Royal College of Surgeons of England
Professional Affairs Board in Wales

Report to Betsi Cadwaladr University Health Board
Reconfiguration of General Surgery Services

June 2011
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**Introduction**

Betsi Cadwaladr University Health Board (BCUHB) was brought together as part of the most recent NHS Wales reconfiguration of Trusts and Local Health Boards. This was the amalgamation of three previously independent NHS Trusts and their commissioning Local Health Boards and Primary Care providers. A declared purpose of this reconfiguration was to bring together smaller providers into units of a more sustainable and autonomous size. A series of service reviews were started in mid 2010.

The Royal College of Surgeons of England (RCSE) Professional Affairs Board (PAB) in Wales offered to be involved in advising on the surgical services project and sometime after the process had started, the Director (CF) attended several meetings of the project board by video link.

The process became the subject of public and political scrutiny and reports were received by the PAB that several consultants felt that there had been inadequate consultation. Requests were made to the Professional Affairs Board to become involved by some of the Consultant General Surgeons in Ysbyty Glan Clwyd, who had concerns that their services were in jeopardy and they felt their views had not been properly taken into consideration. BCUHB agreed to the PAB visiting in this context.

During our visit on the 18th and 19th April, 2011 we were aware that we were not able to speak to every consultant to elicit their views. We were also aware that there was a need to demonstrate that these views had been sought and considered. We therefore decided to undertake two surveys of opinion through the RCSE mechanisms, the first of the substantive Consultant General Surgeons in post in BCUHB and the second of all surgical consultants in BCUHB. The first survey has been completed and the results are appended with some comment and interpretation in the body of the report. The second survey is underway but not yet completed; results of this survey will be reported subsequently.

Co-incidental with this, the RCSE report Emergency Surgery: Standards for Unscheduled Surgical Care was published on 7th April 2011. The PAB believed that these standards, along with several other standards and advisory documents from Professional Societies might illuminate the discussions.
The PAB Visitors

The visitors comprise the RCSE Director of Professional Affairs in Wales, the RCSE/Specialty Association Regional Specialty Professional Advisers for General Surgery and the Vascular Society of Great Britain and Ireland Adviser for Wales. This panel was selected and invited to help with the visit by the Director and none have any conflicts of interest. The advice given is their own views and is compatible with the policies of the organizations they represent.

Colin Ferguson, Consultant Vascular Surgeon ABMUHB
RCSE Director of Professional Affairs for Wales

Wyn Lewis, Consultant General Surgeon Cardiff and Vale UHB
Regional Specialty Professional Adviser General Surgery for Wales
Member General Surgery SAC

Alan Woodward, Consultant General Surgeon Cwm Taf HB
Regional Specialty Professional Adviser General Surgery for Wales

Susan Hill, Consultant Vascular Surgeon Cardiff and Vale UHB
Vascular Society Adviser for Wales
Programme Director Higher Surgical Training in Wales

Francesca Creighton-Griffiths and Elizabeth Collins, RCSE Regional Co-ordinators
Remit

The remit for this visit and report are somewhat ill defined. In some ways it is easier to describe what it is not:

- It is not to arbitrate on decision making about the difficult issues being considered
- It is not to provide external solutions

The PAB visitors feel strongly that these decisions must be made by the BCUHB, following consultation with its stakeholders and the pursuance of its process.

The consultant body is an important part of the Health Board and its views and opinions are vital to both reaching the right decisions and being able to implement them.

Key purposes of the PAB visit were to encourage Consultant colleagues to try to reach consensus and to provide strong clinical leadership.

In addition the visitors are able to:

- comment on the process that has been undertaken which has been raised as an issue by some consultant colleagues
- describe and comment on the services currently in place and some of their strengths and weaknesses
- comment on the plans in relation to what is known of manpower planning and surgical training issues
- comment on the current services in relation to the RCSE and specialty Society guidance that exists, in particular:
  - Emergency Surgery: Standards for Unscheduled Surgical Care (Appendix 5)
  - VSGBI Establishing Vascular Services 2009 (Appendix 6)
  - Provision of Emergency Vascular Services 2007 (Appendix 7)

It is important to recognize that the views expressed are opinions based upon the information gleaned through a relatively short visit, with access to a limited number of consultants and other staff and survey responses received to date from Consultant General Surgeons. It is therefore not a comprehensive service review.

It must also be recognized that the report is opinion, honestly given, of the visitors and cannot be taken as instruction or authorization to act in any particular way, but it can be considered to be Professional advice given impartially and without favour.
**Report Format**

The visitors have each taken areas of responsibility relating to their areas of expertise. They have independently drafted their allocated parts of the report. The visitors have met to consider all parts of the report and where possible have agreed. It was intended that if there were areas of disagreement amongst the visitors that this would be highlighted. However it can be said that all are agreed on the contents of this report.

The parts of the report and principle authors are as follows:

- Process, Consultation and Engagement: CF
- Emergency General Surgery: CF
- Co-dependency of Services: CF
- RCSE Standards and Recommendations: CF
- Colorectal Surgery: AW
- Upper GI Surgery: WL
- Breast Surgery: WL
- Vascular Surgery: SH
- Opinion and Conclusion: All
Process undertaken by BCUHB

The BCUHB initiated the most recent series of service reviews in summer 2010. One of the underlying purposes of the new Health Board is establishing sustainable services in the medium term and achieving economies of scale. In addition to this a stimulus to the service review projects was the announcement of the forthcoming financial constraints that were to be enacted upon the NHS in Wales, believed at that time to amount to some 20% reduction in the budget over 4-5 years.

One of the reviews related to General Surgery. A Project Board comprising a variety of managerial staff including medical managers was established (Appendix 1). A series of Project documents was produced describing the processes that would be used to engage with stakeholders and aid decision-making regarding reconfiguring surgical services (Appendix 2).

The time scale for the project was very ambitious with a plan to make decisions and enact change quickly. Concern was raised at that time from a variety of clinical staff in various specialties. There was also concern from local politicians and other stakeholders. These concerns rightly resulted in a reconsideration of timescales and engagement. As a consequence the Project Board has now taken more time to try to engage and further seek the views of stakeholders including consultant staff. The current report is part of that wider engagement and this is welcomed.

Engagement with Consultant Surgeons

Significant efforts have been made recently by the BCUHB management team to engage with and seek the views of the Consultant General Surgeons on all three sites with two meetings being held to allow them to express their opinions. The membership of the Project Board (Appendix 1) would seem to be inclusive of the consultants in each of the hospitals in the organisation and other stakeholders. Some consultant surgeons have responded very positively by making their views clear, some verbally and some through written submission (Appendices 3, 11 and 12). Despite these efforts however there are consultant surgeons who have not attended the meetings or expressed their views.

