase in the number of consultant surgeons will not necessarily translate into productivity gains. The number of trained surgeons is only one of the constraining factors that affect throughput and capacity. Productivity may be declining in the NHS for a variety of reasons, but what the NHS should be producing is better health and this cannot be measured adequately in units of inputs to outputs. Surgeons have always and must continue to change practice in order to treat patients efficiently and effectively.

There is, however, under-utilised capacity within the NHS and this will be exacerbated by the current political imperative to outsource elective surgery to the independent sector in order to bring waiting list numbers down. At present, Trusts have fixed cost commitments in terms of staffing and buildings and these will remain inflexible as Trusts struggle to match their expenditure to variations in activity. The full impact of this outsourcing initiative will be examined later.

Service pressures

There are a variety of pressures on NHS services. The progressive implementation of the EWTD has had, and will continue to have, profound effects on the delivery and continuity of surgical care, and on the training of future surgeons.[11,12] The impact on training for surgeons will be examined further in Chapter 5.

The new consultant contract, introduced in 2003–2004, dictates that the full-time work commitment of a consultant should consist of 10 programmed activities (PAs) of four hours each (or three hours if the work takes place out of hours) per week. The DH agreed that normally consultants should spend 7.5 PAs on direct clinical care and 2.5 PAs on supporting professional activities.[13] Consultant surgeons often work significantly in excess of 10 PAs per week. Most Trusts have had to pay for these additional PAs, but the emphasis is on gradually reducing the allocation to 10 PAs per week and this will create an additional service pressure as consultants will be reluctant to offer additional sessions to the NHS without pay.

For specialties that have a significant emergency workload, such as trauma and orthopaedics and general surgery, it is imperative that the on-call consultant (together with the rest of the surgical, anaesthetic and theatre team) is free of elective commitments. This does have an impact upon elective capacity, but can improve the quality of care and throughput of emergency patients.[14]

Contracting arrangements for primary care have also changed. GPs are no longer required to work out-of-hours and so there has been an increase in the number of

patients presenting at A&E departments with ailments that, traditionally, would have been treated by their family doctor. This, coupled with the maximum four-hour waiting time targets for A&E, has contributed to an increase in hospital admissions, thus creating severe service pressures.

In addition, evidence suggests that the creation of NHS Direct, NHS Walk-in Centres and other filtering organisations have had little effect on reducing the numbers presenting either to primary care or at A&E. In fact, it could be inferred that these centres have uncovered previously unmet needs and therefore do not have a positive effect on secondary care service pressures.[15]

Foundation Trusts

In 2002, the government announced the creation of Foundation Trusts (FTs), enhancing the devolution and decentralisation of power. The FTs would become public benefit corporations, encouraging local ownership and the involvement of local people, patients and staff in the running of hospital services.[16]

Trusts awarded three (and more recently, two) stars under the rating system are eligible to apply for foundation status and the government is aiming for all acute NHS Trusts to be in a position to apply for foundation status by 2008. The FTs are audited by the independent regulator, Monitor, and inspected by the Healthcare Commission. The Trusts have control over their budgets and can shape and design services to meet local healthcare needs. The FTs can borrow (within set limits) from the government or from private sector lenders and are able to reinvest any profits made from the sale of land or assets. They are also allowed to use profits to reward staff who contribute most to the Trust.

The College is concerned that:

- such 'earned autonomy' increases inequalities by rewarding the highest performing Trusts and allowing the worst performing Trusts to continue to fall further behind;
- the ability to pay bonuses to good staff may affect recruitment and retention in neighbouring Trusts;
- FTs are, like NHS Trusts, experiencing severe financial difficulties;
- the procedure for appointing consultants in FTs is such that the Trust is not required to have independent external quality assurance of the make-up of the post or of the ability of the candidate to do the job. However, recent agreement between FTs and the Academy of Medical Royal Colleges may help resolve this issue;[17] and
- the DH has set up a customer insight unit, which assists FTs in understanding their patients' needs and experiences. Commentators have expressed anxiety that this unit exists to assist Trusts in marketing their services to 'appropriate' patients, ie those who will not require long stays in hospital, and do not have co-morbidities associated with costly treatment.

Private finance initiatives

The Conservative government introduced the concept of public and private sector partners working together as a means of obtaining much needed investment in the public sector. Private consortia were able to bid for designing, building, financing and often operating hospital services in return for profits. The Labour government has continued with the initiative and brought new money into the health service at a scale and rate not achieved before.

Private finance initiative (PFI) contracts usually last 30 years. Private consortia lease the hospital building to the public sector and sell other services such as portering, cleaning and laundry services. At present, there are over 130 PFI hospital projects in operation. The PFI contracts have been attractive to private companies because they offer a long-term investment which, by statute, must continue to be guaranteed by the state. Private consortia stakeholders can expect returns of 15–25% per year.[18] Consequently, Trusts may need to make substantial cuts to services and/or staff to service the ongoing debt. The PFI hospitals have also been criticised for being poorly designed and creating the untenable position of the need for profit above and beyond the healthcare needs of the public.

It was intended that PFIs should be used only where they offered better value for money than a publicly funded scheme. However, there is evidence to suggest that the costs of PFI have been significantly underestimated and that, in some cases, it would have been cheaper to use public sector money to fund existing hospital building projects. Good evaluation is required over the lifetime of a PFI to ensure the public sector receives good value for money throughout the contract period.

It is also quite possible that the buildings may be inflexible and physically unsuitable for healthcare needs over the lifetime of the contract. A system needs to be developed whereby new contracts will have more flexibility to allow Trusts to future proof their investment.

With the introduction of contestability to healthcare provision PFI Trusts are likely to be in an uncomfortable position; encumbered with a 30-year high-cost contract and having to compete in the market for income may create additional sustainability problems for them. There are increasing signs that the government is re-thinking the affordability of some PFI schemes, especially the large (and even medium-sized) ones. Recent examples where PFI schemes have been abandoned or delayed include the Paddington Basin, Birmingham, and Bart's/Royal London schemes. The issues that are causing difficulty are lack of flexibility and the unpredictability of future payment-by-results tariffs.

Interface between primary and secondary care

There is a need for the traditional and unhelpful boundaries between primary and secondary care to be less absolute. Secondary care is expensive and not always the most appropriate method of dealing with ill health. It is widely acknowledged that many chronic disease management services would be better provided in the primary care setting, and there is also potential to move some surgical services into the community. Better negotiation and planning across the two sectors can only benefit patients and improve their experience of the health service.

The government is proposing to move 15 million care episodes from secondary to primary care.[5] This will have an impact on the workload of consultant surgeons, and will possibly affect training opportunities for junior doctors. There needs to be clear and comprehensive thought given to the appropriate type of care to be transferred and this requires a whole-systems approach to redesigning services and ensuring patient safety.

Primary, secondary and private sector integration

Dr Ian Rutter
Chief Executive, Airedale & North Bradford PCT

North Bradford PCT, along with other local PCTs, has used the ISTC scheme to put in place a new treatment centre providing rapid direct access to a wide range of radiological modalities (including CT and MRI), and direct referral to day surgery.

The ISTC is owned by an American-based company, Nations Healthcare, who have employed their own nursing staff. The radiology is run by MIA Lodestone. The approach to the development has been a tripartite agreement between the PCTs, Nations Healthcare and Bradford Teaching Hospitals Trust. This has allowed the development to use, through a secondment agreement, consultants from Bradford Hospitals. This was key to ensuring agreement on care pathways across a substantial range of both symptom complexes and diagnosis. These care pathways ensure a seamless approach to care wherever the patient is being treated.

Diagnostic care pathways have been designed by building on the learning from the international quality improvement programme *Pursuing Perfection* in which Bradford health economy took part. The approach to imaging is based on ensuring tests are performed in parallel, not series, and to agreed pathways. This approach is the same as that used in a one-stop breast clinic (ie all tests performed, if needed, at the same visit). Patients who, unfortunately, are found to have serious pathology are then referred automatically into the appropriate multidisciplinary team meeting. This has dramatically reduced hidden waits for diagnostics. Using the same consultant staff, whichever the facility, has ensured appropriate continuity. Clear care pathways are ensuring a more integrated approach with primary care.

The treatment centre is getting very positive feedback from doctors and patients. GPs like the fact that there is a maximum four-week wait for surgery, patients are pleased that there is a local and very patient-focused service, and consultants are happily moving between the local NHS Trust and the treatment centre to deliver the activity. The service has removed the barriers that were in place between primary and secondary care. This is a good example of how all parts of the NHS can work in harmony with the private sector to deliver new and improved services for patients.

CHAPTER 3

The New NHS

Key Messages

- The College supports the fundamental desire to increase capacity and improve services for patients.
- Treatment centres have created additional capacity within the NHS, but a lack of funding has meant that this capacity is under-used.
- The strive to create 'constructive discomfort' within the health service and the introduction of contestability will destabilise NHS care provision.
- Initiatives of contestability, patient choice and payment-by-results will create sustainability problems for the NHS and may lead to the closure of some units. Essential services must be protected from market forces to ensure equity of access to healthcare is maintained.
- The financial support and guaranteed income to entice independent sector provision of health services has created an uneven basis upon which to provide services.
- Independent sector treatment centres are focused on profit and throughput. They will, therefore, be reluctant to provide complex and emergency care.
- Training can, and should, be provided within the independent sector and ISTCs.
- The College is concerned about the depersonalisation of care in the independent sector, and about quality of outcome for patients.
- National tariff rates for episodes of care do not currently adequately reflect complexity, co-morbidity and increased length of stay. This will disadvantage NHS units as they will be required to take on patients of this complex nature.
- The College supports the empowerment of patients, but the concept of true patient choice is at variance with competition, which may reduce local services and create increasing health inequalities.
- The introduction of market principles must be carefully considered and NHS provider units must not be unfairly disadvantaged.
- Consultant surgeons in specialties with a significant emergency workload must be free of all elective commitments.

Involving the public and patients

The NHS now has a statutory duty to consult and involve the public and patients in decisions made about service delivery and much progress has been made to ensure that such consultation takes place.[19] In every Trust, patient advice and liaison services (PALS) operate, and in each Trust or PCT area, patient and public involvement forums (PPI forums) have been set up to involve and obtain the views of local people about local health services. The College fully supports this initiative and has had, since 1999, its own patient liaison group (PLG), the lay chairman of which is an invited and valued member of College Council.

The government is keen to have a truly 'patient-led' NHS and the DH document *Creating a Patient-led NHS: Delivering The NHS Improvement Plan* outlines new ways of delivering services that are responsive to patients' needs.[5] The report calls for the development of fast and convenient services provided locally and shaped around the needs of the local population.

Don't forget to consult the service user

David Astley
Chief Executive, East Kent Hospitals NHS Trust

There are many pressures on hospital managers today as they attempt to deliver top-quality healthcare, to the greatest number of patients, at the most economical cost.

It is probably fair to say that whatever solution a Trust offers it will not please all of the patients all of the time.

The argument that, as in our case, we are redistributing services, equipment and skilled personnel across several sites and therefore users will benefit on the 'swings and roundabouts' concept of sharing is all very well until the end user becomes a real patient and has to travel thirty miles for treatment.

It is unrealistic to expect a man with kidney stones who has to travel for his treatment to agree that because his next-door neighbour was able to have her baby locally it means that there is an equitable distribution of resources.

That is why, in our experience, getting the patients on board by including them in the initial clinician-led discussion groups and the full consultation process is imperative.

There are other important patient-focused organisations such as the overview and scrutiny committee and the independent reconfiguration panel whose professional support can help your case but without the, albeit sometimes reluctant, support of patients the future can be filled with anger, protest and newspaper headlines.

We cannot offer our patients every service they would like in a hospital at the end of their street, but by involving them in the decision-making process they may understand why a re-organisation was inevitable and be more ready to accept the situation.

And, when our arguments for re-organisation, better facilities, better trained staff, more surgeons with better skills and so on, are confirmed by the excellence of our patient's treatment and his or her rapid recovery then he or she won't really mind – we hope.

The College's PLG considers that the government's well-publicised attempts to reduce waiting times and increase capacity have a serious weakness in that patients' views are seldom heard. The PLG has created a list of guiding principles that it believes are important to patients, including the need to make certain that stated priorities reflect clinical need, separating elective and emergency surgery to avoid delays created by unplanned episodes, clear and consistent management of waiting lists, and access to sufficient information throughout the process.[20]

Public and patient involvement is vital but can hinder flexibility within the NHS to reconfigure services. On average, formal consultation processes last for two years, and are often poorly managed. This will be discussed further in Chapter 8.

Patient choice

The increased involvement of patients and the public in healthcare provision underpins the government's aim to create a truly patient-led NHS. This has been supported by the report *Building on the Best: Choice, Responsiveness and Equity in the NHS*.[4]

Choice seeks to empower patients to make informed decisions about their healthcare and, in order to support this, the government has committed to improving IT services within the NHS. One of the key tenets of this commitment has been the initiative *Choose and Book*.[21] This electronic booking service will enable GPs to make initial hospital appointments for patients, with a range of venues, dates and times to choose from.

Patients will initially be offered a choice of four or five providers (including foundation hospitals and independent sector suppliers), and, by 2008, will be able to choose from any provider.

The intention is that GPs will support patients by discussing the treatment options available and offering advice where necessary.

There are a number of concerns related to the choice agenda.

