



THE IMPACT OF EWTD ON DELIVERY OF SURGICAL SERVICES: A CONSENSUS CONFERENCE

**A one-day Consensus Conference organised by the
Association of Surgeons of Great Britain and Ireland**

APPENDIX 1

Friday 30th May 2008

at

**The Royal Society of Medicine
1 Wimpole Street, London, W1G 0AE**

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NATIONAL WORKFORCE PROJECTS

ASSOCIATION OF BREAST SURGERY AT BASO

ASSOCIATION OF COLOPROCTOLOGY OF GREAT BRITAIN AND IRELAND

1. Who will deliver the service?

There is still some discussion about whether surgeons in some other subspecialties should perform colon surgery, particularly in emergencies: this will surely stop, particularly as GI surgeons are left holding the emergency baby. Complex pelvic surgery requires expert assistance. If junior support diminishes, nurse specialists will be required in greater numbers, trained to a higher level.

2. What is the projected workload?

The volume of major colorectal surgery may fall as medical therapies (Crohn's, ulcerative colitis) become more effective in avoiding or at least delaying surgery. Screening, particularly with flexible sigmoidoscopy, will decrease the incidence and the degree of advancement of cancer; the proportion presenting as emergencies should also fall.

3. Impact of new technology and treatment options

As in previous section. Laparoscopic surgery will come to play a much greater part; a national training programme is set to allow up to 360 consultants to learn this approach if they have not learned it in pre CCT training.

4. Reconfiguration – where should surgery be done?

Regional centralisation is beginning piecemeal. Anal cancer is already a regional sub-specialist area, and it is likely that recurrent colorectal cancer and complex IBD surgery will follow. Dedicated laparoscopic theatres are very expensive, so this may lead to some centralisation, particularly for more complex laparoscopic cases. As 30% of cancers present as emergencies, local access for potentially sick patients will be still needed.

5. Treatment centres

Diagnostic and treatment centres might well take over the early investigation of patients with the common symptoms, treating those found to have haemorrhoids and fissures, and passing on the cancers, etc. This might lead to the export of diagnostic services from hospitals to TCs, with some inevitable duplication of facilities if adequate in-patient support is to be maintained. Care will be required to avoid diagnostic errors due to symptomatic overlap between 'minor' and major conditions.

6. Private hospitals

These would be keen to take their share of the 'market' open to Treatment Centres.

7. Polyclinics

Most patients present with one or more of a small set of symptoms that are most likely due to minor pathology, but which often require expensive investigations to identify those with serious conditions. This process is more likely to be based in Treatment Centres than Polyclinics.

8. Separation of elective and emergency cases

Colorectal cases form a considerable proportion of emergency admissions and surgery in the UK. Importantly, many major emergency procedures lead on to later elective surgery (Hartmann's reversals, stoma closures, pouch procedures). Geographical or even service division would lead to inefficiencies in care, and the loss of continuity

would lead to major difficulties in training. The ACPGBI has been very unenthusiastic about the separation of these two areas, either as separate services or on different sites.

9. Impact on training

It is plainly evident already to those working with senior trainees that many, while adequately versed in the generality of specialist practice, do not have the depth and breadth of training to deal with some of the more challenging clinical situations that may face them very soon after CCT. The post CCT fellowships are likely to be beneficial, but will not be available widely enough, and are specifically aimed to give experience in 'niche' areas that will remain as regional specialties rather than in the generality of hospitals.

10. What do the trainees expect?

There is a high level of awareness of the major issues, and we keep abreast of their views, aspirations and suggestions.

11. Female trainees

There has been a considerable increase in the numbers of female trainees, despite the heavy workload. It is most unusual for them to seek job shares.

12. Rural isolated communities

There are relatively few incidences where travel would cause detriment, even in emergencies.

13. Centralisation of specialist services

As mentioned above, this has begun, and is likely to continue in the more complex, less common problems such as advanced cancer and IBD cases.

14. Centralisation of training

Because of the great range of seriousness and complexity of colorectal disorders, separation of cases into those treated in TCs, district hospitals (emergency and elective) and regional centres will mandate comprehensive rotations. Lack of experience and training in any area of complexity will lead to mis-diagnosis and unnecessary morbidity and mortality.

15. Future of small hospitals

Because of the need for 'joined up' care, smaller units will fall by the wayside as emergencies and major elective cases are taken away. The temptation to continue with the 'bussing' of cases between hospitals for political expediency must be resisted vigorously.

