



Senate of Surgery of Great Britain and Ireland

Reconfiguration of Surgical, Accident and Emergency
and Trauma Services in the UK



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Summary

Our aim is to provide an excellent surgical service for all those who need it. An ageing population, higher patient expectations and increased sophistication of surgical care are changing the demands on healthcare and requirements on the NHS. The European Working Time Directive (EWTD) is forcing a reduction in working hours. Advances in surgery make it impractical to provide state of the art facilities for treatment everywhere. For these reasons, without reconfiguration there would be an inevitable and rapid decline in the quality of treatment for all patients.

We believe whenever appropriate, clinical care should be provided locally. However, if then decided that further specialist treatment or diagnosis is required, it may be necessary for the patient to move to an appropriate centre of excellence.

The NHS needs a framework to match the reality of modern surgery. The requirements are:

- (a) to train more surgeons;
- (b) for surgeons to work more flexibly;
- (c) for surgeons to receive the appropriate service and infrastructure support from management, and,
- (d) to integrate IT facilities for all areas of patient care.

Senate urges that resource allocation and structured reorganisation takes full account of these fundamental points.

Introduction

The Senate of Surgery of Great Britain and Ireland (The Senate), represents the four Surgical Royal Colleges, The Dental Faculties, the 10 Surgical Specialty Associations, which includes Accident and Emergency, and has lay representatives. Given this broad representation, the Senate is in a unique position to speak on behalf of all Surgeons in the United Kingdom. The Senate acknowledges the need for reconfiguration of Surgical, Accident and Emergency and Trauma services in the UK to ensure the prompt delivery of high quality elective and emergency care in a modern National Health Service (NHS).

The Senate recognises the many pressures facing the NHS including the New Deal and the European Working Time Directive (EWTD), as well as demographic changes and rising public expectations while ensuring the best use of all available resources - especially staff. The Senate welcomes the direction of travel outlined in various recent consultation papers in conjunction with publications from the devolved Parliament in Scotland and the Assemblies in Wales and Northern Ireland.

The Senate recognises the clinical and administrative advantages to the patient of separating emergency, elective and ambulatory care surgical services. The Senate notes the policies set out in "Keeping the NHS Local - A New Direction of Travel" in that Surgical Services should, wherever possible, make use of existing facilities to provide a safe and sustainable service for patients as close to their home as possible. This could include outpatient services, a cost-effective range of diagnostic facilities, day case and some short stay surgery and post-operative rehabilitation. The Senate agrees that there are many innovative ways including multi-disciplinary skill development to support such arrangements, eg, critical care teams might enable a greater range of surgery to take place in local hospitals. Nevertheless, there is a limit as to what can be achieved in this direction. Whilst the reconfiguration of secondary care surgical facilities may, at first sight, be unpalatable, the overriding consideration which drives Senate and the NHS must be that of patient safety and the outcome of surgical treatment. The pressures of the New Deal, EWTD, the shortage of skilled surgical manpower and the requirement for High Dependency and Intensive Therapy Units mean that, for most surgical specialties, there is an inescapable need to provide elective and emergency surgical services in larger hospitals for complex in-patients.

The Senate fully supports the involvement of patients and the public in discussions on service reconfiguration, but such consultation can only be meaningful if the public is fully informed on the issues involved. The Department of Health has still not involved the public in any understanding of EWTD. Rising public expectation demands full information and lay involvement.

Reconfiguration of Surgical, Accident and Emergency and Trauma Services in the UK is necessary to address the essential requirements of

changing patterns of work. Senate strongly believes that there is an immediate need to reconfigure secondary and tertiary surgical services and that the introduction of Foundation Hospitals is premature until reconfiguration is agreed.

The Way Forward

Through its Specialty Association representatives, the Senate has undertaken a detailed review of Surgical, Accident and Emergency and Trauma services in a modernised NHS. Several common themes have been identified, crossing traditional specialty and professional boundaries, ensuring that hospital reconfiguration will make the best use of all available resources. All the Surgical Specialty Associations have developed proposals as to how best their respective services can be reconfigured to meet the requirements of a modernised NHS treating patients in the appropriate facility.