- Patients may not be able to exercise choice fully because they may be unable to judge adequately the quality of services offered. There is much developmental work to be completed in order to provide an appropriate and meaningful level of information to patients about the treatment they require and the best place for them to undergo that treatment.
- Because it is impossible to know how consumers (patients) will behave in the choice environment, it may be safe to assume that a number will choose to be treated in the private or independent sector – especially if their perception of the local NHS unit is poor. This may lead to NHS units becoming under-used.
- The secretary of state for health has stated publicly that some services may close if patients choose not to use them.[22] This will have a detrimental effect on other services offered by the NHS unit – for example, in emergency services. Thus, choice could undermine the universality of care provision currently enjoyed within the NHS.
- It is possible that the exercising of choice by a relatively small number of patients might affect the viability of a unit leading to its closure. This would effectively deny choice to a much larger cohort of current and potential patients.
- There have been numerous delays to the IT systems that are essential to the implementation of patient choice. The Connecting for Health[61] IT infrastructure is still not fully functional and it is still unclear as to when appropriate systems will be operational and useable. Continual changes and slippage in the timetable as well as alterations to the software have undermined clinical engagement with the programme.
- Patients may disproportionately choose to receive their care in the independent sector for a variety of reasons such as lower rates of methicillin-resistant *Staphylococcus aureus* (MRSA) and other hospital acquired infections, perceived higher quality care, or even to relieve the strain on the NHS.
- Choice may in fact stimulate demand, and therefore uncover previously unmet needs. Both the NHS and the independent sector may have the inbuilt capacity to deal with such a rise in demand, but it remains to be seen as to whether appropriate funding will be made available to meet this rise.
- The socially disadvantaged, the poor, the less articulate and those with impaired mobility or suffering from mental ill-health may not be able to access choice in the same way as more articulate middle-class professionals.
- The costs (in terms of time, finances and effort) associated with exercising choice (for example, arranging for carers or transport to more distant health centres) may prohibit some members of society from participating fully. Factors such as poverty, education level, language, employment and gender may also affect an individual's ability to exercise choice.
- GPs will likely be the gatekeeper to services and if they have a conflict of interest (due perhaps to their practice-based commissioning activities) and do not present the full range of choice to patients, how can true choice be achieved?
- GPs are concerned that the *Choose and Book* process will significantly prolong already pressured consultations.
- There is concern that GPs may not always have sufficient knowledge (or access to such knowledge) about local services to enable them to provide appropriate information to their patients, let alone have information about services outside their immediate area. It is also of concern that a proportion of primary care consultation time will be spent in making these decisions.

- Primary Care Trusts (PCTs) and GPs may be pressured into sending patients to independent sector treatment centres (ISTCs) for treatment because they have already paid for the operation. There is concern that commissioners will be able to manipulate the choice options available to patients and GPs. It is clear that, in some cases, commissioning arrangements and choice do not mix.
- For many conditions and operations there is a marked absence of appropriate clinical indicators of quality. In addition, many patients (rightly or wrongly) assume that clinical quality can be guaranteed and need not affect their choice of provider. Patients may, therefore, make decisions based upon non-clinical factors such as access, ease of parking or recent press coverage.
- It would seem that the patient choice agenda is being introduced as a means of effecting a patient-driven, bottom-up change process. As such, patient choice is not an end in itself, but rather a means of stressing the system and achieving change.
- There is a lack of choice in cancer services, especially for the relatively rare cancers that require surgical intervention.[21] Patients will be referred to their local cancer network and from there to the nearest pre-determined cancer centre.
- There is a need for more systematic collection of surgical outcomes data.
- The limitations of choice are yet to be decided – for example, could patients make treatment choices at each stage of their care pathway?

The College supports the concept of patient empowerment and it considers the two-way process of discussing a patient's needs and concerns as an extension of the existing doctor–patient relationship. The College remains concerned that patients should be provided with appropriate and accessible information, and that equity of access for all members of society is guaranteed. The provision of individual performance data for surgeons is a controversial concept – it is difficult to adjust performance data adequately to ensure clear and accurate information is provided to the patient. There is also the possibility that individual surgeons will not wish to treat complex conditions or patients with co-morbidities for fear of affecting their performance data, as has been the case in the US.[23] Outcome results do not always reflect the performance of the individual surgeon because surgery is a team effort. The College supports the publication of comparative data for surgical outcomes. Where there is evidence of an improvement in outcomes the College supports appropriate centralisation of services.[24]

Payment-by-results

Payment-by-results (PBR) is a funding mechanism that allows commissioners to pay providers for units of activity. While PBR reflects the cost of care by activity, healthcare resource groups (HRGs) measure care based on the diagnosis made and the complexity of treatment required to create a 'unit of care cost'.

There is evidence already to suggest that some Trusts may be using the system to their advantage.[25] For example, there has been found to be a disproportionate rise in the numbers of short-stay patients admitted via A&E in some FTs that have piloted the PBR and HRG schemes, and yet, there has not been a significant change to their mean episodic cost. In addition, concern has been expressed that some Trusts may reclassify patients as requiring more complex treatment and therefore receive a higher HRG tariff rate for their treatment in order to gain additional revenue. Last year, the DH carried out a consultation on a code of conduct for appropriate behaviour in the implementation of PBR. The results of this consultation have now been published.

The PBR system will require careful monitoring and audit and HRGs will need to be regularly reviewed and updated. Clear systems of coding must be imposed on all Trusts to facilitate fair and appropriate practice. PBR purports to provide a transparent system of payment for services. It should reward efficiency, support choice and encourage activity to reduce waiting times. The aim is to provide a consistent basis for funding rather than relying on historic budgets and continual negotiation between hospital and PCT managers. A PBR system introduces standard national price tariffs, adjusted for regional

Current policy – a personal view

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The NHS is in transition. Its publicly funded system of publicly owned and provided healthcare is being replaced by a healthcare market, in which public providers of services compete with private ones for NHS funds, with legal contracts and external regulation replacing direct political accountability. The new NHS is radically different from the old. The role of the NHS will be government funder and payer, but not provider. Publicly owned and publicly accountable services are being turned into hundreds of competing businesses, each using the NHS logo. The market brings new costs to providing care: the costs of marketing services, billing and invoicing, and profits to shareholders and bankers. There are less visible costs such as service disintegration and fragmentation, the loss of risk pooling and the erosion of entitlements. Healthcare providers will pick and choose the profitable treatments, staff, and patients and services. NHS money is thus diverted to the private sector.

At the heart of the market is the notion that services can be translated into goods and separated out and priced accordingly. Service integration and planning, core features of the NHS along with the rationale for public provision, has been abandoned. The argument is made that if IT, catering, cleaning, land, buildings and asset management can all be outsourced and privatised then why not radiology, pathology, elective surgery and all clinical services? The model the politicians appear to have in mind is of the NHS as a holding company where health services are franchised out to different companies which in turn lease or rent space in return for a share of income and profits from patients and service.

Foundation Trusts are now in discussion with large US healthcare corporations and US medical schools, including Alliance Medical, United Health Group, Kaiser Permanente and Harvard Medical School Inc, developing proposals for profit-sharing arrangements in the provision of clinical services like radiology and pathology and cardiac and cancer services through joint ventures.

But healthcare is not a standard off-the-shelf product; rather it has to be tailor-made for all patients to take account of their different healthcare needs. This makes it difficult to specify and break down into component parts. It also makes it unpredictable to price. The challenge for those planning for emergency and elective surgery in the new NHS is how to provide universal coverage on the basis of equal access for equal need and how to provide high-quality services to the same standard of access and high-quality care in the face of a healthcare market where the internal logic is to create winners and losers among areas, communities, patients, staff and services.

But the biggest challenge of all is the politicians of all parties who would forget the past and ignore the evidence that markets and the profit motive are incompatible with the planned delivery of equitable services and the public health. In doing so they have placed the sixty-year legacy of the NHS, which conferred on each citizen and resident of the UK the right to 'freedom from fear', in awful jeopardy.

variations, for each unit of activity and grouped into HRGs.[26]

Each Trust has a reference cost – the cost to the Trust for each unit of activity. National tariffs have been based upon the average reference cost per unit, and, it is hoped, will encourage Trusts to drive their costs down and become more competitive. It is possible that, in the future, tariff prices will be set at progressively lower levels in order to encourage continued efficiency gains.

In practice PBR actually places emphasis on increased activity rather than on ensuring quality outcome results. Market principles would dictate that it is not possible to

have a single price for a product that varies. For example there are mechanisms in place to attempt to compensate for associated co-morbidities but these are quite basic and may not reflect the diversity of clinical practice. The costs of treating different individuals will not be the same. The temptation for providers will be to concentrate as far as is possible on treating more straightforward cases and certainly ISTCs will not have the facilities to treat patients with co-morbidities. In addition, Trusts receiving significant numbers of tertiary referrals or performing complex surgery may be particularly disadvantaged. The recent example of the Oxford Radcliffe deciding not to provide routine cardiac catheter ablations suggests that national prices do not reflect the costs of providing services, although until PBR is fully rolled out it is unclear whether this is a national or local issue.

Funding of NHS providers has often been related to elective activity. As this shifts away from traditional providers, the NHS risks being left to treat a case mix skewed towards expensive, unpredictable and relatively under-funded emergencies.

The PBR scheme has been introduced to facilitate payment streams to independent sector providers, but more thought is required as to how essential services, which ISTCs will be reluctant to provide, will be maintained at a local level. This will be examined further in Chapter 8.

Increasing capacity

The government's aims of reducing waiting times and increasing choice for patients revolve around the development of additional capacity. Major investment has been made in creating additional capacity – for example, new hospitals (under PFI arrangements), additional beds, and additional staff (mainly from overseas). The DH also promised additional capacity through the use of diagnostic treatment centres (DTCs) and ISTCs. The impact of these centres and the drive towards contestability and the plurality of service providers are explained below.

Diagnostic treatment centres

Diagnostic treatment centres were introduced to provide extra clinical capacity to allow the NHS to meet its waiting list targets and deliver swift access to treatment for local populations. The DTCs are dedicated units that offer either day or short-stay surgery and diagnostic procedures. The aim is to completely separate emergency and elective care within Trusts, thus avoiding cancellations and disruptions to one service being caused by unpredictability of the other.

Treatment centres are either operated by NHS Trusts or by independent sector providers. There is evidence to suggest that several NHS-operated DTCs are failing. While the capital building costs of DTCs were centrally funded, the host units were not provided with reliable revenue streams such as contracts guaranteeing income. Many units now have spare capacity, but funds are not available to allow patients to benefit from that capacity. This puts the DTC into debt, which also has a knock-on effect for the operating Trust. Such instability may not have been intended by either the government or the DH. However, the inbuilt reciprocity arrangements within Trusts and health systems have diminished sufficiently so as to make Trusts unable to deal with debts of this nature.

Independent sector provision

The government's aim of having 15% of elective activity (1.1 million procedures per annum) provided by the independent sector by 2008[5] has created a change in the way that services are planned and provided.

Historically, the NHS had 'spot purchased' services from the private sector to meet certain needs (for example to reduce unacceptable waiting times for a particular operation). The DH estimates that the cost of purchasing such activity was 40% more than it would cost in the NHS. It estimates that purchasing from ISTCs will cost approximately 9% more.[27]

The ISTCs work in line with the PBR initiative, whereby providers are paid per unit of activity. By 2008, all episodes of care will be based on HRG tariffs, the

intention being to give incentives for healthcare providers to treat and manage patients efficiently.

The ISTCs were originally created to be fully additional to the NHS – ie staffed from a non-NHS, overseas workforce, although units set up in the second wave of contracts will be able to second or directly employ NHS staff to work for the ISTC providing they have fulfilled their contractual obligations to the NHS. The ISTCs were originally intended to be sited in areas where the gap between waiting times and targets was greatest. It would appear, however, that the DH has not always followed this practice.

The government has underwritten ISTC start-up costs and has guaranteed the level of work that units will receive. This has created a zero-risk environment for the first wave of ISTCs for the initial five years of their existence, and has consequently undermined the financial stability of NHS providers who will lose a significant proportion of their activity and hence a large amount of their income. The PCTs have already pledged to pay ISTCs for the contracted activity and so if patients choose not to use the ISTC, the PCT will have to pay for the episode of care twice (once in the ISTC and again in the NHS unit). Of greater concern is the possibility of PCTs in these situations actively discouraging patients from using their local NHS unit in order to avoid double payments – this seriously undermines the choice agenda and surely contravenes patients' rights.

The government has assured the profession that such preferential terms will not be offered to the second wave of ISTC contractors, although there is still some time to run with the existing first-wave contracts and these cannot be changed. Attention must be paid to ensure that future contracts with ISTCs and the independent sector do not unfairly disadvantage NHS units. It is clear that private sector providers will wish to grow their core market year on year. A DH analysis found that they would need to guarantee an additional 250,000 cases per year to ISTCs in order to facilitate good engagement with the independent sector and to guarantee their continued growth.[27]

ISTCs have adopted the 'focused factory' model of service provision – high volume, less technical and less complex cases that guarantee an agreed level of throughput and income. In order to maintain this production line approach, ISTCs will not wish to take on the more difficult cases – those patients with complex needs and co-morbidities, or those patients requiring revision operations. The effects of this policy on NHS services are twofold:

- the NHS will be expected to deal with complex and refractory cases, thus increasing costs and service pressures; and
- the very cases from which surgeons in training gain basic surgical skills will be removed from the NHS and placed in the independent sector. Clearly, there is a need for training to take place within ISTCs, but much work is required to quality assure the centres so that they are able to accept trainees and also to negotiate funding mechanisms for this. These issues will be examined further in Chapter 5.