16. The other nations

All for one and one for all. To varying extents all our nations are confronted by the same cocktail of challenges.

17. Comparison with other countries

Our cancer outcomes are amongst the least impressive in Europe. As we try to cope with EWTD we must not allow this situation to worsen. We have some of the worst population/doctor ratios in the Western world, so we are well set for deteriorating outcomes if ETWD is the final straw.

ASSOCIATION OF SURGEONS IN PRIMARY CARE

1. Who will deliver the service?

ASPC firmly believes in *'shifting appropriate surgical services to the primary care settings – where skills and infrastructure are available and in place'*. The workforce required to deliver the service will essentially be 'primary care surgeons'. Primary Care Surgeons will come from the medical or nursing fraternity and be trained and competent surgeons --- delivering surgical services in the community -- within their approved and accredited skills. Huge numbers of surgical trainees will not get Consultants posts (as per recent Consensus Statement – ASGBI Jan 2008) and this skilled workforce could be gainfully employed in the primary care setting. Level of delivery of service, being competence achieved and accredited by relevant organisational bodies – e.g. Royal College of Surgeons.

2. What is the projected workload?

90% of all NHS consultations take place in the primary care setting. Majority of the routine elective minor and intermediate surgical procedures could be easily done in the primary care setting. ASPC has classified three levels of workload – depending on the skills and infrastructure available. (ASGBI Newsletter Mar 2008). Further expansion and classification will be revisited.

3. Impact of new technology and treatment options

Phakoemulsification for cataract surgery and mesh repair for groin hernia surgery are good examples where modern technology has made an impact and is being delivered in the primary care setting – with excellent results. Endoscopic procedures will add to this diversity.

4. Reconfiguration – where should surgery be done?

Patient pathway should be reconfigured, by ensuring procedures that do not require hospital infrastructure and skills be diverted to the community. Care Closer to Home – has firmly established that patients prefer such a service – as long as quality and safety of care is not compromised. (DH 23rd Oct 2007 – Shifting Care Closer to Home)

5. Treatment Centres, Private Hospitals and Polyclinics

Again appropriate surgical procedures could be performed in these settings – as long as the infrastructure, staff and skills are approved and accredited.

6. Separation of elective and emergency work

It is now well recognised that elective and emergency work ought to be separated and functions very much better as far as service provision is concerned. Waiting lists and waiting times are certainly reduced. Training of future workforce is a subject of much concern and collaboration and co-operation between the two centres (elective and emergency) is of importance.

7. Impact on training

Specialisation and Sub specialisation ensures high volume of clinical cases will be seen in these centres. For future primary care surgeons and basic surgical trainees – it would be prudent to learn effective and evidenced based techniques from these centres. Again co-operation and collaboration between primary and secondary care settings is important. Surgical trainees need 'hands on training' besides having important skills as decision making, etc...

ASSOCIATION OF SURGEONS IN TRAINING

1. Patient care must not suffer as a result of the EWTD, neither in terms of continuity of care nor quality of and level reached at the end of surgical training. The American College of Surgeons have suggested that it is lack of continuity of care rather than tired Doctors that presents the greatest risk to patient safety.
2. As the inevitable consequence of EWTD is to reduce overall hours and increase the proportion of time spent in providing out of hours cover, methods must be identified to protect the quality of training, whether this be by increasing the length of the training programme or by fundamentally changing the way in which training is delivered.
3. Simply increasing the number of doctors working at each tier of the rota level is not an acceptable solution and the number of trainees appointed must be determined by the availability of training opportunities.
4. The introduction of cross-cover between specialties at the level of Higher Specialty Training is unacceptable.
5. EWTD must not result in a decline in the quality or abilities of trained surgeons and must not be allowed to provide a catalyst for the introduction of a sub-consultant grade.
6. If NHS work were to move, even in part, to the independent sector as a result of working time pressures, then tariffs must be negotiated that permit the provision of high quality training within this sector.
7. In formulating plans - allowances must be made for the increasing "feminisation" of the surgical workforce and for better opportunities for flexible working patterns.
8. The quality of training should be preserved by improving recognition of good training at both the individual and unit level, and equally a robust QA system put in place to swiftly identify and deal with underperforming trainers and units, as shorter time for training should lead to a lower threshold for withdrawal of a training placement. Provided that the system for training is formalised, there is no requirement to centralise training.
9. Bullying of trainees to return false declarations of hours worked (as is known to happen in some units currently) is not a solution to the EWTD and cannot be tolerated.
10. Surgery, as a craft specialty, will have different requirements and will need a different solution to EWTD to the medical specialties. Even within surgery itself, there may not be a "one size fits all" solution for all of the sub-specialties.