Provision of Service

The Senate recognises that proposals designed to improve Postgraduate training and the provision of integrated multi-professional and multi-disciplinary patient care cannot be achieved without significant reconfiguration of hospital services and the adoption of new approaches to surgical, accident and emergency and trauma care. The Senate recognises that priority must be given to meeting the needs of the emergency patient and believes this should be addressed by reviewing the relationships that currently exist between primary care, the ambulance services, accident and emergency and trauma care. Minor Injuries Units (Local Emergency Units) should have no role in treating severely ill or injured patients and explicit by-pass policies must be in place so that these units do not receive "blue light" ambulances.

The Senate recommends that the public should be fully involved in any discussion reviewing the provision of both emergency and elective services. Risk assessment of new patterns of service will need to be conducted and the results shared with the public.

A&E and Trauma Services

The Faculty of Accident and Emergency Medicine recognises that any major Accident and Emergency Department providing a 24 hour a day, 7 days a week service that accepts all unscheduled and undifferentiated emergency cases will liaise with smaller district and peripheral units managing an agreed range of clinical conditions. The district and peripheral units will be supported by diagnostic services but surgical and trauma services will be restricted, eg, 8am until 8pm. The Faculty stresses that protocols for managing the critically ill and major trauma will need to be agreed to avoid delay in establishing definitive care. Diagnostic

services and patient management will increasingly rely on improved information technology enhancing consultation between the central unit and its network of smaller units, ensuring onward referral after stabilisation, where appropriate.

The district and peripheral units which provide elective surgical services on a day case or planned admission basis will be supported by the “hospital at night” concept. A single plan may not fit all acute surgical services.

Postgraduate Training

Implementing the New Deal, EWTD, and a shorter time to CCST as outlined in “Unfinished Business: Proposals for Reform of the Senior House Officer Grade”, can only be achieved with radical changes in the way surgeons and A&E staff are trained.

The Senate reaffirms that modern postgraduate surgical training requires a major resource commitment and secure funding from the NHS

The Senate believes that there is an urgent need to set aside dedicated sessions for training within the consultant job plan. This should include operating sessions free from the constraints of service delivery targets. There is a pressing need for this now, but it will become more acute with the introduction of competence based training and assessment.

Competence based assessment in conjunction with structured educational programmes delivered by integrated Basic and Higher Surgical/Accident and Emergency Training Schemes is essential. Basic Surgical Training needs to be increasingly focused to enhance the possibility for seamless transfer between Basic and Higher Surgical/A&E Specialty training programmes. The Senate believes that well structured Foundation Programmes will cover many generic aspects of an introduction to Surgical or Accident and Emergency training, allowing Basic Specialty Training to be more focused.

Higher Specialty training in the core or generality of an individual Specialty, allowing consideration of an earlier CCST, can only be achieved following detailed consideration by the Surgical and Accident and Emergency Specialty Advisory Committees (SAC), the Joint Committee for Higher Surgical Training (JCHST), the Colleges and the relevant Specialty Association. The current Higher Specialty training programmes will need to be restructured to ensure adequate exposure to the core elements of a Specialty, emphasising the management of emergencies

The Senate cannot accept that Advanced Sub-specialty Training Opportunities (ASTO's) should take place following the completion of core training (post CCST) unless it can be reassured that adequately supervised and fully funded training will be available in the UK, Europe and Internationally. The SACs would be responsible for approving the

programmes under consideration and assessing the outcome of training. The Senate would expect SAC involvement in the appointment of ASTOs in conjunction with the relevant Deanery Training Committee.