The College remains concerned that ISTCs create a depersonalisation of care. The factory focus of ISTCs means that the patient's pre-, peri- and post-operative care is no longer the responsibility of a named consultant surgeon or even a team. For some procedures, eg cataracts, this may not be of concern to patients. However, for more involved procedures such as joint replacements, patients will wish to have contact, before, during and after their operative stay, with the same consultant surgeon and team. The aftercare offered by ISTCs is also a matter of concern and there is evidence that without good rehabilitation, communication and aftercare support, patients are more likely to require revision operations at a later date.

The College feels that it is preferable for ISTCs to share a site with existing NHS hospitals, and supports the concept of 'structured secondments' of NHS staff to ISTCs.

The continued focus on productivity and throughput may mean that the surgeon is conceptualised not as a professional, but as a technician. The College strongly

Tomorrow's medical leader

Professor Jenny Simpson
Chief Executive, British Association of Medical Managers

In the patient-led NHS of the future, with plurality of provision, patient choice, Foundation Trusts and funding streams driven by clinical activity, the role of the medical leader and manager is crucial. To succeed, services will depend on three factors – their clinical quality, their financial viability and the demand for them.

Medical leaders and managers carry the responsibility for the quality of clinical care. No longer can the medical manager be simply 'the clinical representative on the Board' or the medical rubber-stamp on an executive decision. Tomorrow's medical leader sits with both clinical and real management responsibility and authority. He or she is managerially accountable to the organisation for the performance of clinical colleagues. The medical leader sits at the point of fusion between clinical and managerial decision-making and must maintain consistency and integrity within both worlds. The skills, knowledge, expertise and experience to do this – and to do it well – do not appear by magic. Like every other complex role, medical leadership and management demands high-level education, development skills, coaching and monitoring based on a realistic assessment and evaluation of the individual's capability to do the job (see www.fittolead.co.uk). This must be supported by an infrastructure in which medical leadership and management is a recognised career aspiration with the same education, rewards and recognition of the senior leadership position in the NHS as the role has now.

believes that consultant surgeons, as well as operating upon patients, provide holistic patient-centred care that incorporates judgement, decision-making and the assessment of risk and this must continue. Separating the technical and non-technical skills and depersonalising care will be detrimental to patient safety.

Commissioning arrangements

The PCTs manage and commission services for the local population; they take a multi-agency approach to commissioning services across the health and social-care spectrum. The PCTs now receive over 75% of the NHS budget and are responsible for coordinating services to ensure they are appropriate for the local community.

The DH publication *Commissioning a Patient-led NHS*[28] aims to create a sea-change in the way services are commissioned in order to reflect patient choice. It seeks to engage local clinicians, review the functions of PCTs and strategic health authorities (SHAs) and develop their skills to ensure better commissioning and contract management.

Commissioning a Patient-led NHS requires the NHS to once again consider the optimal configuration of PCTs and SHAs. While the effectiveness of PCTs varies across the country, and their reconfiguration may be long overdue, there is concern this represents yet another reorganisation of health services that will stifle working relationships between providers and commissioners at a time when collaboration is most required.

GPs are being encouraged to become commissioning agents in their own right under the *Practice-based Commissioning* arrangements from the DH.[29] GP practices or groups of practices will be given the right to an indicative budget to identify the health and social care needs of the local population and, with support from their PCT, to identify appropriate services to be provided. Although practice-based commissioning is still in its infancy, the DH plans to bring forward the universal roll-out of the programme to October 2006. There are concerns about the commissioning expertise of GPs, and that, once fully developed, practice-based commissioning may further distort rational clinical planning.

Contestability and competition

The introduction of the internal market to the NHS during the early 1990s aimed to create a competitive environment that would improve performance by providing incentives for innovative and cost-effective policies and penalising poor performers.

The Labour government has continued to attempt to introduce competition and stimulate efficiency gains to the health market throughout its term of office. Simon Stevens describes the move towards bipartisan

agreement on introducing contestability and challenging the power of the medical profession as the search for 'constructive discomfort' – finding a source of tension that will provide incentives and overcome inertia in the health service.[30]

While it could be argued that there was a need to create such 'constructive discomfort', the College remains apprehensive about the severe destabilisation it may cause, resulting in the removal of essential services as providers seek to gain a competitive edge within the market. Health services require good partnership working and long-term planning to facilitate stability and viability.

It can be assumed that the government's enthusiasm for opening up the health market to independent providers has been fuelled by the unfavourable comparisons made between UK and US models of care and service delivery.[31] The US models (for example that of the Kaiser Permanente healthcare system) are widely believed to be more cost effective and efficient than the NHS. However, it is extremely difficult to draw comparisons between such widely diverse health systems. The Kaiser Permanente model actively selects patients for inclusion, and those patients pay insurance premiums in return for cover. This means that they are more likely to be in employment and therefore relatively healthy. The Kaiser system provides selected healthcare for approximately 8 million members. By comparison, the NHS provides healthcare for almost 60 million residents, and care is provided free to all citizens, regardless of their ability to pay, their age, health or socio-economic status. Therefore, it can be argued that any comparisons drawn are severely flawed. It is almost impossible to assess like-for-like because Kaiser and the NHS differ in cost, coverage and performance levels.[32]

If contestability and competition are to be introduced to the healthcare sector, a better use of competition law is required to guarantee fair and consistent business processes.

Workforce

Modern surgical practice requires effective multiprofessional teamworking. This is increasingly widespread in the NHS and workforce planning and design will need to reflect service design and the diversity of roles within the clinical team.

A well-developed and flexible workforce underpins the development of any new model of care. It is the College's role to ensure that the future surgical workforce is appropriate to meet patient needs and specialty requirements.

The College's report *Developing a Modern Surgical Workforce* concluded that there was a shortage of consultant surgeons.[8] The College and the government are committed to developing a consultant-delivered service and the College will continue to target the expansion of consultant surgeon numbers in defined shortage specialties in order to support service delivery and training.

The government has tried to increase the medical workforce through a variety of short-term measures, eg by international recruitment. What is required is long-term investment in an appropriately skilled and resourced workforce. The government has increased the numbers of medical student placements and this is to be commended. However, that increase must be matched by a rise in the number of funded specialist training places, and the issue of the many talented and dedicated

What is contestability?

In market theory, contestable markets have no barriers to entry. The threat of potential new entrants to the market is sufficient to ensure that existing providers act competitively to ensure lowest costs and reasonable profits.

Independent healthcare providers are being offered a 'zero-risk' environment and incentives to enter the market.

How does contestability differ from competition?
Competition is used to improve standards and provide better value for money in the market place.

What is plurality?
The introduction of a range of service providers to the market to ensure competition.

surgical staff who are stuck in the training system without prospect of moving on to achieve consultant status must also be addressed. In particular, as MMC comes into effect, there is a very real risk that many talented, current SHOs will be unable to find places on higher surgical training schemes. Indeed there is evidence that this is already starting to happen.[33]

Long-term workforce planning is complex – the introduction of independent sector provision further complicates the calculations required in matching supply to demand. For example, NHS staff were prohibited from working within the independent sector in the first wave of ISTC contracts. However, more recent contracts will enable NHS staff to be seconded to ISTCs provided they have fulfilled their contractual obligations to the NHS. This move is welcomed (as it will help to ensure the level of care offered in the ISTCs is of a high standard). However, the College considers that if NHS staff are drawn away from the NHS and into near full-time working for the independent sector and/or ISTCs, workforce planning will become increasingly more complex as NHS teams become destabilised. In addition, the investment in training will become more difficult to recover.

It may be that future employment arrangements will encompass both NHS and independent sector organisations, or that consultant surgeons will be appointed to a network, rather than to any individual hospital Trust – this method of contract arrangement requires further development and there would still need to be some form of national workforce planning in place.

Clinical interdependencies

The College's report in 2000 on *The Provision of Elective Surgical Services* called for services to be coherent, sustainable and acceptable to patients.[34] To enable this, multiprofessional teamworking is required at all levels. The report set out the complementary services required to support various surgical services. These clinical interdependencies are still valid today but better use of IT, facilities and staff may reduce them. Adequate resources and clear protocols for care must be employed. Patient safety must be paramount when considering the restructuring of services.

Emergency provision

Major supporting services normally accessible on the same hospital site:

- acute general medicine;
- coronary care;
- acute general surgery and major operating theatres;
- orthopaedic trauma;
- anaesthetics;
- intensive care;
- radiology including the following modalities: X-ray, CT and ultrasound;
- laboratory services including haematology, clinical chemistry and transfusion; and
- paediatrics if children are treated in emergency department.

Unselected medical take in units that cannot provide the above services on the same site would be unsafe.

If any of these services, eg emergency surgery or trauma, are not present on site, then the College asks for an indication as to how service is provided for emergency patients needing that type of care.

The specialties listed should be supported through liaison with paediatric surgery, cardiothoracic surgery, neurosurgery, ophthalmology, oral and maxillofacial surgery, otorhinolaryngology, plastic surgery and urology, and obstetrics and gynaecology.

Elective inpatient surgery

Elective inpatient surgery is often better carried out independently of emergency provision in order to minimise disruption to both services. Therefore, the minimum provision for inpatient elective surgery alone would be:

- anaesthetics;
- radiology and access to pathology;
- post-operative care (at least to high-dependency unit level);

- access to general medical opinion;
- relevant surgical services;
- operating theatre services;
- resident medical cover (for post-operative management of complex surgery and routine surgery on patients with complex co-morbidities); and
- access to intensive therapy unit facilities, if required.

Day surgery

The minimum requirements for day surgery, in addition to protocols for urgent transfer to a district general hospital (DGH) if required, would be:

- anaesthetics;
- operating theatre services;
- radiology;
- relevant surgical services; and
- post-operative care.

Accident & emergency service

Alongside the clinical interdependencies stated above, a fully functioning 24/7 A&E service (ie a centre that accepts all emergencies) requires a critical population mass in order to provide efficient and effective services. Such units should be consultant-based and led and offer excellent training opportunities for junior doctors. There is a need for A&E services to link effectively with services within the base hospital, neighbouring DGHs and peripheral centres to allow for the effective management of all conditions.[35]

While very few general surgical emergencies require an immediate operation, patients do require immediate expert assessment. A&E departments must be staffed by appropriately trained A&E specialists, supported by a trauma team and appropriate diagnostic and anaesthetic facilities.

Consultant surgeons on-call for general surgery and trauma must be free of all elective commitments.

Unselected medical take without the ability to provide on-site surgical opinion is unsafe, eg for patients presenting with severe gastrointestinal haemorrhage.

There has been an increase in innovative ways of handling emergencies, for example the increased use of emergency-care centres and of surgical or medical assessment units near to A&E to better triage patients requiring urgent attention.[36] These are to be commended. Appropriate transfer and bypass protocols will be required for those centres that cannot offer the full range of services. These protocols must be agreed with ambulance teams and other hospitals within the area on a network basis.

A&E must be considered an essential service – one that patients will expect to access locally. Careful thought needs to be given to the sustainability of A&E services within the context of PBR, choice and contestability. The College believes such services should be protected from the competitive environment or be guaranteed financial stability. This will be examined further in Chapter 8.

Sustainability

The Labour government has pledged an unprecedented additional investment in healthcare spending – to reach £105 billion by 2008. The percentage of the country's gross domestic product spent on healthcare will have risen to 9.4%. This additional investment in health services has been welcomed, and improvements undoubtedly have been made. However, continued growth in healthcare spending depends on a strong economy and, currently, the level of investment post-2008 has not been defined. In addition, there has been an inevitable time delay in implementing some improvements, for example an increase in workforce numbers and developing IT solutions.

Critics would argue that the increased level of investment has not been seen on the front line. The College's working party heard evidence that, despite the government's move to 'shift the balance of power' to frontline clinical staff, funding was often held by SHAs and PCTs and used for projects at that level rather than

being fully devolved to enable development of new treatment opportunities or service improvements at a local level.

The introduction of stronger market principles to the NHS along with changes to the method of payment for units of activity and the extension of the patient choice agenda pose a significant threat to the stability and sustainability of NHS units. The secretary of state for health has reiterated the claims of her predecessor, stating that NHS units that fail in the market may be forced to close. The College is concerned about the implications of this policy and is particularly anxious to know how vital local services will be protected in such instances. This will be further examined in Chapter 8.

Funding pressures

Many Trusts, Foundation Trusts, SHAs and PCTs are in severe financial difficulty.[37] The reasons for this are varied and complex.

- The PBR initiative, which pays hospitals per unit of activity, represents a clear risk to the financial stability of the NHS. In addition, it may stimulate activity to the detriment of quality.
- The extension of the choice agenda, coupled with the increased use of independent providers, will increase uncertainty about income levels and thus disrupt long-term planning.
- The costs of implementing the new consultant contract have been underestimated. There is some concern as to whether such a time-based contract (held with individual Trusts) is the most appropriate model for the new ways of providing services in the NHS.
- The employers' contributions to NHS superannuation have increased significantly.
- Most health systems are having to cope with rapidly increasing levels of emergency workload.
- Updating IT systems and incorporating new payment structures under the *Agenda for Change* initiative have proved costly.