There are some who feel they have not been part of the process, however during our visit we gained the impression that this variable engagement has deep complexity underlying it. Some Consultants feel that the services they have developed are under threat. This has resulted in some complaining vociferously while others may feel that the services they have developed are not threatened and have not engaged as a consequence.

We also had conversations with Consultants who demonstrated huge wisdom and common sense about these difficult issues who have not engaged, some because they are near the end of their career. There may also be some who have been engaged with the change agenda yet have felt disempowered and have subsequently disengaged. It will be difficult to change their view.

It is vital that there is full clinical engagement if a consensus is to be reached, however those that choose not to be involved must recognise that they may lose their ability to influence subsequent development.
Interpersonal and Inter-Hospital Relations

During our visit it became clear that there are long standing issues of competition between the three main hospitals, with some consultants finding it difficult to come to terms with the need to collaborate with consultants in another hospital with whom they have been professional rivals.

Having said that we were not exposed to any feelings of animosity between consultants as individuals and each group sought to present their own services positively rather than decrying the services of others.

It was also very clear that the Consultants Surgeons on all three sites are very committed and passionate about the services they provide. They went to great effort and lengths to present their services to us in a positive way. There are many aspects of the services and the consultant endeavour that are indeed excellent.

There are examples of collaboration taking place, in Vascular Surgery, Upper GI Cancer and sharing facilities in Llandudno Hospital for example. However there are also examples of services that could be collaborating more and where Consultants on different sites would benefit from working more closely as colleagues.
Current Configuration of BCUHB Emergency Services

The three main Hospitals within the Health Board currently provide comprehensive secondary care emergency services. These comprise full A&E service, unselected medical and surgical emergency admissions from Primary care and A&E, trauma and orthopaedic services, ENT and ophthalmology services and paediatric medical and surgical admissions.

Each unit has access to level 2 and 3 Intensive care.

Each unit has access to emergency operating theatres 24 hours per day however this access is mostly dependent upon stopping elective operating lists to allow staffing. Most Tertiary services including neurosurgery, burns and plastics surgery, specialist paediatric surgery, cardiac and thoracic surgery are provided outwith the Health Board.

Vascular Surgery is provided on all three sites with a networking arrangement recently put in place for out of hours emergency work.

Emergency General Surgery Staffing and Activity

Data has been provided from BCUHB regarding the admissions and theatre activity for emergency general surgery on each site. They have also provided information on the medical staffing arrangements. From the discussions during our visit it became apparent that it is difficult to interpret some of this data as there are slight differences in what is counted, in terms of head injury admissions and paediatric admissions between the sites. There are also differences between the patterns of practice in terms of urgent caseload. Having stated this however these data are the best that are available and give some useful information.

West Unit - Ysbyty Gwynedd

This unit covers the biggest geographical area but has the smallest intrinsic population base. This is swelled most during summer months.

Staff

Consultant Staff:

- 2 Breast, 2 vascular and 6 general Surgery
- Middle grade 1:9
- 4 SpR posts, 2 Associate Specialists, 2 Staff grades, 1 research fellow.
- Core Training 1:10
- Urology 6 CTs, 3 F2s (1 academic), 8 F1 Shared rota with Medical f1 posts.

At present 8 surgeons contribute to the on call rota, plus 2 vascular surgeons contributing to the network. There are at least 2 retirements pending. Currently the consultants continue with full clinical planned commitments during their on call periods

Activity 2009-10

- Emergency Admissions 2589
- Theatre Cases 775
Facilities
• Beds available 96 (72 w/e)
• Two wards and a day case unit.
• No dedicated Emergency Assessment Unit at present
• 8 ITU beds and 5 HDU beds

Emergency Medicine
• Full A&E service 60000 attendances per year. 2 consultants in post

Central Unit - Ysbyty Glan Clwyd

This unit covers the Conwy valley with a dependent elderly population and also has an increased summer population due to tourism.

Staff
Consultant Staff
• 2 Breast, 2 Vascular and 5 GI  3 Locums currently in post.
• One vascular consultant due to retire soon
• There is also one temporary locum in post not recurringly funded.

Middle grade  1:9
3 SpR posts

SHO level 1:8 Shared with urology

F1 8

8 Consultant surgeons contribute to the General Surgery on call rota plus 2 Vascular surgeons contributing to the network. Consultants are freed of elective commitments to provide the emergency service. There is a dedicated emergency theatre available and there is a Surgical Assessment unit in operation during weekdays.

Activity 2009-10
• Emergency Admissions 3183
• Theatre Cases 915

Facilities
• Beds available 98 (83 w/e) shared with urology.
• 6 ITU and 2 HDU beds

Emergency Medicine
• Full A&E service 60000 attendances per year. Single consultant in post
East Unit - Wrexham Maelor Hospital

This unit covers the most densely populated area in the East of the region bordering England

Staff
Consultant Staff
• 2 Breast, 3 vascular and 5 GI.

Middle grade 1:8
• 4 SpR posts

SHO rota 1:10

F1 11

All consultant posts substantive and filled. One of the vascular posts is the Medical Director who does not contribute to on call and has minimal clinical input. General on call 1:7, 2 vascular consultants contribute to network. Consultants perform elective duties while on call. SpRs are freed of elective commitments.

Activity 2009-10
• Emergency Admissions 4073 (including head injuries and paediatrics)
• Theatre Cases 988

Facilities
There is a Surgical Assessment unit that is well established, with 6 trolleys and 6 beds and clear operational policies are in place.
There are a further 71 beds shared with Urology for elective and emergency patients.
5 ITU and 8 HDU beds
There is an emergency theatre available but it is not dedicated and during day time requires the interruption of elective surgery lists in order to release staff to open it.

Emergency Medicine
Full A&E service. This is a highly developed unit with currently 7 and soon to be 8 Consultants in A&E medicine.
These staff provide an essentially consultant delivered service including triage of all medical and surgical emergency admissions from both A&E and primary care. This service is highly efficient and admission rates to specialties are consequently low.
Surgical Standards

Emergency Surgery

The recent RCSE document ‘Emergency Surgery: Standards for unscheduled surgical care 2011’ sets out a series of standards and recommendations as guidance to managers and clinicians involved in the difficult decision making that is inherent in configuring these services. It is not a didactic set of recommendations but gives some simple and clear principles against which current service provision can be measured and plans for future services assessed.

The standards in summary are as follows:
- Emergency Surgery requires prioritization over elective surgery
- Dedicated clinical and managerial leadership
- A defined governance structure with focus on outcomes and audit
- A consultant led service across all specialties with consultants free of elective commitments to provide this service
- The availability of sufficient suitably trained staff throughout the patient pathway
- The presence of agreed protocols to assess and manage risk
- Timely input of senior decision makers
- Appropriate and adequate facilities to provide safe and expeditious care
- Timely access to emergency theatres
- Appropriate pre and post operative care including ITU and intensivists
- Consultant led communication with patients and supporters

Relevant Recommendations from the RCSE Emergency Surgery Standards

The RCSE document should be read alongside this report and we do not seek to interpret where BCUHB currently stands in relation to these standards. However whatever plans are made should aspire to meet the standards and any plans which clearly fall short of the standards should not receive professional support.