ASSOCIATION OF UPPER GASTROINTESTINAL SURGEONS OF GREAT BRITAIN AND IRELAND

1. Emergency surgery has suffered as there are no "targets". Hence it is under-resourced and over-stretched. Managers need to be encouraged to address this, possibly by the use of DOH targets.
2. Day time access for emergency/urgent GI surgery needs to be protected from Plastics etc. as it is impossible to get near theatres in most Hospitals because of lack of theatre provision.
3. Once this is addressed, Consultant Surgeons will need to reorganise their weekly programmes to accommodate the emergency work. This has already happening in some Hospitals but needs to occur across the board.
4. To compensate for the loss of elective work additional Consultant appointments will be needed. These new posts are also needed in the Cancer Centres to support Centralisation (28/46 O-G Centres have <3 Consultants).
5. Trainees will be at work less so they need to be trained more intensively. Protected day time emergency lists will allow Consultants to train them in Emergency Surgery just as they currently do for elective surgery.
6. If emergency theatres were available, acute gall bladder pathology could be operated on during the initial admission reducing waiting lists and freeing up elective capacity.
7. Small Hospitals will always struggle to have enough staff to provide out of hours surgery. Some of them may have to change their focus and become elective only institutions or act as an "assess and refer centre". This is politically unpalatable but emergency GI surgery in every Hospital is probably impossible in the future.
8. Not all Consultants make good trainers and we need to get away from the concept that everyone is a trainer. Those who are willing and able need support to make it worth their while being a trainer and the commitments to training should be recognised in their job plans.
9. General Surgery in its traditional sense no longer exists and the term should be dropped as soon as possible. It is hindering our ability to get adequate resources. I would favour the term Gastro-intestinal surgery. This is then provided by GI surgeons (not anyone else).

BRITISH ASSOCIATION OF ENDOCRINE AND THYROID SURGEONS

1. A small specialty like endocrine surgery will have difficulty providing the service because in most hospitals the care is provided by one surgeon, who when not there can not be readily covered.
2. Because the commonest current model of care for endocrine patients is one surgeon in a given hospital, there will be a serious problem in providing continuity of care for patients.
3. The EWTD will provoke a review of the critical mass of staff needed to care for endocrine patients and provide an MDT and a centralist approach will likely emerge.
4. Should consultants move to shift working for emergency and elective work, including sleeping in?
5. There will need to be an expansion/improvement of clerical support to deal with patient issues when medical staff are not present.
6. The impact on training for both elective and emergency work will be substantial.
7. The department of health should consider separating DCC from SPA in the current job plans, thus at a stroke producing flexibility to work round compensatory rest periods. The current timetabled approach to SPA should be abandoned (but DCC Timetabling kept) so that flexible working can be used to avoid huge gaps in service provision.

BRITISH TRANSPLANTATION SOCIETY

1. Providing sufficient training opportunities in a sub-specialty within the EWTD constraints, where many of the opportunities arise out of hours.
2. Managing the training numbers in small sub-specialty.
3. Managing the staffing of a specialist service with major out-of-hours commitments
 - a. Consultant
 - b. Middle-grade staff
4. The issue of whether consultants will continue to work across transplantation and another specialty.
5. Integration of academic activities with NHS service commitments.
6. The development of organ retrieval as a defined sub-specialty skill and the opportunities for training that this implies.
7. Problems of training in smaller transplant units which not have the volume of activity to support training.
8. The need for a small sub-specialty to rotate trainees across Deanery boundaries.

SOCIETY OF ACADEMIC AND RESEARCH SURGERY

1. Where will the time out in research be taken?
2. Should all surgeons have time in research?
3. Should we be looking at building new hospitals of a larger size to take a reasonable number of patients in order for European Working Time Directives?
4. Vascular surgical services should be placed at certain hospitals, not all, preferably in association with cardiac services.
5. Private hospitals should be brought into the NHS.
6. Polyclinics.
7. The European Working Time Directive's implication on training.
8. Throughput of cases.
9. Inefficiencies of the service.
10. The Consultant contract.