Many PCTs are also struggling financially, with the cost of GP and consultant contract implementation, coping with an ageing population, rising prescribing costs, the increased costs of funding GP out-of-hours services and the compulsory commissioning of 15% of elective services from the independent sector.

Given this, the idea that funding for healthcare treatment will follow the patient and stimulate choice and contestability appears to be far more complex than originally imagined.

The College's working party heard evidence from various PCTs during Trust visits and it would appear that they are beginning to set more stringent eligibility criteria for certain treatments (and so restricting choice). In some cases, PCTs have been forced to create incentives by providing travel subsidies to patients and relatives to encourage them to choose the independent sector over NHS services.

It is clear that Trusts will not be able to rely upon an income-led solution to their financial difficulties. The Trusts' attempts to market profitable services to patients may be thwarted by the lack of commissioning funds to purchase such services and the inherent inflexibility of NHS provision. The predominant solution to Trusts' financial problems will be in controlling expenditure and this may lead to service and staffing cuts.

CHAPTER 4

Drivers for Reconfiguration

Key Messages

- The link between the need for clinical reconfiguration to ensure the best use of staff and resources and assure patient safety must not be ignored.
- The reconfiguration of services must have a sound clinical and evidence base. Financial and managerial expediency must not be primary drivers for reconfiguration.
- There are a range of organisations involved in defining and determining the need for clinical reconfiguration and this is unhelpful.
- The College and surgical specialist associations have developed recommendations for the optimum configuration for highly specialised services.
- Over-arching authority is required to organise some services on a national, or international, level. This is beyond the policy reach of Primary Care Trusts and strategic health authorities.
- Remote and rural hospitals require special attention in debates on contestability, competition and payment-by-results.
- The provision of surgical services in London needs particular attention.
- Patient choice favours patients living in urban areas. Patients cannot exercise choice in rural areas as effectively.
- NHS Trusts lack the inherent flexibility, in terms of both staffing and buildings, of the independent sector and are hampered by the formal requirements for consultation regarding service change. As a result they will find it very difficult to respond to the inherent unpredictability of the patient choice agenda.
- The fast pace of policy development from the centre places an additional burden on the NHS – units cannot easily develop or adhere to long-term strategic plans.

Introduction

Previous chapters have discussed the foundations of the NHS and the changing political, clinical and financial climate.

As outlined in the introduction to this report, there are three main drivers for reconfiguration:

- reconfiguration driven by clinical need;
- reconfiguration made necessary by the introduction of contestability and competition to the health service; and
- reconfiguration driven by the cost of providing the service.

Clinical requirement for reconfiguration

Specialised services

Responsibility for strategic planning and the commissioning of services rests with SHAs and PCTs (in England) and with local health boards and the Health Commission Wales in Wales. However, some highly specialised services highlight the need to concentrate workload, expertise and training opportunities in fewer centres. In these cases, planning is beyond the policy reach of PCTs and SHAs. Only a national or, occasionally, international perspective is appropriate to organise such services.

Additional pressures on the centralisation of highly specialised services include shortened hours under EWTD, the need to provide an appropriate level of

training within specialist units and the requirement to ensure surgeons have sufficient volume of surgical activity to avoid de-skilling.

Many of the surgical specialist associations have been instrumental in developing blueprints for the centralisation of highly-specialised services,[38–49] but there has been political reluctance to concentrate services to ever fewer locations, despite professional logic on the need to assure patient safety, limit costs and ensure the effective use of resources.

The absence of validated clinical markers for defining standards for some surgical interventions, coupled with the range of organisations involved in defining clinical standards and quality in surgical services, has confused the issue of configuring services for clinical need. The College would strongly urge service planners to take account of evidence-based recommendations. In addition, we would strongly urge the DH and central policy makers to use their over-arching powers to initiate the organisation of some services, eg paediatric and congenital cardiac services, on a national scale.

Providing services in smaller hospitals

The preferred catchment population size, as recommended in previous reports, for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency medical and surgical care would be 450,000–500,000.[48] It is estimated that hospitals of this size account for less than 10% of acute hospitals in England. This size of hospital would produce very large numbers of medical admissions each day and they are likely to be located a significant distance away from patients' homes, family and social services contacts. It is unlikely that there is going to be a significant shift to this size of hospital in the short to medium term. The majority of acute hospitals currently have, and are likely to continue to have, a catchment population of approximately 300,000. Some rural hospitals do not reach even this population mass and yet are still required to provide as full a range of services as possible. Such units have a particularly difficult task in providing services that are local, safe and cost effective. There needs to be, in the first instance, strategically planned re-organisation so that, where feasible, smaller hospitals are able to merge to achieve a catchment population of least 300,000.

Hospitals serving a population of 150,000 or less are found in many geographically remote parts of England and Wales. Advice offered regarding the organisation of services usually centres around the hospital working in

Presidential visits

Sir Peter Morris
Past-president, The Royal College of Surgeons of England

After becoming president I initiated a new scheme of presidential visits around England and Wales. During this time I visited approximately 50 Trusts.

One common problem I encountered was the provision of emergency vascular services. In many places there were perhaps one or two peripheral vascular surgeons in a Trust. In some areas, surgeons had developed their own rota and cross-cover arrangements. However, in many cases this had not happened. In terms of reconfiguration, there should be one major vascular unit in each region with members of that unit working on a hub-and-spoke arrangement with their referring district hospitals. Although there is little resistance to the necessity of rationalising services in this way, there appears to be a reluctance to push the agenda forward.

Another area of need for reconfiguration was the provision of renal transplant services. Although the number of units has been reduced considerably since the publication of the College report on transplantation,[46] there are still too many units. In order to provide a 1:4 on-call ratio , the unit needs to have five transplant surgeons. In order to avoid becoming de-skilled, the unit must be of an adequate size to provide sufficient transplant work and experience for five surgeons. It has been suggested that this level would be more than 75 transplants per year.

Both of these issues are solvable with good leadership; both from managers and clinicians at a local or central level.

close partnership with adjacent services to make use of those specialist services not available on site.

During the working party's health-system visits it became clear that this advice, while well intentioned, is not always practical. Hospitals do work closely with other units within the Trust wherever possible, but often there are such distances between sites that networking is not possible, and providing outreach services to different hospitals within the Trust is difficult. There is a potential conflict between the trend toward managed clinical networks and contestability. Also, outreach services are costly to provide and do not help with running a competitive service. However, outreach services may help to generate new referrals and thus potential income in an era of patient choice.

Rural hospitals will now also face the difficulties of competition, contestability and new funding arrangements. Where more centrally located units will have the option of closing down services on one site to be provided on another, the rural units do not have such inherent flexibility. Furthermore, in many cases, the Trust must provide, for example, A&E services on each site and have no hope, therefore, of lowering their reference cost. This means that rural units will be severely disadvantaged in the world of PBR and contestability. The siting of ISTCs near to rural hospitals will seriously compromise their already fragile income base. The College would strongly urge the government to consider the plight of rural hospitals and act accordingly to protect them. Multi-site rural hospitals may have some flexibility when it comes to centralising onto a single site but this flexibility may be impaired by clinical or political factors.

In addition, there are limitations on the extent to which patients in a rural setting can exercise choice. The larger urban areas of the country will offer a more accessible choice of service provider. Rural areas with a smaller population density are less attractive to independent sector providers entering the market. This, combined with the distance to the neighbouring acute Trust, may restrict patients' ability to access a choice of service providers.

Reconfiguration driven by changes to healthcare provision

The introduction of independent sector providers, together with the implementation of PBR and contestability, will force many NHS Trusts to examine critically the services they can safely and cost-effectively offer.

As has been outlined throughout this report, because of the constraints placed upon public sector services, the NHS lacks the ability to respond quickly to fluctuations in the healthcare market. Traditionally, the NHS has often subsidised poorly performing services but PBR makes this much more transparent and therefore harder to do.

Furthermore, because of the rapid pace of policy change from the centre, many Trusts find it difficult to make and adhere to long-term strategy plans, thus further alienating them from the competitive market. This issue will be discussed further in Chapter 8.

CHAPTER 5

Training

Key Messages

- Full shift solutions to the European Working Time Directive (EWTD) are detrimental to training. Some specialties have reported a significant reduction in operative experience post-EWTD and surgeons may need to spend longer in training to compensate.
- Surgery is a craft specialty and it takes time and practice to acquire the relevant skills. Hence the training of future surgeons requires specific consideration within the context of EWTD implementation.
- Modernising Medical Careers aims to streamline training wherever possible by focusing on competence-based training rather than time spent in the grade.
- In order to deliver training within shortened hours and within the new curriculum, consultant surgeon trainers must be identified and given appropriate incentives and support to provide training, within contracted hours.
- Surgical training is expensive in terms of both trainer time and reduced patient throughput and needs dedicated funding mechanisms.
- The time taken to train aspiring surgeons must be adequately estimated and appropriately recognised within consultant job plans.
- Trusts must recognise that trainee doctors will become less able to contribute to service delivery.
- An expansion of the surgical workforce is required to deliver the current level of service.
- Training can, and should, take place in the independent sector and in ISTCs. This may be best organised as part of a modular training programme.
- The College is working to provide guidance on how training might be provided within the independent treatment sector setting and within primary care – the College will need to quality assure such training posts.
- The College must work with hospital Trusts, ISTCs, PCTs and the deaneries to ensure that services are organised in such a way as to optimise training.
- All units that are required to provide training should be adequately compensated.

Specialisation

Surgery comprises many procedures that are highly technical yet small in volume. In this era of patient-centred care, it is difficult to predict with any certainty how patients may exercise their individual choice. It is, however, highly likely that patients will want to be treated by a doctor who specialises in the type of care and surgical intervention they require.

Increasing sub-specialisation creates difficulties in meeting the demand for emergencies – many breast surgeons, for example, no longer participate in the general surgery emergency rota. The continuing trend towards ever greater specialisation in surgery will further exacerbate difficulties in the provision of emergency surgical services. In the quest to meet demand for medical emergencies, physicians have introduced the specialty of acute medicine.[51] This will need to be appropriately rewarded to enable recruitment and retention. In order to maintain the viability of NHS hospitals, and to ensure patient safety, there will need to be similar arrangements to encourage surgeons to maintain an emergency commitment. The benefits of an emergency surgical consultant grade should be examined further.

Training in independent sector treatment centres

Dr Sarah Crowther
Deputy Chief Executive, East & North Hertfordshire NHS Trust

The original concept for the ISTC programme was to provide extra capacity to the NHS using additional, often overseas, staff. The focus on service provision has meant that both medical and nursing training opportunities in the units are negligible. More recently, a number of ISTCs have emerged with large amounts of activity transferring from the NHS. There is a need, therefore, to ensure that adequate training opportunities exist in ISTCs to maintain suitable training placements and accreditation.

This shift in the nature of some ISTCs has identified a number of practical issues.

- While the DH has used standard documentation to provide consistency between ISTC schemes, no nationally agreed training schedule exists suitable for dealing with large-scale training activities.
- The role of the national implementation team is to support the commercial process of procurement. Its focus is, therefore, primarily on the loss of efficiency to the ISTC by providing training. Thus the issue of the quality of training provision needs to be locally driven.
- A lack of understanding from some bidders on training requirements.
- An inability to easily quantify the impact of training currently undertaken in the NHS in a format that can be shared with bidders.
- Uncertainty about future accreditation processes – does the NHS body remain accountable for the provision of training within the ISTC or are the units accredited separately?

The GC9 East & North Hertfordshire ISTC scheme has a high proportion (90%) of transferred activity and training is a significant issue for both acute Trusts involved. A number of learning points for the ISTC programme can be drawn from the GC9 experience.

- Trusts need to engage closely in ISTC plans in their local health community early on and be prepared to put time and resource into the process both clinically and managerially.
- There is a need to identify the volume of transferred activity and the subsequent impact on training as accurately as possible so it can be detailed within the invitation to negotiate.
- Agree if, or how, training should be priced in the bid. Is it included in the tariff or will the health community consider a separate premium?
- Ensure that the evaluation criteria for the contract are weighted to give sufficient emphasis on training.
- Start work early on the training schedule of the project agreement, with good legal input.

Training in independent sector treatment centres

Throughout this report, we have explained that ISTCs are focused on providing basic elective surgery to patients – the very cases on which surgeons in training build their experience and expertise. With the first wave of treatment centres geared towards providing approximately 210,000 operations per year,[52,53] the effect of losing this quantity of basic operative experience from trainees' portfolios is likely to be drastic.

It is estimated that if an operative procedure includes a training element, the activity can take up to 30% longer when compared with a solo consultant surgeon performance.[51a] This will have an effect on the throughput of the ISTC and their operators will no doubt demand to be compensated for that loss in activity and income. The College, however, believes that whichever unit provides quality training, NHS or independent sector, it should receive the appropriate compensation to allow for the reduction in throughput. It should also be recognised that more senior specialist registrars can make a significant service commitment to the NHS. Their salaries are funded from deaneries and hence an organisation with larger numbers of more experienced trainees is effectively receiving a subsidy if it utilises these doctors to provide a major contribution to service delivery. This could also be a potential perverse incentive to use these funded doctors for service delivery rather than to give them the training they need.