Unless life or limb threatening, emergency Surgery should be performed during the normal working day

According to data provided by BCUHB around a third of emergency cases are currently performed outside working hours. To improve on this there needs to be operating theatres and consultant surgical staff free of other commitments during the working day on all sites performing emergency surgery.

Clinicians & Managers need to focus audit work on outcomes of emergency surgery.

This recommendation could be used to establish an Emergency Surgery Champion with the remit for audit and governance of emergency care.

Emergency and Elective surgery should be separated from each other as far as is possible. This should preferably be on the same site.
Serious consideration should be given to this recommendation in the current discussions.

*The initial assessment of suspected emergency surgical patients needs to be completed by a senior clinician with appropriate skills and competencies.*

The exact nature of the individuals performing this service can vary, but could be a Consultant surgeon or A&E consultant, or senior middle grade surgeon or A&E doctor. The important factor is that they have the competencies as described for decision making about referral, investigation or admission. The A&E service that exists in Wrexham Maelor Hospital meets this standard well and has much to commend it.

*All patients must have a clear diagnostic and monitoring plan on admission, including a formalized pathway for unscheduled surgical care incorporating a risk grading strategy (CG50, MEWS etc).*

See CG50 Document Appendix 14

*Hospitals accepting undifferentiated medical patients have access to 24-hour on site surgical opinion (MRCS and ATLS provider level).*

The RCSE Emergency standards document specifies that an MRCS/ATLS provider must be available as the minimum.

*Patients requiring surgical opinion or intervention must be seen at an early stage by a surgeon with the required skills (MRCS and ATLS provider).*

This means that surgical middle grade staff must be free of elective commitments when on call for emergency duties.

*All patients with an estimated mortality risk of >10% must be seen by a consultant surgeon within 4 hours and their operation carried out under the direct supervision of consultant anaesthetist and surgeon.*

*In case of a predicted mortality of > 5%, consultant anaesthetists and surgeon must be present for any operative procedure.*

These standards require consultants free of elective commitments and dedicated to the emergency service.

**Provision of Surgical Assessment Units**

There needs to be a critical mass of emergency work to optimize Surgical Assessment Unit (SAU) functions. There are SAUs on the Wrexham and Glan Clwyd sites with good operating protocols but the levels of activity described to the visitors are marginal in terms of justifying a dedicated facility.
Provision of an emergency floor

Surgical units need access to acute medical services

Where emergency general and orthopaedic surgery are provided there must also be:

- Anaesthetics critical care and acute pain
- Acute medicine
- Diagnostic and interventional radiology
- Pathology
- Gastroenterology
- Cardiology
- Bronchoscopy
- Endoscopy
- Elderly care and rehabilitation

If children are admitted as emergencies, inpatient paediatrics and specialist children’s facilities are required.

Where services are provided across a Network, transport and ambulance services need to be considered. Protocols need to be agreed for transfer and bypass.
Specialist Surgical Services

Colorectal Surgery

Elective colorectal services are provided by eight consultant surgeons across North Wales (3 at Wrexham Maelor, 3 at Ysbyty Glan Clwyd and 2 at Ysbyty Gwynedd, one consultant has recently retired at Ysbyty Gwynedd and one locum consultant has recently retired at Ysbyty Glan Clwyd both without replacement) with all surgeons contributing to the on-call rota at each hospital. The number of major bowel resections in each site is significant and the workload is high for each individual consultant with all aspects of colorectal surgery being provided. Laparoscopic colorectal surgery is developing significantly in Ysbyty Gwynedd and Ysbyty Glan Clwyd but the majority of colorectal resections at Wrexham Maelor are via open surgery currently. There are separate Multi Disciplinary Meetings for each site and patients who require chemoradiotherapy attend Ysbyty Glan Clwyd. Complex surgical conditions including anal cancer are referred to Manchester though this is a relatively small number of cases. Bowel cancer screening is available in each separate unit via their own endoscopy departments.

Upper GI Surgery

Upper GI surgical services are currently provided by 5 surgeons working across the 3 sites (Ysbyty Gwynedd 1, Ysbyty Glan Clwyd 2, and Wrexham Maelor 2). All of the general GI surgeons (upper and lower GI) appear to provide an elective benign surgical service in terms of routine cholecystectomy, the main burden of upper GI elective surgical work. Anti-reflux surgery is provided across all three sites by the dedicated upper GI surgeons. Oesophagogastric cancer surgery has been centralised at Wrexham Maelor Hospital for over 2 years and has been independently appraised and highly rated. This work is serviced by a multidisciplinary team meeting hosted by Wrexham Maelor Hospital (teleconference with Ysbyty Gwynedd and Ysbyty Glan Clwyd) and specialised radiological support (Endoscopic Ultrasound) is centralised at Ysbyty Glan Clwyd, where the medical oncology service is also centralised. There are two in-reach Consultant Surgeons also working at WMH who are otherwise based at Chester Hospital. Hepato-pancreaticobiliary cancer work is referred out to Liverpool. There is no NHS Bariatric surgical service at present, in keeping with the remainder of Wales and WAG policy. None of the three sites have the benefit of an out of hours endoscopy service rota for patients presenting with acute GI bleeding.

Breast Surgery

Breast surgery is provided across 4 hospital sites which include an elective hospital at Llandudno. The provision of this service is outside the remit of this paper, save for the consideration that in future it is very likely that the contemporary generation of newly
appointed specialist breast surgeons will undoubtedly not partake in any emergency
general surgery. Moreover, the majority of surgeons currently in post are all likely to
withdraw from acute general surgical rotas within the next five years.
The Llandudno site has the potential for development into a first rate elective breast
outpatient, screening and surgical unit. This is in keeping with the fact that the Breast
Test Wales Regional Screening is already centred in Llandudno.

Vascular Surgery

At present vascular surgery is provided across all three sites. There are 2 surgeons
(previously 3) at Wrexham Maelor, 2 at Glan Clwyd and 2 (one definitive, one locum)
at Ysbyty Gwynedd. There are 3 higher surgical trainees supporting the vascular
surgery network. An emergency network exists across the three sites with emergency
patients being transferred to the on-call hospital outside normal working hours.
Endovascular aneurysm repair has been performed at all units.
Co-dependencies

Data from the Consultants Survey can inform these discussions which need to occur within BCUHB with full engagement of the Consultants body.