Appraisal/ Revalidation/ Life Long Learning

The Senate supports the General Medical Council's proposals for annual Appraisal and Revalidation with the proviso that adequate time and funded opportunities for Continuing Professional Development and Medical Education are available for all staff. The Senate believes that retaining senior and experienced staff in the NHS can best be achieved in the front line surgical specialties and those with significant emergency work loads by ensuring that flexible strategies are available which will allow senior members of the profession to modify their clinical commitments from their mid-fifties onwards. These options should include consideration of reduced "out of hours" commitments, less than full time working or job sharing, and increased administrative, educational and supervisory roles.

Flexible career options must also be available to facilitate changing patterns of clinical practice as a result of advances in surgical techniques and developments in related specialties.

Academic Surgery

The Senate wishes to emphasise the importance of reinvigorating and supporting Academic Surgery and Academic Accident and Emergency Medicine. Academic Departments fulfil several vital roles, namely:

1. A major commitment to surgical education of medical students
2. To help define and practice state of the art surgery
3. To provide an environment and infrastructure for surgical research and development
4. To promote the development of modern teaching practices in surgical training

Team Working/ Mentoring

The Senate supports team working within clinical services and units, across managed clinical networks involving central, district and peripheral hospitals, and primary care. The senior clinician(s), responsible for leading a clinical service would need adequate administrative support to ensure integrated managed clinical networks. Members of a managed clinical network should meet regularly, face to face and using teleconferencing, for in-service educational opportunities, many of which will be multi-professional, as well as clinical case conferences and business meetings.

All new Consultant or Career Grade (Staff and Associate Specialist) appointees to a clinical service or unit should be mentored by a senior member of the team with whom they will work and further develop their clinical, administrative, audit and teaching skills.

Responsibilities for functions such as audit, clinical research, education and training, appraisal and assessments etc. should be clearly delegated among senior staff in a clinical network with appropriate "line management" identified to the lead clinician.

A flexible approach to working by consultant colleagues in different hospitals forming a managed clinical network should be encouraged, allowing a consultant working in a central unit to invite a colleague from a district or peripheral unit to participate in appropriate clinical or educational opportunities within that central unit, and vice versa.

Enhanced Roles

The Senate supports the development of enhanced roles for appropriately trained, qualified and experienced members of the nursing profession and the Allied Health Professionals working within a clinical service or unit as outlined above, responsible to the relevant Clinical Director.

The Senate supports the development of surgical, non-medically qualified, staff members to participate in patient care as members of a clinical service or unit, responsible to the relevant Clinical Director and within the NHS.

Action Required to Redesign Surgical Services

The Senate wishes to participate actively in the discussions considering the Reconfiguration of Surgical, Accident and Emergency and Trauma Services in the UK. The Surgical Specialty Associations have detailed knowledge of the provision of their specialist services in a geographical context and Senate considers their input essential. The Senate strongly supports service redesign but this redesign must:

- respect the access needs of patients and relatives
- allow expert assessment and co-ordinated surgical care from presentation through to rehabilitation and return to the home environment
- ensure adequate clinical experience for all members of surgical teams
- provide adequate supervised training opportunities
- take cost-effectiveness into account
- recognise the importance of collecting outcome data
- conform to accepted standards tested through audit to improve provision and patient care
- foster the further development of national standards of surgical care
- realise that the achievement of acceptable standards and outcomes will determine the future reception of surgical patients in all receiving hospitals and treatment centres, irrespective of size.

BACKGROUND DOCUMENTS

1 THE SURGICAL SPECIALTY ASSOCIATIONS

Documents have been developed by the Surgical Specialty Associations as to how best their respective services can be reconfigured to meet the requirements of a modernised NHS treating patients in the appropriate facility.