The government has recently recognised that ISTCs must provide an element of training and have given assurances that provision for training will be included in future contracts. The College welcomes this initiative, and is currently working to develop guidance on how training might take place within ISTCs. However, with the current concerns over quality in some ISTCs, more work needs to be done to inspect and quality assure ISTCs as appropriate to provide training. This initiative must be translated into action and there must be a willingness to look beyond the financial issues to training and quality.

Training in primary care

The government aims to move 15 million episodes of treatment from the secondary to the primary care setting.[5] The extent to which GPs can realistically and cost effectively take on the work of hospital consultants remains to be seen. However, during the health-system visits, the working party heard that, in some areas, GPs with specialist interests (GPwSIs) were already performing a large number of minor operations within the primary care setting (one PCT estimated that GPs in its area provided up to 5,000 such operations per year).

There is a need to ensure that surgeons in training can participate and benefit from the experience of working and training in the primary care setting. The MMC initiative aims to provide dedicated training slots in community care for trainees in foundation years 1 and 2 and the College supports this aim. Surgical trainees will also need to participate in some form of training in basic surgical techniques within primary care during their early years of specialist training and partnership working with the deaneries is required to facilitate this.

European Working Time Directive

Possibly the most important workforce pressure facing surgery is compliance with the EWTD. The service pressures created by the requirement to shorten hours for doctors in training are well documented.[11,12] Recent surveys of trainee and consultant surgeons undertaken by The Royal College of Surgeons of England EWTD working party and surveys conducted by the Royal College of Physicians suggest that arrangements are exceptionally fragile and have had a detrimental effect on training and on the quality and continuity of care given to patient.[54–57] The NHS is working towards implementation of EWTD by 2009, which will further limit junior doctors' working hours to 48 per week. Great effort will be required to find innovative ways of working, especially within smaller hospitals. There will be a requirement for a substantial redesign of services and training models.

Lincolnshire primary care surgical scheme

Dr Pete Calveley
PEC Chair, West Lincolnshire PCT

The Lincolnshire primary care surgical scheme currently delivers day-case surgery to approximately 5,000 patients per year in 20 primary care settings across Lincolnshire. The procedures are performed mainly in GP surgeries by GpwSIs, but three of the providers are either current or retired consultant surgeons. All procedures are carried out under local anaesthetic. Procedures performed in primary care include inguinal hernia repair, carpal tunnel release, trigger finger, vasectomy, excision of ganglia, lipomas, sebaceous cysts, meibomian cysts, skin lesions, toenails, etc., and haemorrhoid injection and banding. Most of these procedures are now exclusively performed in primary care and are on the local low-priority list for secondary care. The scheme was developed with the full support of the local hospital Trust.

To be accepted as a provider on the scheme a GP must pass an accreditation panel, which is chaired by a local consultant surgeon, and participate in the quality assurance arrangements of the scheme. These include attendance at an annual study day, independent patient satisfaction survey, buddying/peer review of operating technique, etc.

Each GPwSI has a consultant mentor who is available for advice, clinical support, fast-tracking of referrals, outpatient joint clinics and annual appraisal. It is hoped that the scheme will be included in the local junior surgical rotation.

The scheme is well supported by patients with average waiting times from referral to procedure being two months, procedures usually performed in a more local and convenient setting than the hospital and 97% positive returns in patient satisfaction surveys. From an NHS point of view the scheme saves over £2m against NHS tariff prices and helps the local acute Trusts achieve their waiting time targets by diverting large volumes of outpatient and day-case work to primary care, thus allowing hospital surgeons to focus on the work that only they can do.

There are, in some specialties, set guidelines recommending that trainees conduct a minimum number of operations in order to gain appropriate competencies. Shortened hours under the EWTD and streamlined training under the MMC initiative mean that volume of activity for trainees may fall short of those suggested. Consequently, the length of time required to train surgeons may need to increase.

Surgery is a craft specialty and a long period of training is required 'at the elbow' of a consultant. Surgery cannot be learned only from textbooks or educational courses. Shortened hours and full-shift working reduce the amount of time trainees can spend with their consultant trainers. Changing consultants' working patterns may also mean that their daytime availability is affected.

The College's EWTD working party continues to work with DH colleagues to find workable solutions for surgery.

Modernising Medical Careers

The MMC initiative aims to create demonstrably competent consultants who will be able to deliver the care required to treat patients. MMC also aims to streamline training.[58] To this end, trainees will not be able to spend as much time providing service commitment as they will need to maximise their training opportunities during shortened working hours. In addition, the MMC process requires a variety of workplace assessments to be undertaken, and this additional burden on consultants will create further service pressures. The *Curriculum for the Foundation Years in Postgraduate Education and Training* consultation document indicated the time commitment likely to be required for assessment processes to take place.[59] It was estimated that assessment time per trainee would amount to approximately 4 hours 20 minutes per year. The validity of this estimation has not yet been widely tested and it is thought to be optimistic.

The MMC initiative will produce doctors with generalist skills who are safe to undertake emergency duties. The aim is to produce surgeons with fewer sub-

specialist skills, thereby creating a more flexible workforce. The profession is anxious that patients receive the care they require and argue that, in many cases, patients will require the attention of a specialist. Continuing technological advancements will add fuel to the ever-increasing trend towards greater specialisation.

The shift of elective surgery into the independent sector means that much non-complex surgery is being undertaken outside the NHS. These cases provide the core of clinical material for surgical training. Processes for ensuring NHS trainees can gain access to such cases is a priority target for the College.

The new surgical curriculum

Surgical training is essential to the provision of the highest possible care for patients. The intercollegiate surgical curriculum project aims to develop a unified competence-based curriculum across the nine surgical specialties. The framework for this initiative is modular, identifying standards in four key domains:

- specialist knowledge;
- technical skills;
- clinical judgement; and
- professionalism.

All nine specialties will share a common definition of professionalism, for which there will be a generic curriculum. This will enable the public, healthcare professionals and all those involved in surgical training to know what trainees should be competent to do at each stage of their career.

The curriculum project has worked to provide essential faculty development for trainers, assessors and programme directors; to pilot the various modules; and to improve training practice within the workplace. The evaluation report of the pilot phase has warned that the level of support needed to develop the new curriculum must be not underestimated.[60] The report identified that those involved in surgical training were poorly resourced in terms of recognised contractual time or otherwise have little faculty development, no recognised career structure and little incentive to be involved in training. Clearly, these matters must be addressed to ensure the success of the curriculum project within the restraints of the EWTD, consultant contract arrangements and service requirements.

Postgraduate Medical Education and Training Board

In September 2005, the Postgraduate Medical Education and Training Board (PMETB) became the competent authority for approving the specialist training of doctors and certifying that doctors have reached a level of competence to be included in the specialist register maintained by the General Medical Council. The PMETB has taken over these functions from the Specialist Training Authority and will establish, maintain, and develop standards and requirements relating to postgraduate medical education.

The PMETB will require the colleges' assistance in setting up programmes of quality assurance and inspection of training programmes.

The College is concerned that some of PMETB's initiatives may be undermined by the changes to service delivery outlined above.

CHAPTER 6

Clinical Quality and Outcomes

Key Messages

- Measuring relationships between activity levels and outcomes is complex.
- An NHS-wide system of quality assurance and measurement is required.
- Performance measures based on outcome and throughput are flawed and do not enhance the patient experience.
- Well-designed health-related quality-of-life measures would be useful both to measure the effects of surgical intervention and to engage with patients.
- The competing priorities arising from guidance documents such as national service frameworks, improving outcomes guidance, National Institute for Health and Clinical Excellence reports, etc. are confusing and in many cases do not improve quality.
- The College fully supports the empowerment of patients via the provision of information about the surgeon who will be operating on them – but insists that this standard should be adhered to both in the NHS and the independent sector.
- The College is working to provide guidance in supporting surgeons to provide meaningful information to patients.
- The quality of staff, training and services provided in independent sector treatment centres must be to the same standard as that of NHS services.
- Contestability and competition in the health market may well adversely affect the quality of services provided to patients.

Clinical activity and outcomes

There is evidence to suggest that, for some highly specialised surgical interventions, eg cardiac, vascular and some cancer services, there is a positive relationship between large volumes of activity and clinical outcome.[24] However, this relationship is not demonstrable in all surgical specialties and variants such as case-mix, co-morbidity, age, class, gender, and severity of illness will have an impact on the clinical outcome of each case. Measuring relationships between activity levels and outcomes is complex and there are many variables to consider – for example, the skill and expertise of individual clinicians, the skills of the wider surgical team and the resources made available to them.

Assuring quality

Measuring quality of outcome in healthcare is difficult, not least because it is challenging to define the information required and to determine the relative importance of the many variables involved.

Performance measures have tended to focus on the quantity of funding or staffing of the NHS, coupled with the productivity levels that such funding and staffing brings. Definitions of quality relating to the fulfilment of performance objectives are often too narrow. Measuring quality of outcome must involve patients.

Assessing health-related quality-of-life outcomes for various surgical interventions, especially for malignant disease and cardiac surgery, has become more commonplace. However, the NHS does not routinely measure the impact of its care on patients' health-related quality of life. The subjective experiences of the patient are important, but there are a variety of different conceptual models at play that make personal experience difficult to quantify. In the era of patient choice and commissioning of services from a plurality of providers, health-related quality-of-life outcome measures could prove extremely useful. However, an NHS-wide system would need to be agreed and appropriately funded to provide true representation.

Health-related quality-of-life measures

Professor Alan Maynard
Department of Health Sciences, University of York, and Chair, York NHS Hospitals Trust

Measuring success in surgery is essential to provide consumer protection and meet clinical governance requirements. The current focus on the measurement and management of failure, for instance mortality, re-admission and complication rates, gives no insight into how patients view the success of surgery in terms of improving their physical, social and psychological functioning. Two generic measures, short form 36 (www.sf36.org) and EQ5D (www.euroqol.org) are increasingly being used before and after surgical interventions to measure changes in patients' quality of life after surgery. These measures have been used in thousands of clinical trials and will be used to evaluate the performance of ISTCs.

The attributes of these generic measures need careful consideration and their use has to be evaluated carefully. While the British United Provident Association have found them quite inexpensive to use (£3 per patient), they may not be sufficiently sensitive in some clinical areas (eg ophthalmology) to detect change and may need to be supplemented with specific measures. However, in many clinical areas they clearly give highly pertinent information that can be used for the management of surgical practice, eg patient management, appraisal, job planning, clinical excellence awards and GMC revalidation.

Various organisations and initiatives have been set up to look at quality issues – for example, the National Institute for Health and Clinical Excellence (NICE) was set up to provide a single focus for clear and consistent guidance for clinicians about which treatments work best for patients; and national service frameworks (NSFs) have been put in place for major care areas or disease groups to set out what patients can expect from the NHS. Other initiatives establish national quality standards and are applied consistently within local practice through the clinical governance system and professional self-regulation. In addition, the Healthcare Commission promotes improvement in the quality of NHS and independent healthcare. The Commission has a statutory duty to assess the performance of healthcare organisations, award annual performance ratings for the NHS and coordinate reviews of healthcare by others.

Media interest in the reporting of individual performance data for surgeons raises concerns about the validity of such data and about the requirement to provide patients with information that is meaningful and complete. The College fully supports the empowering of patients to enable them to make informed decisions about their healthcare, but considers that much work is required to make available data that are clear and unambiguous.

Quality in the independent sector

The government assures the profession that ISTCs work to the same standards of care and are subject to the same monitoring processes as the NHS. However, there are concerns over the quality of outcome, staffing and recruitment.[52,53]

The College is concerned that ISTCs weaken the patient–doctor relationship, do not provide adequate pre- and post-operative assessment and have no facilities for dealing with complications arising from surgery.

The College's clinical effectiveness unit (CEU), in association with the London School of Hygiene & Tropical Medicine, has been commissioned to undertake a pilot study to ascertain whether patient-reported outcome measures are suitable for examining the performance of ISTCs. The project will run until September 2006. This project is most welcome but it concentrates on examining the process for auditing outcomes rather than measuring outcomes *per se*.

CHAPTER 7

Networking and Organisational Aspects

Key Messages

- When designing new service delivery models:
  - patient pathways must be defined and appropriately costed before work begins;
  - essential services must be protected; and
  - the consequences for other services must be considered.
- Centralisation is vital for some services where there is evidence of a positive relationship between large volumes of activity and clinical outcome.
- In other specialties, tenuous data are often used to support the argument to centralise services.
- Decentralisation would support local access to services for patients, but payment-by-results and contestability do not adequately support this method of service delivery.
- Rapid progress of IT solutions is required to facilitate the provision of care in smaller or rural units.
- Smaller and rural units provide excellent training opportunities, which must be utilised.
- Managed clinical network solutions should be used where possible, rather than organisational mergers, to resolve service configuration issues.
- Managed clinical networks must be appropriately designed and resourced – accountability is an issue that must be addressed.
- Current employment contracts do not support the managed clinical network approach.

Current models of service delivery

Acute surgical services have traditionally been arranged either via emergency admission to hospital or by GP referral for elective treatment. Hospital services provide a range of interconnected facilities and resources that allow them to deliver healthcare to their catchment population. This arrangement has often not used the resources available in the most effective manner and, in some cases, the provision of a full range of services within Trust boundaries has been difficult to sustain both financially and clinically. Services must be arranged so as to ensure effective use of resources and high-quality, equitable and sustainable services.