The co-location and co-dependency of services is one of the most difficult aspects of reconfiguring services. It has already been stated that Emergency and Elective surgery should be managed separately, but preferably on the same site. It similarly makes clinical sense that all major and complex surgical interventions occur on a site with full access to emergency services, anaesthetics, critical care, acute pain services, out of hours operating and a full surgical team. It is also a pre-requisite that emergency medicine is available on sites providing emergency surgery.

The question then is what specialties, or parts of specialties, can be located on a site that does not perform emergency surgery and what surgical provision, in terms of opinion, is required on those sites.

The following are specialties for which there are examples and experience in Wales and the UK of services that have been provided without access to emergency surgery on that site:

- Short stay and day case General Surgery
- Short stay and day case Orthopaedic surgery
- Acute Medicine with protocol led admissions.
- Acute medicine without formal protocol for admission
- Obstetrics
- Gynaecology
- Ophthalmology
- A&E medicine
- Minor Injuries and GP Out of Hours Service
- Elective Orthopaedic Inpatient Surgery
- Neurology
- Neurorehabilitation
- Elective Gastroenterology

Experience of reconfiguring services elsewhere in Wales has concluded that the following services must be co-located with Emergency General Surgery:

- Complex and Major Elective General Surgery
- Trauma Surgery
- Paediatrics
- ENT
- OMFS Surgery
- Vascular Surgery
- Interventional Radiology
- Neurosurgery
- Cardiothoracic Surgery
- Emergency Gastroenterology
- Critical Care Level 2&3
- Nephrology
Clearly there is much debate to be had about the wisdom of separating emergency general surgery from other services and the provision that would be required on a site that would be so configured.

If emergency general surgery is not performed on a hospital site then there is a need for 24 hour access to a senior on site surgical opinion. Depending on the services involved and the competencies of staff available, there are models whereby this is provided by Consultants and middle grade surgeons working in an elective capacity on that site during day time working hours and out of hours by a middle grade MRCS/ATLS holder in consultation with the consultant based at the emergency site.

There is also an absolute requirement for adequate staffing and transport to allow expeditious transport of patients to the emergency site when required.
Options For Change

The Case for Change

The BCUHB have made the case for change both through meetings with consultants and through its project documentation. The drivers quoted include:

- Sub-specialisation with vascular surgeons and breast surgeons stopping general surgery on call
- Moves to develop consultant delivered services
- Reduction in trainees imposed by the Deanery
- Financial constraints imposed by government

The extent to which the case for change has been accepted by the General Surgery consultants is not clear. Many believe that the organisation has not successfully made this case but data from the survey of General Surgeons indicates that the consensus is that there is a need for change.

Discussion of Options for Change

Options for change arose following discussions with clinicians. These include the maintenance of the status quo, establishing 2 centres for emergency surgery and establishing a single centre.

In making these decisions it is essential to look to what is known about future trends in medical manpower, and specialty and technical developments.

It is also important to estimate service demand and measures currently in place, and those being planned, to manage that demand. Within these determinations there are unique local factors and generic national factors. There are also known financial factors that must be considered.

In addition there are important local political factors but it is more difficult for us as clinicians to comment on these, although managerial staff must take these into account.

Within the RCSE Standards document there are a variety of models of care described.

The principles underlying these are:
- Consultant based care
- Separating elective and emergency surgery
- Establishing Surgical Assessment Units
- Developing Clinical Networks
- Extending the working day
- Audit and outcomes

Key to these decisions in BCUHB is whether there is a model of care that allows A&E and emergency medicine services to be delivered without full emergency surgery being performed on that site. The RCSE believes that the optimum configuration is that all emergency and acute services are provided together. The visitors do however recognise that this may not be
possible given financial and political constraints, i.e. there may not be capital money available to redevelop a single site, and the prospects of closing A&E and acute medical services on any site may be politically unacceptable. In these circumstances a compromise solution may be required. We accept that this is not the ideal but may be the best that can be achieved. However the RCSE cannot endorse a solution that does not meet the Standards we have set.
Option 1 – The Status Quo

All three sites continuing to provide all emergency and elective surgical services.

Option 2 – One Super Site

One Super Site, geographical venue not determined.

Option 3 – The Compromise Solution

Two Acute Sites, 3 elective sites - the compromise solution.

Table 1. This table gives the Visitor’s opinion of the relative positive and negative influences of the above options and service models on surgical training, education and service delivery related to general surgery in BCUHB.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Option 1 Status Quo</th>
<th>Option 2 Super Site</th>
<th>Option 3 2 Acute Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training:</td>
<td>negative</td>
<td>positive</td>
<td>positive</td>
</tr>
<tr>
<td>Undergraduate</td>
<td>negative</td>
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<tr>
<td>Postgraduate</td>
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<tr>
<td>Consultant job plan change</td>
<td>positive</td>
<td>negative</td>
<td>negative</td>
</tr>
<tr>
<td>Staff recruitment</td>
<td>negative</td>
<td>positive</td>
<td>positive</td>
</tr>
<tr>
<td>EWTD compliance</td>
<td>negative</td>
<td>positive</td>
<td>positive</td>
</tr>
</tbody>
</table>

| Service delivery:             | negative            | positive            | positive               |
| Acute                         | negative            | positive            | positive               |
| Elective                      | negative            | positive            | positive               |
| Service development           | negative            | positive            | positive               |
| RCS Standard compliance       | negative            | positive            | positive               |
| Supports vascular spec.       | negative            | positive            | positive               |
| Recurrent expenditure         | negative            | positive            | positive               |
| Capital expenditure           | positive            | negative            | positive               |
| Political considerations      | positive            | negative            | negative               |
| Patient Access                | positive            | negative            | negative               |

The above table is an attempt to summarise some of the issues and consideration, but weightings have not been applied nor any conclusion drawn.
Option 1 – The Status Quo

The status quo, has the advantages of not meeting political and public opposition, nor indeed opposition from some within the profession including the local BMA. This option would meet the optimum standard of providing all acute services co-located. However we perceive it as having a wide range of professional, training, recruitment and service disadvantages. While this might in many ways be the easiest option for the management of BCUHB to support, it will serve the Health Board and the population poorly in the medium term.

Option 2 – One Super Site

A single major acute and complex services unit has many obvious advantages clinically and professionally, and also in terms of the long-term welfare of local secondary care services in North Wales. This option would meet the optimum standard of providing all acute services co-located. The major negative aspect is the capital requirements and the time scale involved which makes this option implausible in the current economic circumstances for the health budget in Wales. It also has a negative aspect in terms of patient access and transporting patients between units

Option 3 – 2 Acute Sites

This option appears to share a similar profile of attributes to Option 2. It shares the same problems of access, but perhaps less so. This compromise solution of two acute sites and a separate elective site may be politically less sensitive then a single site and has a wide range of advantages in terms of service development, training and clinical standards. The Consultants who responded to our survey formed the greatest degree of consensus around this option, although a significant proportion favoured a single site.