VASCULAR SOCIETY OF GREAT BRITAIN AND IRELAND

1. Who will deliver the service?

Vascular interventions are generally only delivered by Consultants working in specialist vascular teams, including vascular surgeon and vascular radiologist. Any lack of junior support, however, will mean that much of the basic service will also be delivered by consultants e.g. assessment and investigation of admissions, daily ward rounds. Complex vascular interventions require experienced assistance, so any loss of support may mean these will need to be done by two consultants working together.

2. What is the projected workload?

As our populations become more elderly and also request earlier treatment of social diseases such as claudication it is likely that the burden of pathology will increase. This should be balanced against better medical treatment including the use of statins and antiplatelet therapy. The prevalence of diabetes is escalating and a common complication of this condition is limb threatening ischaemia that often needs amputation. Minor diabetic foot surgery usually falls to the vascular surgeon, often as unscheduled treatment. Workload could also increase depending on the Government's recommendations for endovascular stenting and the approach to asymptomatic carotid artery disease.

3. Impact of new technology and treatment options.

There is a big move away from open vascular surgery to endovascular treatments for both peripheral vascular disease and aortic aneurysms. This has a considerable impact on our specialty since it requires the retraining of current vascular specialists and also a new training curriculum for vascular specialists of the future. The new NHS Stroke Plan will alter working practice to speed the delivery of the interventions, that will require more flexibility in work and job planning.

4. Reconfiguration – where should surgery be done?

The long term aim of the Vascular Society is to centralise the delivery of interventions into large units where a number of vascular specialists will work together. It has the advantage of increasing procedure volume which improves outcomes and offers the potential for improving expertise in rarer conditions. In the interim, groups of district general hospitals will gather into networks that will work, and undergo Clinical Governance together. This will probably be facilitated through the National Aneurysm Screening Project.

5. Treatment centres.

Treatment centres have not yet had a major impact on vascular surgery although they could deal with a lot of patients with asymptomatic, uncomplicated varicose veins. This has implications for training junior vascular specialists (there is no suggestion yet that this can be done in a treatment centre). They may affect vascular laboratory services if they undertake investigations such as ultrasound imaging.

6. Private hospitals.

As above.

7. Polyclinics.

These are not likely to have a significant effect in the vascular speciality since there are not likely to be enough patients to warrant a specialist visit to a polyclinic for vascular disease. The possible exceptions include leg ulcer or claudication clinics.

8. Separation of elective and emergency.

Over forty percent of arterial interventions are done for patients not admitted electively so a strong emergency service is essential. Ninety percent of the UK is currently covered with on call vascular surgical services by a vascular specialist and the aim should be to increase this to one hundred percent either by networking or centralisation. It will never be possible to separate elective and emergency vascular intervention so therefore there needs to be a degree of flexibility about how elective services are delivered.

9. Impact on training.

Future vascular specialists will need to be trained in both vascular and endovascular techniques. We have a working party with the Royal College of Radiologists that is working on pilot programmes for training and sub speciality status for vascular surgery. In the interim it is going to be increasingly important using pilot training post schemes to try and obtain a proper vascular training for those who wish to undertake vascular intervention. The new post CCT Fellowships will help a great deal in this regard, and it is important that the funding for these posts is recurring.

10. What do the trainees expect?

We are working with the Rouleaux Club of vascular trainees to ensure their training needs are catered for.

11. Large increase in female trainees.

This does not seem to have been the case in vascular surgery as it has in other specialties but to date we have not had any debate about this.

12. Rural isolated communities.

It is clear that to get vascular treatment, patients will have to travel. Fortunately, for most vascular conditions (other than perhaps ruptured aortic aneurysm) this has not proved detrimental to their treatment.

13. Centralisation of specialised services.

The Society is moving towards this.

14. Centralisation of training.

This logically follows the above. There is a need for specialist endovascular training, which is only available in a small number of units. Also due to the short training times, vascular trainees should spend as little time as possible undertaking work that is not of direct value e.g. general surgery cover and elective general surgery. This does pose the problem of how to provide out of hours services, as there will not be enough trainees to do this

15. Future of small hospitals.

These will not offer a full range of vascular services but may be an outreach area for out-patient and minor surgery such as varicose vein treatments.

16. Different solutions for Scotland, Wales and Ireland.

It is not anticipated that the solutions will be any different in the rest of the UK.

17. Comparisons with other Countries.

The rest of Europe seems a long way ahead of us! European Vascular Surgeons have separated completely from general surgery and now have their own specialty.



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