The College has a responsibility for guaranteeing the high-quality training of future surgeons and for maintaining and improving the standard of care given to patients. It is therefore vital that service configurations take into account the geography, demography and epidemiology of the population.

Centralisation

Centralised services have traditionally been arranged on hub-and-spoke arrangements. The main specialist service is provided at the centre, the hub, and other local hospitals within the Trust or area, the spokes, often provide outreach services.

To enable such a configuration to work effectively, consultant surgeons need to split their time between providing specialist operative services at the centre and providing less specialised services, eg outpatient clinics, pre-operative assessment and less major operations, in local units. The consultant surgeon requires a full supporting structure in both the hub and the various spokes provided by intermediate surgical staff, specialist

nurses, technicians, rehabilitation professionals, diagnostic services, etc.

While it is recognised that specialist care cannot be offered in every hospital unit, centralisation has often created severe (and avoidable) congestion at the central unit coupled with difficulties of discharge planning. In addition, it is reported that, in terms of clinical outcomes, little is gained.

Centralisation based on clinical need

As with any method of service configuration, there are advantages and disadvantages to the centralisation thesis. The College does not support the wholesale centralisation of services for a number of reasons, not least of which is the difficulty of repatriating patients to their local hospital and community service. However, where there is evidence to suggest a positive relationship between large volumes of activity and clinical outcomes, as is the case for some highly specialised surgical interventions, then the centralisation of services must take place.

Research has shown that patients are willing to travel to access specialist care. However, because of the method of strategic planning and governance within the NHS, centralisation based on clinical need has often been difficult to achieve, despite professional evidence on safety and cost having been provided.

Identified benefits should be considered when designing services and the relationship between volume and outcome should not always be used to support the centralisation of services – a critical mass of patients can also be met using the managed clinical network approach across geographical areas. For example, centralisation of specialist services has occurred with regard to the surgical management of a number of cancers. Such decisions have not always adequately taken into account the knock-on effect on the provision of surgical services to patients with benign and emergency conditions. In addition, the creation of specialist centres can lead to de-skilling of surgical teams in peripheral hospitals.

Strategic planning across Trust boundaries – reconfiguring upper and lower gastrointestinal services in Nottingham

Dr Julian Skoyles
Clinical Director for Surgery, Nottingham City Hospital

Clinicians identified that the reconfiguration of upper and lower GI services across the Nottingham City Hospital and Queen's Medical Centre was a viable option and a working document was produced by the clinical directors of both Trusts. One of the main difficulties of the reconfiguration related to those surgeons who were required to move their practice to the other Trust and the need to reapportion theatre sessions and clinics. There were also concerns around staffing issues, such as the transfer of discretionary points and moving secretaries and teams across site borders. Clinically, the gastroenterologists were concerned that there would be no colorectal surgeons on site and there was concern from thoracic surgeons that their oesophageal workload would be diluted. Multidisciplinary teamworking gradually dispelled these concerns. A great deal of time was spent in meetings with consultants, both in groups and individually, and also in regular steering group meetings with Trust executives. Clinical engagement was good throughout and as the idea of the reconfiguration came from the clinicians themselves, there was a good sense of ownership.

Outreach services took a while longer to organise due to recruitment issues. Again, good multidisciplinary teamworking across the Trust was key to the development of the service. Agreement was also reached at an early stage to determine which lower GI emergency cases should be transferred.

Centralisation based on financial pressures

Hospital Trusts that merge together often make the case for the centralisation of services. Certainly there is common-sense logic to the centralisation of some services within Trust boundaries for financial and resource purposes. However, verbal evidence to the working party suggested that mergers and centralisation

The case for decentralisation

Mr Andy Black
Senior Partner, Durrow Limited

The trend towards centralisation in acute hospital care has well-known and unresolved tensions with local public opinion and the settlement pattern of Britain, for example Kidderminster.

The NHS has perhaps invested insufficient creativity and energy in exploring alternatives, particularly the concept of the local emergency assessment centre. While frequently ruled out as impractical, local emergency assessment at market town level has a number of beguiling attractions:

- public acceptability;
- short travel distances and times;
- better chance of returning to habitat on same day; and
- avoidance of false positives in major acute units – the eight out of ten patients who were not really acutely ill do not have to travel.

Such units will not be easily or quickly created but this does not mean they are unattainable or impractical. Our early experimentation suggests that they could be successfully established and be able to offer medical or surgical assessment to district general hospital (DGH) standards. A number of departures from the NHS tradition would be required:

- unified medical or surgical assessment under single direction;
- integration of the ambulance paramedics with the emergency nurse practitioners at local level (and the co-location of the ambulance station);
- financial incentives for both the hospital and GP members of the assessment team;
- full-service imaging and diagnostics at local level; and
- ultra-modern communications and techniques.

Our work suggests that the economics would be positive and there would be many quality gains. As Confucius says, 'best place to hide a leaf is in a forest'. It is not in interest of the very ill patient to be one of a hundred in a busy DGH assessment or admission unit surrounded by others who are not really ill but approaching their four-hour deadline.

policies are often poorly managed, costly and fail to meet the expectations of staff, patients and the wider community.

Such initiatives have often led to the de-skilling and demoralisation of staff working in the spoke units, which in turn leads to concerns for patient safety.

Centralisation and the rural hospital

The introduction of PBR and the setting of national tariffs for certain procedures do not currently support the provision of services on multiple hospital sites. This is an acute problem for rural hospitals which, by nature of the distance between sites, often have to provide acute services at each hospital to protect local access for patients.

In addition, some rural areas can experience difficulties in recruitment and retention of high-quality staff. Wherever possible, the College should seek to accredit training in rural units that can offer excellent training opportunities. Offering training in such units may help

to alleviate the difficulties of recruitment and retention and will assist in meeting the EWTD requirements by 2009, which may be particularly difficult to achieve in a rural setting. However, the quality of training must not be compromised.

It is important to note that organisational mergers should be considered as wholly separate to the planned reconfiguration of services based on clinical need – although the two often coexist and can become confused.

Decentralisation

Larger units that are remote from peoples' homes create difficulties for patients in terms of time and effort to attend appointments, accessibility and equity of access.

Recommendations, based on the optimum size of a hospital unit for the provision of surgical services, have tended to produce larger medical admissions and thus create an avoidable imbalance, placing pressure on already tight resources. Fully-staffed and well-equipped smaller units in localities could effectively triage and refer only the most appropriate patients for specialist care and this would greatly reduce congestion at the central point.

Decentralisation would require the wholesale adoption of cultural change and a significant investment in telemedical and technological support. *NHS Connecting for Health*,[61] the government's drive to modernise computer systems and electronically connect primary and secondary care may alleviate some of these issues, although the timescale for implementation of the initiative may be a hindrance and clinical input has thus far been patchy.

The decentralisation of services would almost certainly appeal to patients, who want to have care provided as locally as possible. It would also meet the government's aims of patient choice and local access initiatives. It remains of concern, however, that where local units have remained open, the staff and services have become severely destabilised and their ability to deliver a safe and efficient service may have diminished.

Managed clinical networks

Mr Nigel Edwards
Director of Policy, NHS Confederation

The UK is unusual in having relatively large hospitals with concentrated services, which in the past have aimed to be self-sufficient. Further large-scale concentration is unlikely to be acceptable to the public, who have an expectation of many of their services being provided locally, nor is it likely to be achievable given the scale of capital investment that would be required. In future, hospitals will need to be increasingly networked and connected to local primary care services rather than isolated institutions.

The pressing challenge is how to provide high-quality emergency services that are both safe and accessible. The answer may lie in challenging some of the ideas that have traditionally underpinned hospital planning in the UK. In particular, there is a need to find a way to safely run medicine without 24-hour on-site surgery.

This will require new types of staff running emergency care services and a different form of specialist support. It may mean that surgeons and other specialist staff with scarce expertise will need to become part of larger networks rather than being tied to a single institution or site. The use of information technology to link sites together will be essential. Further strengthening of ambulance services and emergency care networks will ensure that patients needing immediate access to emergency surgery or other specialised services can be routed appropriately and promptly.

Managed clinical networks

Another model of service delivery is the managed clinical network.[62] The emphasis on this mode of service is partnership and distribution of resources to match patient need. In managed networks, care is delivered seamlessly via a chain of individual, but interconnected, healthcare practitioners. Such arrangements can prove challenging for service management in that networks often develop across traditional employment

boundaries, creating virtual organisations of service, but are essential in providing some specialised surgical services. This model heralds a move away from traditional thinking about the bricks-and-mortar of the hospital, and requires more lateral thinking about how services might be provided in the safest and most convenient location for patients. The best method of treating patients must be the driver for the creation of networks.

Networks can help to remove or avoid unhelpful barriers between primary and secondary care and often evolve or develop as an extension of GP referral patterns.

There are concerns about patient safety, accountability, clinical governance and risk management. Clinical networks must be effectively managed – roles and responsibilities must be clearly defined and protocols of care agreed by all healthcare professionals operating within the network. In addition, the network must be sufficiently resourced and accommodated and this often requires innovative negotiation across traditional Trust boundaries.

The combination of Trusts wishing to protect their clinical workload and hence income and clinicians' loyalty to their employer may stifle the development of clinical networks. In addition, many, including clinicians, support the networked approach as long as their own unit or hospital is perceived as the primary organisation. In the future, therefore, employment arrangements may require that a clinician is appointed to a network, rather than to an employing Trust or, more radically, teams of consultant surgeons and support staff may set up their own managed clinical network and sell their services to a number of Trusts. Contestability will create competing interests and this may make the management of clinical networks problematic. While it is not the role of the College to become involved in individual doctors' employment status, there is a need to consider whether new employment practices may deliver a better service for patients.

There are already networks in place for critical care and for some cancers. Thus, hospitals may belong to a number of different networks at the same time. There may also, however, be a need to develop networks so that services can reach an appropriate population size – for example, in neurosurgery or upper gastrointestinal services.

The overarching principle of managed clinical networks is that clinicians will be required to lead, develop and map detailed service descriptions and patient pathways and be at the centre of care provision. The key to a successful network is the relationships between the staff within it. Effort and investment in both time and sometimes resources is required to make networks work effectively.

CHAPTER 8

Unit Viability

Key Messages

- It is government policy that, should patients exercise choice and fail to use certain services, then those units may be forced to close.
- Contestability and payment-by-results will ensure that patient choice is not the only driver – commissioning patterns will also dictate which services will succeed and which will fail.
- The knock-on effects of unit closure on other services cannot be quantified.
- NHS units do not have the flexibility to withdraw services that are not cost effective.
- The market will create winners and losers and this will be detrimental to providing equity of access and ensuring patient safety.
- Essential services must be defined and protected from market principles.
- Services that are essential to the provision of another core service must also be protected.
- Payment-by-results must reflect the increased reference costs borne by rural units and by hospitals dealing with complex cases.

Profitability and cost effectiveness

From the working party's health-system visits it became apparent that Trusts were already examining the services they offered in terms of their suitability for growth, profitability and potential loss. Early indications suggest that surgery may represent an interesting cross-section of profit and loss for hospital Trusts – the introduction of ISTCs in some areas may create potential losses and sustainability issues for Trusts in, for example, basic joint replacement services. Conversely, some units are seeking to create a niche for revision and complex joint replacement surgery and to grow those services – provided appropriate tariffs can be identified.

Such forward thinking by Trusts must be commended and the government would argue that finding innovative ways to plan and deliver services was the intended outcome of introducing choice, contestability and competition to health services. However, the College would argue that there are many unintended consequences to the introduction of such policies, which are detailed below.

Public and patient involvement, choice and flexibility

Under the auspices of the patient choice agenda and public and patient involvement initiatives the NHS lacks the flexibility to be able to make service delivery decisions as quickly and effectively as an independent provider could.

Substantial developments to, or variation in, the provision of health services must first be put out to public consultation and may require assessment by the local authority's overview and scrutiny committee (OSC).[63] If the OSC is not satisfied with the Trust's plans it can in turn refer proposals to the secretary of state for health, who can then refer to the independent reconfiguration panel for a formal review.[64]

A lack of formal guidance on conducting public consultations, coupled with the sensitivity and parochialism that often permeate any proposed changes to the NHS, means that public consultations are often prolonged. Even well-planned and well-executed consultations can last a considerable period and this seriously undermines the ability of the NHS to react to possible market opportunities and to exit from services that are causing an overspend.

Payment-by-results and reference costs

Some Trusts have no choice but to offer duplicate services on more than one site – this is especially relevant to rural hospitals where the distance between hospital sites dictates that essential services such as A&E be offered in more than one place.

Such duplication of services inevitably raises the reference cost and there is no mechanism within the current national tariff structure to recognise this additional burden.

Contestability and collaborative working

The introduction of contestability to the healthcare market will almost certainly inhibit collaborative working between Trusts, and between Trusts and the independent sector providers. Collaborative thinking has been essential in designing sustainable services for cancer, vascular surgery, etc., but the increased emphasis on competition and on payment by activity may create unhelpful barriers.

There is no doubt that healthcare providers will need to work together in multidisciplinary teams to make services accessible to patients and the government may need to provide appropriate incentives to such collaborative working.