With regard to the geographical location of a two-site solution there are valid arguments for locating services in different ways on each of the current sites. We will not comment further on these unless and until a decision on these options has been made.

We believe that making progress around a decision on one of these options is the essential first step to further deliberation on the matter.
Comments on PAB survey of Consultant General Surgeon’s Opinion

There was a good response rate to the survey with 18 out of 23 consultants responding within 2 weeks.
The vast majority of the consultants were aware of the process that BCUHB had established to engage with the clinical opinion but less than half felt that their opinion had been taken into account properly.
65% of the consultants felt that BCUHB had not made the case for change satisfactorily but the same proportion felt that such change was necessary and were aware of the options that had been presented.
70% felt that Consultants should be free of elective commitments to attend to the emergency service in line with RCSE guidance.
80% of the respondents felt that, given circumstances free of political and financial constraints, the optimum configuration of services was not the current 3 site model with 47% recommending a 2 site model and 33% recommending a single site model. A variety of opinions were expressed regarding services that should be co-located with emergency general surgery and service that might be located on a site performing elective colorectal and upper GI surgery.
The question asked about networking of services has produced a variety of responses with no clear patterns other than a predominance of support for the networking of upper GI and Vascular surgery.
83% of respondents believed that the commitment made to continue providing full A&E services on all 3 sites is a constraint on the options to reconfigure services. Opinion is divided about the use of Llandudno Hospital as a centre for Breast services and day case surgery.
A variety of other comments on options were made in the free text questions. We believe the most important outcome of the survey is that the great majority of the consultant body understand and support the need for change but that the case for this change has not been made to them successfully by management. There is clearly scope for further debate and engagement about the details of the changes that are required.
Opinion

The PAB visitors believe that it is not in the long term interest of the BCUHB, the patients and population it serves, and the staff who work for it, for the status quo to be maintained. It would seem from our survey that the majority of substantive consultant general surgeons who responded agree with this opinion.

Drivers for Change

In addition to the drivers for change outlined above, there are longer term changes in the nature of General Surgery. Vascular Surgery is about to become a separate specialty from General Surgery, as did Urology in the past and as Breast Surgery will in the future. Emergency General Surgery in the future will be provided by Upper GI and Colorectal surgeons. The current generation of trainee surgeons are training with these expectations.

There is ongoing discussion within the profession about developing Emergency Surgery as a specialty that might be attractive to surgeons in the earlier parts of their career as they develop their specialist interests and skills. Such a model will only be feasible in large units.

In addition to these factors the pool of experienced generalist surgeons from overseas that we have relied on in the past is not going to be a part of our future workforce. We are aware that the Deanery is planning to reduce the number of Core Trainees in Surgical Specialties and may also seek to reduce the numbers of Higher Trainees. While the PAB does not endorse these changes they may go ahead irrespective. There is now compelling evidence for improved outcomes in units with a higher volume of case load and with teams of surgeons working collaboratively. This applies particularly to vascular surgery but there is increasing evidence of this effect in almost all areas within general surgery.

Colorectal Surgery

The future of elective colorectal services across North Wales is inextricably linked to the reconfiguration of emergency general surgical services since most general surgical emergencies are colorectal in nature. Clearly it is not desirable to provide a general surgical rota based solely on colorectal surgeons (unless there is massive expansion in numbers) and inevitably any future rota will require the upper GI surgeons to continue providing emergency general surgical cover. Breast surgeons of the future will not undertake emergency surgery and vascular surgeons will be on a networked service outside of general surgery.

There is unanimous agreement between surgeons across North Wales that elective major colorectal surgery should be on the same site as emergency surgery because of the presence of critical care and the desire to avoid looking after major cases on multiple sites. This represents the safest practice and is supported by the PAB. It follows that radiological services including imaging with CT and MRI with facility for intervention, such as drainage of abdominal abscesses and mesenteric angiography, should also be on site. Furthermore, although endoscopy services can be
undertaken in an isolated unit there is a requirement for onsite endoscopic stenting of colonic tumours.

Excluding financial considerations, the main driver for reconfiguration should be to improve the quality of services to patients both of elective care and emergency care. Co-location of elective and emergency colorectal services should enable this to be achieved. Intuitively, quality is achieved by ensuring a consultant delivered service as early as possible in the patient’s illness and this is the backbone of the Emergency Standards document.

Can this be achieved by maintaining the status quo? In principle, a consultant delivered service is possible with the current configuration but the impact of consultants working longer and more unsocial hours is unlikely to be palatable to the organisation, not least because there would be an inevitable increase in waiting times for elective surgery. Two issues which are as yet unresolved and would impact on a decision to maintain the status quo are:

a) there is a planned reduction in the number of trainees but this could be contested
b) the UK government is considering changes to its interpretation of EWTD which would enable surgical trainees to work longer hours legally.

It is for the organisation to decide whether or not these two issues should be resolved before engaging in wholesale reconfiguration of the North Wales provision of emergency general surgical services.

The ideal model would in fact be a single central unit admitting general surgical emergencies from the East and West, but given that orthopaedic trauma and vascular surgery would also be admitted to this single central unit, this would require a major expansion of Ysbyty Glan Clwyd which in the current climate seems unlikely. Although, this option appears on the face of it to be financially non-viable, it is ultimately for the organisation to prove the case against this. If money were no object, then this option could possibly gain most support from the profession, but may not from politicians and patients.

If a single site is not feasible and reconfiguration is seen as inevitable, then there is only one realistic option. This option would be to have two centres admitting general surgical emergencies simply because of the large numbers of both elective and emergency cases which present on a daily basis. This option would obviously be supported by two centres leaving the third centre as a centre for elective activity, diagnostics, out patient services but would require a different model of A&E and emergency medicine.

**Vascular Surgery**

The Provision of Vascular Services document produced by the Vascular Society of Great Britain and Ireland 2009 (Appendix 6) makes it clear that the preferred model is a unit staffed by one vascular surgeon and one interventional radiologist per 150,000 population with 24/7 consultant cover for in patients and emergencies. Consultants should ideally work a 1 in 6 on call with no more arduous a rota than 1 in 4. The population of North Wales could be covered by a 5 consultant unit on one site. This would not be detrimental to patient safety as emergencies are already transferred the
length of the North Wales corridor. Two or three of the consultants presently providing vascular surgical services are approaching retirement. Recruitment to small units is likely to be difficult.