Accident & Emergency Medicine

Implications of Reconfiguration of Surgical Services for the Specialty of Accident and Emergency Medicine – Personal Overview. Mr A. McGowan.(2003)

Cardiothoracic Surgery

DoH - National Adult Heart and Lung Transplant Service: Discussion Document. September 2001

www.doh.gov.uk/ncts/cardiothoracic.pdf

Joint Report from the Society of Cardiothoracic Surgeons and the British Cardiac Society on Models of Care for the Delivery of Cardiac Surgery (2002)

<http://www.scts.org/file/modelsfinalDec2001.doc>

General Surgery

Reconfiguration of General Surgical Services – Personal Overview for Discussion. Mr R W G Johnson 2002

Neurosurgery

Safe Neurosurgery 2000: A report from the Society of British Neurological Surgeons

http://www.sbns.org.uk/docs/Safe_Neurosurgery_2000_Booklet.doc

Safe Paediatric Neurosurgery 2001: Society of British Neurological Surgeons Working Group: Chumas P, Hardy D, Hockley A, Lang D, Leggate J, May P and Steers J. British J of Neurosurgery 2002; 16(3): 208-210

http://www.sbns.org.uk/sbns/safety_standards_paediatric.htm

Standards for Patients Requiring Neurosurgical Care. Joint Standards Development Group of the Clinical Standards Committee of the Society of British Neurological Surgeons and Regional Specialised Services Commissioning Group. (2002) Hardy, D

Factors likely to affect the location and provision of future neurosurgical services: a discussion. (2002) British Journal of Neurosurgery 17(1) 8.14

The Consultant Neurosurgeon Post: Principles and Practices Underpinning Job Planning (2003) forthcoming

Oral/Maxillofacial Surgery

The Organisation of Oral & Maxillofacial Services in the United Kingdom. BAOMS.

March 2002

<http://www.baoms.org.uk/miscellaneous/orgserv.pdf>

Orthopaedic Surgery

"Reconfiguration" – Changing the model of Trauma and Orthopaedic Care in the NHS. Professor P Gregg (forthcoming)

Otolaryngology/Head & Neck Surgery

Provision of Otorhinolaryngological and Head & Neck Services in the UK. (2003)

Paediatric Surgery

Paediatric Surgery: Standards of Care. BAPS 2002

Children's Surgery: a First Class Service

http://www.rcseng.ac.uk/services/publications/publications/pdf/chil_rep.pdf

Surgical Services for the Newborn (BAPS) 1999
<http://www.baps.org.uk/documents/newborn.pdf>

Provision of General Surgical Services for Children (1998). Senate Paper 3. July 1998

Reconfiguration in Paediatric Surgery. BAPS (2003)
<http://www.baps.org.uk/reconfigpaed.doc>

Plastic Surgery

The Way Forward - the future of plastic surgery" BAPS (2003)
<http://www.baps.org.uk/reconfigpaed.doc>

Urological Surgery

The Provision of Urological Services in the UK. BAUS (2002)

2 ROYAL COLLEGE OF SURGEONS OF ENGLAND

The following reports and policy statements can be found on the web site of the Royal College of Surgeons of England.

Provision of Emergency Surgical Services (1997)

The Report of the Working Party to Review Organ Transplantation (1999)
http://www.rcseng.ac.uk/services/publications/publications/pdf/rep_orgt.pdf

The Report of the Working Party on the Management of Patients with Head Injuries (1999)
http://www.rcseng.ac.uk/services/publications/publications/pdf/rep_hi.pdf

Better Care for the Severely Injured (July 2000)
http://www.rcseng.ac.uk/services/publications/publications/pdf/sev_inj.pdf

Provision of Elective Surgical Services (December 2000)
<http://www.rcseng.ac.uk/services/publications/publications/pdf/elecsc.pdf>

The Surgical Workforce in the new NHS (2001)
<http://www.rcseng.ac.uk/services/publications/publications/pdf/surgworknhs.pdf>

The European Working Time Directive: A Policy Statement from the Royal College of Surgeons of England (2003)
http://www.rcseng.ac.uk/services/publications/publications/pdf/wtd_policy.pdf



Senate of Surgery Secretariat
232-242 St Vincent Street
Glasgow
G2 5RJ
t +44 (0) 141 227 3224
f +44 (0) 141 221 9260