Protecting essential services

Where Trusts have higher costs, for example, because they treat more patients with complex needs, this will initially be recognised, but the eventual aim of the PBR initiative is to have a set of tariff prices that will apply irrespective of where a procedure is carried out. It is difficult to see, therefore, how Trusts will cope with the complex and co-morbid cases the ISTCs will undoubtedly reject. This could result in some Trusts withdrawing from providing certain services, which are not cost-effective or profitable. Similarly, they may continue to perform profitable services even if clinical factors would suggest that they were more appropriately performed elsewhere. In addition, there is a disincentive for Trusts to join managed clinical networks as the method of payment for units of activity may prove difficult to manage across organisational boundaries.

Independent reconfiguration panel – Formal and informal advice

The independent reconfiguration panel (IRP) is the independent expert on NHS service change. It has wide-ranging expertise in clinical healthcare, NHS management, public and patient involvement and in handling and delivering successful health service change.

The panel was originally established to advise ministers on proposals for NHS service change in England that have been contested locally and referred to the secretary of state for health. But because prevention is better than cure the panel also offers support and generic advice to the NHS, local authorities and other bodies involved in the reconfiguration of NHS services.

While locations may vary, the issues that concern people locally are often the same. The panel can help by sharing experience from elsewhere, offering advice on appropriate consultation as well as providing guidelines on good practice. Taking advantage of the experience and expertise of panel members early on in the development of proposals can help to maximise the benefit to patients and minimise the chance of later referral to the secretary of state.

Anybody looking for free help or advice on NHS reconfiguration issues can contact the IRP Secretariat on 020 7389 8045/8048 or IRPINFO@DH.GSI.GOV.UK. The panel's website can be found at www.irpanel.org.uk.

This leads us to the question of the effects of PBR on essential services such as A&E. The College believes that these services should be protected from PBR and competition in order to protect their sustainability, and that some other form of payment be negotiated in order to maintain essential services locally.

Similarly, in order to guarantee the sustainability of local services, perhaps smaller, but essential, hospitals should receive an inflated payment per unit of activity or be protected from the full force of market principles.

Critical interdependencies will need to be considered carefully and a credible method of defining essential services and protecting them from market forces will be required. This may encompass a regulatory framework that definitively identifies non-contestable services, a different funding mechanism for protecting essential services and a method of intervention that will support those services at risk. It will be a complex task and the College would be willing to work on this with the DH.

Sustainability and cost

There is an absolute requirement to evaluate the cost impact of new models of care in order to secure long-term sustainability. Pump-priming funds should be provided where necessary.

The College is concerned that the government has not, so far, completed the required level of detailed financial examination required – for example, does the cost of outsourcing elective surgery while keeping essential services within the hospital really equate to cost savings? It is recognised that such in-depth analysis is costly, complex and time consuming, but surely it is essential when introducing change on such a massive scale.

Long-term planning in an uncertain future

We would reiterate that the long-term planning capacity of NHS units has been severely undermined by the rapid pace of change. There is widespread confusion amongst both clinicians and patients over the current state of play. The colleges are struggling to put in place new training and assessment methods to underpin the MMC initiative; Trusts are struggling to support rotas, training and maintain sustainable services; and patients are struggling to understand choice, who will be treating them and how they might access services in the future.

The raft of policy initiatives needs time to settle in. The medical profession is not averse to change, but it does require an objective assessment of change to make certain it achieves what is intended, without detriment to training, quality and patient safety.

CHAPTER 9

Findings

General findings

- Patients want a comprehensive surgical service delivered as locally as possible for common problems, but are happy to travel for highly specialised treatment.
- Patients want the availability of treatment to be as flexible as possible to fit in with their busy lifestyles. Treatment must be speedy, effective, safe and, where possible, evidence-based. The College fully supports these aspirations.
- There is no 'one size fits all' solution to issues of service design, configuration and provision. A flexible approach is required.
- For NHS hospitals, it is preferable to have a degree of separation between emergency and elective work, as well as ring-fenced elective surgical beds. While being physically separated, emergency and elective work should, wherever possible, be undertaken on the same site.
- The College supports the fundamental drive to increase capacity and improve services for patients.
- The NHS is capable of increasing capacity if adequate resources are directed to it, and appropriate and motivated staff are recruited.
- The NHS has moved from being the sole *provider* of healthcare free at the point of delivery to the *guarantor* of healthcare, coordinating the provision of services throughout both public and private organisations via commissioning bodies.
- The College fully supports the drive for patients to be involved and consulted on decisions about the provision of surgical care.

Training and teaching

- The training of future surgeons as well as undergraduates must be protected within the environment of contestability, payment-by-results and independent sector provision.
- There is a need to enable surgical trainees to have access to high-quality training opportunities within independent sector treatment centres (ISTCs) and the independent sector.
- Payments made to units providing training must apply equally to both NHS and independent sector providers. Failure to implement such funding mechanisms will seriously undermine the training of the next generation of surgeons.
- New training patterns, as determined by Modernising Medical Careers, require additional consultant commitment. This must be appropriately recognised and resourced. There must be acknowledgment of the time commitment required of consultant surgeons to provide increasingly focused and intensive workplace training and assessment.
- The imposition of full shift solutions to the European Working Time Directive is detrimental to training in the craft specialties, and achieving a 48-hour working week by 2009 will be challenging.
- In the new structure of surgical training, the number of trainees will be reduced. In addition, trainees will be less able to contribute to service delivery. This will significantly reduce the overall capacity of the service and this deficit will need to be filled.
- The aim to provide a variety of services in the primary care sector may have a negative impact on the training of surgeons.[5a] The College will need to monitor the situation and work closely with other medical royal colleges to ensure training standards are maintained.

Contestability and market principles

- Collaboration and not competition is the key to developing patient-centred services.
- The introduction and extension of contestability and market principles present a potential threat to the quality of services and of training. The implementation of such principles must be carefully monitored.

- Essential services must be defined and maintained in order to preserve patient safety, which will require careful planning and negotiation.
- Contestability in the health service may create perverse incentives and behaviours and will need careful management to protect patient safety.
- The drive to create 'constructive discomfort' in the health service via the initiatives of patient choice, practice-based commissioning, contestability, independent sector provision and payment-by-results may threaten the survival of some NHS units and hospitals.
- It remains to be seen if the resolve, across the political spectrum, exists to see through the impact of contestability and competition with the potential closure of, in particular, hospitals and emergency units.
- Private finance initiatives ultimately are costly. Investment in large secondary care facilities with long-term service contracts may become a significant financial burden to the healthcare needs of future generations. The fixed long-term costs conflict with the inability of Trusts to predict future income.
- Payment-by-results tariffs are as yet unproven as a method of funding activity. They will need accurately to reflect case-mix and also the extra costs incurred through the provision of emergency services, especially for patients with greater co-morbidities.
- A focus on productivity and central targets is not always helpful. The delivery of better health for patients is vital but appropriate models for measuring such performance do not yet exist.
- Not all essential surgical services will be sustainable in an environment of competition, for example, paediatric surgery.
- Failure, either financial or clinical, of certain key departments may affect the viability of entire units and hospitals, including the ability to provide emergency services.

Working practices

- Effective teamworking and networking across the organisational boundaries of primary and secondary care, as well as across traditional employment boundaries, must be implemented or improved as necessary.
- Technological advancement, increased treatment opportunities, changes in the epidemiology of disease and the population demographic will alter clinical working practices.
- The continued focus on productivity and throughput may mean that the surgeon is seen not as a professional but as a technician. The College strongly believes that the non-technical, professional and judgement skills of a surgeon are important components of a quality service. Separating technical and non-technical skills and depersonalising care will be detrimental to patient safety.

Reconfiguration

- Strategic planning is required to organise some highly specialised services on a national, or even international, level. This is beyond the policy reach of practice-based commissioners, Primary Care Trusts, and sometimes even enlarged strategic health authorities.
- The College believes that service reconfiguration should be based on patient need rather than on managerial, financial or political expediency.
- The College and the specialist associations have made recommendations for the optimum configuration of some services in respect of service standards and the provision of training. Such evidence should be considered before reconfiguration proposals are agreed.
- Reconfiguration offers the opportunity to make optimum use of scarce staff and resources and provide high-quality training to enhance patient safety.

- The drive to be cost efficient and to market profitable services may undermine informed patient choice and could undermine the safe provision of services.
- Geographically isolated hospitals require special attention in debates on contestability, competition and payment-by-results.
- The potential for innovative IT development, for example telemedicine techniques, to bring about flexible solutions to support new models of care has not yet been realised.
- Managed clinical networks may provide an alternative method of service provision but must be appropriately designed and resourced, taking into account clinical governance and accountability requirements. There may be benefit in networks acting as employers or providers of certain services.

CHAPTER 10

Conclusions

As identified in this report, the issues affecting the reconfiguration of surgical services are wide-ranging and complex. There are some basic principles that will facilitate the optimum use of staff and resources while ensuring quality services for patients – for example, the separation of elective and emergency services and rotas,[56] better protocols for ambulance triage and assessment, and the development of IT solutions.

However, we recognise that issues of reconfiguration are politically sensitive and difficult and there is no single solution that will suit all services.

Local discussion must take place, and patients and the public must be adequately informed and involved in the decision-making process. A partnership approach is required to facilitate change at a local level. Buy-in is required from management, clinicians, nursing and support staff, strategic health authorities, Primary Care Trusts and patient groups.

It is also clear that the potential impact on other services of the reconfiguration of surgical services, and vice versa, must be considered. In the discussions the working party held with central policy makers and with those Trusts visited, it was clear that reconfiguration should take place by a process of evolution rather than revolution. It is vital to address workforce, training and service requirements before reconfiguration takes place.

Defining the need for reconfiguration

Before any reconfiguration of services takes place, the College would advise:

- examining the entire patient pathway and the effects of the proposed reconfiguration on other services;
- facilitating early patient and public involvement – to include both current and potential patients;
- investigating team-working opportunities across primary, secondary and tertiary care and across sectors from ambulance Trusts, to mental health and social care organisations;
- ensuring that proposed changes are evidence-based;
- calculating the short-term and long-term costs;
- considering the effects on training and workforce provision;
- considering alternative ways to provide the service, eg using IT solutions, outreach, multidisciplinary teams, assessment units, etc.;
- setting standards to achieve high-quality outcomes;
- ensuring early clinical involvement in any proposed changes;
- ensuring effective consultation procedures with staff, patients and commissioners;
- considering the wider social implications of service reconfiguration, eg transport arrangements, equity of access, etc.; and
- considering the requirement for regional planning of some specialist services.

Factors to consider

The following are offered as factors to consider in the design and implementation of surgical services for patients. They provide suggestions for solving the conundrum of providing competitive, cost-effective and quality services to patients, while still ensuring the adequate deployment of resources and the provision of high-quality training.

Innovative arrangements for care provision

- Networking across professional boundaries.
- 'Chambers-style' or groups of consultant surgeons working together to provide services in a given area.
- Integrated systems across primary, secondary and tertiary care to include, as appropriate, ambulance Trusts, mental health Trusts and social care providers.
- Improving patient selection processes to provide adequate and appropriate separation of elective and emergency provision.
- The creation of niche markets or centres for certain specialties (without detriment to other services).

Workforce

- Continued targeted drive for expansion of the consultant surgeon workforce, in defined specialty shortages, to support services and engage with PCTs and commissioners.
- Increasing pressure to fund additional national training numbers where appropriate.
- Promoting teamworking across sectors and innovative ways of working.
- Improving the patient pathway by ensuring that emergency cases are seen by the most senior member of staff and effectively filtered through the system.
- Supporting the extended surgical team of healthcare practitioners, within defined protocols, and agreeing nationally agreed competencies that facilitate skills transfer.
- Removing or alleviating unhelpful employment barriers to enable managed clinical networking.
- Ensuring appropriate skill mix to meet patient needs.

Essential and contestable services

- Define essential and contestable services within each patient pathway or model of care.
- Create national standards for the definition of such services.
- Define and deploy methods of protecting essential services.
- Prevent and regulate against perverse incentives.
- Put in place recovery strategies for hospitals that are at risk in order to continue local provision of services.

Training

- Identify appropriate training opportunities in ISTCs and the private sector.
- Obtain cross-sector agreement on training standards and accountability.
- Ensure training opportunities are quality assured across sectors.
- Devise standards for training provision to apply across sectors.
- Design programmes that allow trainees to follow the full patient care pathway and not just isolated components.
- Define ways of working that are EWTD-compliant while still ensuring optimal training, and patient and staff safety.
- Remove specialist registrars from the night shift in order to maximise training opportunities.

CHAPTER 11

Future Areas of Work

The working party has identified numerous policy directives impacting upon the delivery of surgical services. The College does not have all the answers and this report is intended to stimulate debate amongst professionals and patients.

There is extensive scope for future areas of work, but the College wishes to focus its attention and resources in the areas that are considered vital by patients and by those involved in the planning, commissioning and delivery of surgical services.

We have identified a number of areas we think may merit further exploration, but would welcome feedback from readers on whether we are correctly targeting our resources.

Ensuring safety, cover and training within the constraints of the European Working Time Directive

- Explore safe shift-working and differentiated patterns of cover between day and night shifts.
- Explore opportunities for three-session days by using the extended working day to utilise facilities and staff efficiently and possibly to improve training opportunities.
- Examine opportunities for surgical assessment by specialist nurses and the removal of medical professionals from night duties retaining essential medical cover where appropriate.