It is Welsh Government policy that abdominal aortic aneurysm screening should begin by the end of 2012. There will be a single screening unit for North Wales which will require a single Multi Disciplinary Team. As endovascular repair of aneurysms develops open surgery will become less common and more complex. It is widely accepted that unit outcome data is linked to numbers and the Vascular Society recommends that units performing less than 20 open aneurysm repairs per year should cease. With respect to transient ischaemic attacks best management requires that patients needing carotid endarterectomy undergo surgery within 48 hours of presentation. Theatre and surgeon availability on a daily basis is more reliably provided in a big unit with daily vascular surgical operating sessions. Centralisation of complex surgical cases on a single site will be the best option for outcomes and training. The principle of elective vascular networks to complement the emergency networks and aneurysm screening is favoured by the Welsh Chief Executives and the Aneurysm Screening Project Team have been asked to facilitate the development of elective networks.

With the imminent separation of Vascular Surgery from General Surgery the VSGBI has produced a document setting out the standards required for vascular training. There will be one registrar to three accredited trainers which is a reduction in the present arrangement of 1:2. Trainee Vascular Surgeons will be expected to be on-call from home rather than shift working in order to maximize their exposure to vascular emergencies. In order to provide an appropriate workload for vascular trainees in north Wales one would expect one site, 5 -6 consultants and 2 vascular surgical trainees.

Governance Issues

Good governance dictates that we work in groups and teams in order that standards are maintained. Experience from the RCSE Invited Review Mechanism reports is that governance can deteriorate when surgeons work in isolation and small groups. Performance issues in small groups can result in these issues becoming, and being perceived as, inter-personal disputes which become impossible to resolve.

Recruitment Issues

It is clearly the case that the direction of the workforce development is that we are moving towards a consultant delivered service (Appendix 4). This can only be provided within a satisfactory work/life framework that the generation of surgeons currently in training will demand. The current generation of trainees will not be attracted to a unit that does not provide the pattern of service delivery for which they have been trained. These factors add to the arguments for a reduction in the number of sites that Emergency General Surgery is performed.
Size of Emergency Delivery Units

The scale of the Emergency General Surgery services on each of the current BCUHB sites is relatively small. On average each unit admits 7-12 patients and operates on 2-3 patients in 24 hours. This level of activity does not justify the medical and nursing staff involved to be fully dedicated to the emergency service. As a consequence, even when there is a will to do so, as in the Central Unit, staff are inevitably diverted to other duties when not required for emergency work, or alternatively are inadequately employed, which is bad for training as well as being wasteful. The total number of medical staff providing this service is large in comparison to a centralized urban unit. In order to allow a consultant led and delivered service, with timely access to dedicated assessment facilities, diagnostic facilities and theatres, with full dedicated nursing and medical team support, the scale of the emergency service need to be larger than is currently the case in any of the three units in BCUHB.

Practical Aspects of Developing Models of Care

As stated above the RCSE believes that the optimum configuration of emergency services is to have them all co-located. However we accept that this is not always possible for financial and/or political reasons, and in this circumstance then the standards laid out in the Emergency Surgery Standards document can assist managers and clinicians to design safe services.

The model of care that is developed in BCUHB is the responsibility of the organization. What is concluded needs to meet the standards set out, but can be innovative.

The model of A&E service in the East Unit has much to commend it and we suggest that investment in A&E medicine could be key to developing sustainable emergency services. If there is to be a unit providing A&E and/or emergency medicine services without emergency general surgery on site, consultant delivered A&E medicine supported by experienced surgeons at middle grade might be considered.

Similarly there would need to be investment in the access to diagnostics on all sites to facilitate ambulant care protocols for emergency surgical patients and support in patient care. As stated in the Standards document consultation with Ambulance Services would be required to establish bypass and transfer protocols in order to provide safe services.

It has been argued that North Wales has unique geographical and travel problems but this is not the case. There are very similar travelling times in Scotland, West Wales, Cumbria and in many rural communities. Indeed travelling times in urban conurbations can be as challenging as they are in North Wales. Good transport links will be essential to any major change in service configuration.. Conversion of the A55 to motorway status would enhance the ability of BCUHB to innovate in its plans for service delivery.
We understand that BCUHB management plan to visit other units that have undergone similar reconfiguration of services to learn from their experiences. These visits should involve clinicians from across the Board. It is vital that the Consultant body are engaged with and involved in these important decisions. To this end managers must continue to value their input and listen to their opinions.
Conclusion

It is commendable for clinicians to be proud of and protective of the services that have developed over years of endeavour but these perspectives must not prevent us from taking opportunities to develop sustainable services for the future.

Reconfiguration of services is not a problem unique to North Wales. Similar change has already been undertaken, and will occur, in other Health Boards in Wales. Change of service configuration is also taking place in England where it is to be determined by the vagaries of market forces whereas in Wales we have the option of planning change.

However if we do not take advantage of this option there are significant risks. There may be a crisis that needs to be managed, for instance in staffing levels. Where this has happened elsewhere it has proved a risky and unpredictable process, but crises are powerful vehicles to bring about change.

Alternatively if there is planning inertia the status quo might persist. In that scenario it is likely that there will be a long-term decline, with an inability to recruit high quality staff resulting in services and patients drifting to units elsewhere.

No external body has the ability or wisdom to enforce change on the organization. It is the professional personnel, clinical and managerial, that hold the responsibility and authority to design services.

We believe that the profession should take a strategic view of, and responsibility for, these crucial service developments, and whether it does this successfully will be its legacy. Our survey suggests that the General Surgeons in BCUHB understand that there is a need for development. The challenge for them now is to lead these changes.

The RCSE Professional Affairs Board in Wales are willing to help in any way we can with the development of service delivery models that are aimed at high quality services that meet the standards described. Practical help we may be able to provide include discussions with politicians, Welsh Assembly Government officials and bodies such as Community Health Councils and the BMA, to express and reinforce the surgical professional view with regard to Emergency Surgery Standards. We would also be happy to further meet and discuss with Consultant and management colleagues.

Colin Ferguson
RCSE Director of Professional Affairs in Wales

Wyn Lewis
Regional Specialty Professional Adviser for General Surgery

Alan Woodward
Regional Specialty Professional Adviser for General Surgery

Sue Hill
Vascular Society of Great Britain and Ireland Adviser for Wales
List of Appendices

Appendix 1- BCUHB Project Board Membership

Appendix 2 – BCUHB Project documents

Appendix 3 – Mr Jonathan Pye’s Paper

Appendix 4 – Temple Report

Appendix 5–RCSE Emergency Standards Report

Appendix 6 – VSGBI Establishing Vascular Services 2009

Appendix 7 – Provision of Emergency Vascular Services 2007


Appendix 9 – NHS Abdominal Aneurysm Screening Programme: Quality Standards and Service Objectives

Appendix 10 – VSGBI Quality Improvement for Major Amputation Surgery

Appendix 11 – Letter from Mr Jon Osborne, Secretary BMA

Appendix 12 – Letter from Mr Andrew Maw

Appendix 13 – Result of Survey of Consultant General Surgeons

Appendix 14 - CG50 Document
Appendix 1

The membership of the Project Board consists of:

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
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<tbody>
<tr>
<td>Chair of Project Board / Executive Lead</td>
<td>Andrew Jones</td>
</tr>
<tr>
<td>Project Lead / Assistant Director of Planning – Strategy &amp; Engagement</td>
<td>Sally Baxter</td>
</tr>
<tr>
<td>Planning Lead / Head of Planning</td>
<td>Robin Wiggs</td>
</tr>
<tr>
<td>Chief of Staff – Surgical and Dental CPG</td>
<td>Tony Shambrook</td>
</tr>
<tr>
<td>Associate Chief of Staff (Ops) – Surgical &amp; Dental CPG</td>
<td>Craig Barton</td>
</tr>
<tr>
<td>Associate Chief of Staff (Nursing) – Surgical &amp; Dental CPG</td>
<td>Meinir Williams</td>
</tr>
<tr>
<td>Clinical Director/General Surgeon - East</td>
<td>Lloyd Jenkinson</td>
</tr>
<tr>
<td>Clinical Director/General Surgeon – West</td>
<td>Chris Lloyd</td>
</tr>
<tr>
<td>Clinical Director – Central</td>
<td>Andy Maw</td>
</tr>
<tr>
<td>Chief of Staff – Anaesthesia, Pain and Critical Care</td>
<td>Dave Counsell / Graham Alexander</td>
</tr>
<tr>
<td>Chief of Staff - Radiology</td>
<td>Bob Byrne</td>
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<tr>
<td>Public Health Wales</td>
<td>Jo Charles</td>
</tr>
<tr>
<td>Information Analyst</td>
<td>Lynne Edwardson</td>
</tr>
<tr>
<td>Senior Finance lead</td>
<td>Adrian Butlin</td>
</tr>
<tr>
<td>Improvement and Business Support</td>
<td>Jill Newman</td>
</tr>
<tr>
<td>WAST Representative</td>
<td>(nomination from Dafydd Jones-Morris)</td>
</tr>
<tr>
<td>ED Representative</td>
<td>Aruni Sen</td>
</tr>
<tr>
<td>GP Representative</td>
<td>Tbc</td>
</tr>
<tr>
<td>Staff-Side Representative</td>
<td>Shirley Hockings</td>
</tr>
<tr>
<td>Communications Lead</td>
<td>Barbara Lloyd / Trystan Pritchard</td>
</tr>
<tr>
<td>Vascular Surgeon</td>
<td>Dean Williams</td>
</tr>
<tr>
<td>Breast Surgeon</td>
<td>Walid Samra</td>
</tr>
<tr>
<td>Clinical Lead - Assistant Medical Director</td>
<td>Brian Tehan (or nominated representative)</td>
</tr>
<tr>
<td>Third Sector representative</td>
<td>Tbc</td>
</tr>
<tr>
<td>Local Authority representation</td>
<td>Via NWASH</td>
</tr>
<tr>
<td>Royal College of Surgeons</td>
<td>Colin Ferguson</td>
</tr>
<tr>
<td>Screening Services</td>
<td>Dr Rosemary Fox</td>
</tr>
<tr>
<td>Healthcare Professional Forum – observer with speaking rights</td>
<td>Dr Andy Fowell</td>
</tr>
<tr>
<td>BMA/LNC Representative - observer with speaking rights</td>
<td>Jon Osborne</td>
</tr>
<tr>
<td>Community Health Council Representative - observer with speaking rights</td>
<td>Chris Jones</td>
</tr>
</tbody>
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Appendix 2

*Emergency General Surgical Services Rev

Appendix 3
Emergency General Surgery in North Wales
Reconfiguration of Services
Jonathan Pye
Time for Training

A Review of the impact of the European Working Time Directive on the quality of training

Professor Sir John Temple

May 2010
Emergency Surgery

Standards for unscheduled surgical care

Guidance for providers, commissioners and service planners

February 2011
The Provision of Services for Patients with Vascular Disease 2009

“The Vascular Society of Great Britain & Ireland

‘Patients with a vascular emergency should have rapid access to a specialist vascular team in all parts of the UK.’”
Appendix 7

THE PROVISION OF EMERGENCY VASCULAR SERVICES 2007
Appendix 8
This document defines quality standards and service objectives for Abdominal Aortic Aneurysm (AAA) screening programmes in the NHS.
Quality Improvement Framework for Major Amputation Surgery

Aim: To reduce the perioperative mortality rate after major amputation surgery to less than 5% by 2015

Amputation for vascular disease and diabetes should only be undertaken after formal investigation of the arterial system by angiography (DSA, CTA or MRA) or specialist ultrasound imaging, except when the leg is clearly beyond salvage.

Major amputation is indicated when:

1. Revascularisation is not a realistic option
2. Amputation is expected to save or prolong life and/or improve quality of life

The framework

Preoperative

- All patients should be assessed and managed by a multidisciplinary vascular specialist team (that regularly undertakes limb amputation)
- Pain should be controlled, and the pain team involved as needed
- The agreed decision with the patient to amputate should be timed and recorded in the notes
- A named individual should be allocated preoperatively to each patient for support, and to coordinate care, rehabilitation and discharge planning
- All patients should have formal clinical assessment (risk assessment) including review by, or in consultation with, a consultant anaesthetist
- Controllable risk factors should be optimised
- Antithrombotic prophylaxis should be prescribed from admission unless contraindicated, and continued at least until discharge from hospital
- Discharge planning and rehabilitation should be considered at this stage, and reviewed by the rehabilitation team

Perioperative

- Operation should ideally be undertaken on a planned operating list during normal working hours (target 75% of all major amputations)
- Patients not booked on a planned list should have their amputation done within 48h of decision to operate, and no patient should have their operation deferred more than once, unless there are new medical contraindications

www.vascularsociety.org.uk
Appendix 11 – Letter from Jon Osborne, Secretary BMA

Dear Colin

Thank you for asking the BMA to contribute to your report on the surgical services review in North Wales. The BMA have every confidence that the Royal College of Surgeons will present an independent report and would not claim to have expertise in the elements that comprise a safe general surgical unit. We would, however, like to emphasise to the authors of the report that any proposals to downgrade general surgical emergency services at any one of the three sites would have considerable implications for other specialities and for the long term stability of that hospital.

Having heard the sensible recommendations from vascular surgeons we would accept that having one vascular surgery service for the whole of North Wales is the most practical way forward. We would also accept that there are clear advantages in concentrating some elective surgical services on a particular site in order to concentrate infrastructure, personnel and expertise to provide better results for patients.