Developing outcome measures

- Work with external organisations to examine, understand and develop suitable outcome measures in order to ensure standards across sectors.
- Implement the collection of outcome measurement data.
- Work with patient groups to develop a communication strategy for patients on the meaningful interpretation of outcome data.
- Develop a framework by which organisations can assess their plans for reconfiguration.
- Assess how the safety of reconfiguration arrangements can be assured through agreed risk assessment processes and the evaluation of outcome measurements.
- Ways of appropriately learning through service should be investigated.

Surgical training

- Develop programmes and appropriate quality assurance techniques to provide cross-sector training.
- Develop modular training programmes. These might include secondment opportunities to ISTCs and the independent sector.
- Identify appropriate trainers and training units.
- Define competencies across specialties and professions.
- Identify appropriate and properly accredited units which can offer demonstrable experience and training.

Collaborative working with other colleges and organisations

- Identify common areas of work and maintain standards via the training, accreditation and revalidation of members of the extended surgical team.
- Identify opportunities for collaborative working across primary and secondary care interfaces.
- Identify demographic and epidemiological trends to predict future surgical needs.
- Identify possible combined assessment practices and protocols that are both safe and quality assured.

Workforce development

- Incorporate flexibility in the surgical workforce by examining opportunities for increased interface working across the specialties in order to meet service demands and ensure patient safety.

- Some commentators have discussed the merits of introducing an 'acute surgeon' specialty. The requirement for such a surgeon is not as clear as that of the 'acute physician' specialty being developed by the Royal College of Physicians. The College will need to decide whether this issue is worthy of further investigation.

Consultation

The College wishes to open the debate regarding the reconfiguration of surgical services in the UK for consultation and would welcome the views of patients, healthcare professionals and government. Specifically, the College wishes to ascertain:

1. Are the overall aims of the suggested areas of future work clear?
2. Rate, in order of importance, the three proposed work areas you consider to be priorities for the College.
3. Do you think there are any additional areas on which the College should focus?
4. How do you think the findings from our work could be most usefully publicised or distributed to ensure maximum visibility and usage?
5. What services are core to acute hospitals and how should they be selected and protected?
6. Is there any place for the development of the acute surgeon? Have we got the right balance between sub-specialisation and generalism?
7. Can you provide safe care for unselected medical take patients in a unit without on-site acute general surgery and trauma?

Readers can share their thoughts with the working party through the bulletin boards on the reconfiguration area of the College website: www.rcseng.ac.uk/service_delivery/reconfig.

Alternatively, feedback can be emailed to: reconfiguration@rcseng.ac.uk.

This consultation exercise will close on 30 June 2006 and all suggestions for future work will be considered by the working party.

This report is intended to be the first in a series of publications looking at the reconfiguration of surgical services. As a result of the consultation process launched by this report, the College will continue to identify areas of future work, which will be featured along with other reconfiguration working party developments on the College website at www.rcseng.ac.uk/service_delivery/reconfig.

APPENDIX 1

Guiding Principles and Work Plan

The reconfiguration working party agreed upon guiding principles for the project and a project plan that would enable it to produce this initial recommendation report.

Guiding principles

This project has been underpinned by two guiding principles:

- that care should be provided as locally as possible; and
- there is no compromise on the quality of that care.

The College is not in a position to offer a single solution that will be applicable to all units. Therefore the recommendations contained in this initial report have tried, wherever possible, to be applicable to acute surgery in general and to provide guidance for local negotiation and implementation.

The over-arching principle is that services must be sustainable and affordable and that units can be adequately resourced while avoiding the de-skilling of surgical staff. Units should also be able to provide training for surgeons and an adequate volume of services in specialties, where this has been shown to have a positive effect on clinical outcomes.

It is recognised that an integrated approach to healthcare must be observed in order to protect and promote the health of the nation. This includes disease prevention, reducing inequalities and promoting healthier lifestyles. However, when people become ill, they require access to a coordinated, safe and comprehensive healthcare system.

The working party was guided by the following principles:

- that the identification of drivers for change, which impact upon the delivery and quality of surgical services in England and Wales, should be examined;
- that the working party should consider the impact of such changes over the next five years, and perform horizon-scanning activities for ten years hence;
- that recommendations made should be sufficiently flexible so as to allow for appropriate local interpretation;
- that recommendations made should focus on patient safety, good clinical outcomes, local access, viability and sustainability; and
- that recommendations made would take into consideration opportunities for quality training of the surgical team.

Work Plan

Evidence gathering

The working party has taken evidence from a number of key clinical, managerial, policy and user sectors of the NHS in order to inform debate over the wider political aspects of reconfiguration, service provision and health policy, and to provide guidance on the clinical aspects of service change.

Health-system visits

To complement the evidence-gathering sessions, the working party also considered it vital to hear from those charged with implementing reconfiguration plans. For this reason, visits to a number of health systems were arranged.

The visits were used to view reconfiguration plans from a Trust perspective and to gain an understanding of the challenges faced by Trust management and clinicians in implementing central policy initiatives and identifying reconfiguration needs.

Careful thought was given to the selection of health-system visits, recognising that the working party could not hope to undertake a detailed review of all Trusts, nor of every surgical specialty. The Trusts were chosen because they offered the opportunity for the working party to investigate specific issues and develop principles that would be applicable to surgery in general.

Website

A dedicated area on the College website was set up to inform both the general public and fellows and members of the College of the progress of the working party. The website provided an opportunity for fellows and members to become involved in the work of the group and to share their views of reconfiguration.

For a list of those who submitted evidence either in person, during health-system visits or via the website, see Appendix 2.

Reconfiguration working party membership

Mr Dermot O'Riordan FRCS *(Chairman), Council member and consultant general surgeon, West Suffolk Hospital*

Mr Tony Giddings FRCS, *Council member and retired consultant general surgeon*

Mr Richard Collins FRCS, *Council member and consultant general and endocrine surgeon, East Kent Hospitals NHS Trust*

Professor John Lowry FRCS, FDSRCS, *Council member and consultant oral and maxillofacial surgeon, Blackburn Royal Infirmary*

Mr Chris Chilton FRCS, *Council member and consultant urological surgeon, Derby City General Hospital*

Mr David Jones FRCS, *Council member and consultant trauma and orthopaedic surgeon, Great Ormond Street Hospital*

Professor Irving Taylor FRCS, *Council member and consultant general surgeon, Royal Free Hospital and University College Medical School*

Mr Brian Rees, FRCS, *Council member and consultant general surgeon, University of Wales*

Ms Candace Imison, *Department of Health Strategy Unit*

Dr Ed Glucksman FRCP, FRCS(Ed), FFAEM, *Vice-president, Faculty of Accident & Emergency Medicine and A&E consultant and clinical director, King's College Hospital*

Dr Paul Nicholson, *The Royal College of Surgeons of England patient liaison group representative*

Mrs Jo Cripps, *secretary to the reconfiguration working party*

APPENDIX 2

Evidence

Evidence-gathering sessions

Evidence-gathering sessions were held at the College throughout 2005. Evidence was submitted by:

Mr Nigel Edwards, *Director of Policy, NHS Confederation*

Professor Roger Dyson, *County Councillor for Essex*

Professor Alan Maynard, *Chair of Health Policy and Health Services Research, University College London*

Professor Allyson Pollock, *Public Health Policy Unit, University College London*

Mrs Anna Athow, *Executive Member, NHS Consultants Association*

Sir Peter Morris, *Past President, The Royal College of Surgeons of England*

Mr Niall Dickson, *Chief Executive, King's Fund*

Professor Jenny Simpson, *Chief Executive, British Association of Medical Managers*

Mr Andy Black, *Durrow Limited*

Mr David Mobbs, *Chief Executive, Nuffield Hospitals*

Dr Peter Barrett, *Chair, Independent Reconfiguration Panel*

Dr Ian Rutter, *Joint Chief Executive of Airedale PCT and North Bradford PCT*

Mr Jon Ausobsky, *Consultant Colorectal/General Surgeon and Operations Medical Director – Integrated Surgical & Medical Services at Bradford Teaching Hospitals NHS Trust*

Professor Nick Black, *Professor of Health Services Research, London School of Hygiene and Tropical Medicine*

Ms Candace Imison, *Department of Health Strategy Unit*

Dr Mary Armitage, *Clinical Vice-president, Royal College of Physicians, London*

Sir David Carter, *former Chief Medical Officer for Scotland (private meeting with chairman)*

Health-system visits

The working party visited the following Trusts:

- United Lincolnshire NHS Trust
- East Kent Hospitals NHS Trust
- Nottingham City Hospital NHS Trust
- East & North Hertfordshire NHS Trust

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Glossary

Access	The extent to which patients are able to obtain the services they require.
Acute services	Medical and surgical treatment provided mainly in secondary care facilities. Acute Trusts are responsible for managing units providing these services.
Clinical viability	Arrangements for the delivery of clinical services that can be sustained in the long term.
Commissioning	The mechanism by which Primary Care Trusts or practice-based commissioning groups purchase services to be provided to the local population. Services are provided according to agreement on funding, levels of activity and quality standards.
Competition	Competition is used to improve standards and provide better value for money in the market place.
Contestability	In market theory, contestable markets have no barriers to entry. The threat of potential new entrants to the market is sufficient to ensure that existing providers act competitively to ensure lowest costs and reasonable profits.
Day surgery or day case	Surgery that is performed on a 'same day' basis. The patient may remain in hospital for up to 23 hours.
Deaneries	Postgraduate medical and dental institutes that are responsible for ensuring standards of education and training for doctors and dentists.
Department of Health (DH)	The government department responsible for health and social care services in England. It is responsible for management of the overall health and social care system; developing policy and managing major change in the NHS; regulation and quality assurance of the NHS (increasingly at arms' length through organisations such as the Healthcare Commission), and intervention, should problems occur in the running of the NHS at any level.
Diagnostic treatment centres (DTCs)	Centres designed to provide large volumes of planned (elective) surgery and investigations. These centres are separate from acute surgical admissions within Trusts to eliminate the risk of cancelled operations.
Elective surgery	Surgery that is planned.
European Working Time Directive (EWTD)	A European Union directive that limits working hours for both training and non-training grade doctors.

General Practitioners with special interests (GPwSIs)	GPwSIs have additional training and expertise which enables them to take referrals from colleagues for the assessment and/or treatment of patients outside who might otherwise have been referred direct to a secondary care consultant, or provide an enhanced service for particular conditions or patient groups.
Healthcare resource groups (HRGs)	Healthcare resource groups measure care based on the diagnosis made and the complexity of treatment required to create a 'unit of care cost'. Payments will be made to Trusts and other providers for services provided within given HRG care pathways.
High dependency unit (HDU)	Where patients receive continuous nursing care after surgery. There is usually one nurse for every two patients.
Independent sector treatment centre (ISTC)	Independent sector treatment centres are privately-owned centres that perform elective procedures and tests on behalf of the NHS.
Intensive therapy unit (ITU)	Unit where seriously ill patients on life support receive one-to-one nursing care.
Intermediate care	Services for people who might otherwise occupy hospital beds for prolonged periods. Intermediate care is provided to prevent admission to hospital or to speed up discharge. Such care requires appropriate assessment by a qualified practitioner and the drawing up of an individual care plan for the patient. Intermediate care services are predominantly available for elderly people, or those with long-term conditions.
Intermediate surgery	Surgery requiring a short hospital stay of up to three nights for operations that carry a low risk of surgical complications.
Major surgery	Complex surgery, usually requiring extended inpatient stays and HDU/ITU care.
Modernising Medical Careers (MMC)	Modernising Medical Careers is a new concept of postgraduate medical training introduced from August 2005 and gradually replacing the existing method of training. The new scheme will see people leaving medical school to enter a foundation programme of two years, where they will gain generic skills in caring for the acutely and critically ill. Once they have completed the foundation programme, doctors will then compete to enter specialty training programmes. These programmes combine the two old grades of senior house officer and specialist registrar in a seamless programme of training in a particular specialty. Once in this specialty training programme, doctors are expected to progress through to the point where they will gain their Certificate of Completion of Training.

Multidisciplinary team (MDT)	A team of healthcare professionals providing medical care to a patient.
National Service Framework (NSF)	National Service Frameworks help establish clear national standards for services to improve quality and reduce unacceptable variations in standards of care and treatment. There are NSFs for coronary heart disease, mental health, older people, and the NHS cancer plan. NSFs for children, diabetes, and renal (kidney) services are also being developed in England. Other NSFs are available in Wales.
Outreach services	Services provided in the community. Such services may be provided by primary, or secondary care, and/or social services.
Payment-by-results	A funding mechanism that allows PCTs to pay surgical units for units of activity.
Plurality	The introduction of a range of service providers to the market place to ensure competition.
Primary Care Trusts (PCTs)	Locally managed and free-standing NHS organisations that are responsible for commissioning and delivering healthcare to a defined population.
Private finance initiatives (PFIs)	A government programme that enables the private sector, often arranged into consortia, to finance the building of new hospitals and facilities, which are then leased back to the NHS. A PFI consortium often manages hospital services such as portering, cleaning and laundry services.
Strategic health authority (SHA)	Strategic health authorities are the tier between the DH and NHS Trusts/PCTs. They ensure the delivery of improvement in health services locally by PCTs and NHS Trusts and hold PCTs and NHS Trusts to account through performance agreements. There are 28 strategic health authorities in England, including five in London. A board of executive and non-executive directors, led by a chair, manages them.
Sustainability	Capable of being maintained over the long term, without major change.

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