However, for out of hours surgical emergencies presenting to any one of the three main hospital sites we think it will be essential to have a minimum of CCT accredited surgeon able to cope with emergencies and operate at each site. It has been pointed out that with current and future levels of training that individuals may not be able to cope with the general surgical emergencies that present. We would suggest that the buddy system may be helpful. In this situation a surgeon who unexpectedly finds himself in a situation at laparotomy where he/she may require further expert assistance is able to call on the services of a colleague with special expertise who will travel to the emergency. In our view these situations would be relatively rare and would be preferable to transferring large numbers of patients.

The alternatives to maintaining an out of hours emergency operative surgical service on each site would be transfer of those patients requiring immediate treatment. We would estimate that the total transfer time from decision to arrival in theatre at the recovering hospital would be often 2 – 3 hours rather than the hour quoted due to the inevitable delays arranging transport, accompanying medical staff, reassessment at the receiving hospital and then arranging theatre time there. If out of hours emergency surgery did not occur on a particular site then there would be a deleterious effect on other specialities and recruitment would be difficult to that hospital. Physicians, obstetricians, gastroenterologists and orthopaedic surgeons would also not have as much confidence in the ability of a SASC doctor to manage a situation conservatively and there would be a tendency to transfer everything from that site just in case. The ambulance service may not be able to cope.

We understand the difficulties providing adequate numbers of junior staff on each site, the deanery restrictions and the effect of the European Working Time Directive.
It is obvious that the current situation is not sustainable in the long term without changes. We would suggest that consultant expansion, expeditious use of nurse practitioners, rationalisation of elective surgery and innovative ways of working are the way forward rather than leaving a major hospital with accident and emergency department painted on the front door without the vital core service of emergency surgery.

We believe that when adjacent hospitals are 30 – 40 miles apart and the hospitals serve areas of deprivation with poor access to private and public transport, that the prime determinant of a safe service will be timely access to definitive intervention.

Thank you very much for taking our views into account in your report. We look forward to receiving it.

Jonathan Osborne

Consultant Otolaryngologist - ENT Department

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board
Dear Colin

Many thanks for coming to North Wales and for meeting with us. I hope that the Royal College of Surgeons will present an independent report that will assist in the provision of a safe and acceptable general surgical elective and emergency service to the people of North Wales.

It is also necessary that any such service should be designed to follow the best practice guidelines for such a service along the principles laid down in the recent publication on this matter from the RCS. The current arrangements for emergency general surgical services differ widely across North Wales and in some cases are, currently, a long way from these professional recommendations.

The geography and infrastructure in North Wales is such that any proposals to downgrade general surgical emergency services at any one of the three sites would have considerable implications for other specialities and for the long term stability of that hospital and the well being of the population. It is also likely to affect the local economies very significantly as the NHS is a major employer. Any changes will significantly affect other areas of the local economy in a detrimental way. The general population are unlikely to accept this.

The area is not well served by public transport links and there are many deprived areas of poverty, particularly in the central area, where the health of the population is poor. There is also a very large elderly population many of whom live alone and a lack off community based beds for these patients. Being a tourist area, the central and western areas also have to deal with a large influx of population during the holiday months. When an enquiry was made about this in the past the catchment population in the central area increased from circa 200,000 to 360,000 in the summer months.

Recent announcements are that there are to be an additional 2000 properties built in Denbighshire, all in Bodelwyddan which will increase the catchment for the local population significantly.

It is apparent that with changes in training, the creation of a CCST in vascular surgery, and the inevitability of a consultant only delivered vascular surgical service in the future, that having one vascular surgery service for the whole of North Wales is the only practical long term way forward. With the rebuilding of Glan Clwyd, the immediate rebuilding of theatres and expansion of ITU at YGC there exists a fantastic opportunity now for this service to be centralised with state of the art operating facilities. Centralising such a service at YGC would mean that most of the patients in North Wales would have access in a reasonable time. This change should be instituted now and not delayed. It may also help to affect any other changes necessary.

I would also accept that there are clear advantages in concentrating some elective surgical services on a particular site in order to concentrate infrastructure, personnel and expertise to provide better results for patients. Ideally this should be centrally located to minimise the effects on most of the population for travelling etc. If there were 2 sites, one at either end of North Wales this would not provide this as there
would still be the need to have specialist units in only one of these two sites. This would mean very long travelling distances for many, many patients and their families in North Wales. Whilst I believe this may be acceptable for certain very specialist services with small numbers of patients, e.g. max fax, emergency vascular, this would not be the case for services with large numbers of patients e.g. elective and emergency general surgery and general medicine. YGC has the largest number of medical emergency admissions annually of any of the North Wales Hospitals (~ 33,000). How would surgical cover be provided for this?

For out of hour’s surgical emergencies presenting to any one of the three main hospitals it is essential to have a minimum of CCT accredited surgeon (i.e. a consultant) able to cope with emergencies and operate at each site. This also requires a surgical team to support the consultant. It is not possible as a consultant GS to be on call at more than one site in North Wales or to travel between sites in the times necessary for this to occur.

It has been pointed out that with current and future levels of training that individuals may not be able to cope with the general surgical emergencies that present. I would suggest that the buddying system may be helpful. In this situation a surgeon who unexpectedly finds himself in a situation at laparotomy where he/she may require further expert assistance is able to call on the services of a colleague with special expertise who will travel to the emergency. This situation would be preferable to transferring large numbers of patients.

The alternatives to maintaining an out of hour’s emergency operative surgical service on each site would be transfer of those patients requiring immediate treatment. The total transfer time from decision to arrival in theatre at the recovering hospital would often be 2 – 3 hours rather than the hour quoted due to the inevitable delays arranging transport, accompanying medical staff, reassessment at the receiving hospital and then arranging theatre time there. A lack of critical care beds at the on call hospital is likely to be a problem as it is now. What happens to these patients?

If out of hours emergency GS surgery did not occur on a particular site then there would be a deleterious effect on other specialities and recruitment would be difficult to that hospital. Physicians, obstetricians, gastroenterologists and orthopaedic surgeons would also not have as much confidence in the ability of a SASC doctor to manage a situation conservatively and there would be a tendency to transfer everything from that site just in case. The ambulance service may not be able to cope.

Internal audits have clearly shown that 50% of the emergency surgical workload does not come from emergency GS admissions but from patients already in hospital. These comprise referrals from other specialities such as acute medicine and paediatrics and patients from the elective surgical service who become ill. There are also emergency referrals from the North Wales Cancer centre.

*Any move of emergency GS services to fewer sites would have to be accompanied by the move of all complex elective GS cases as well.* Whilst day case surgery up to a certain complexity could probably be performed safely without CCST on call cover, more complex work such as major lower and upper GI resections could not. These cases frequently have complex complications and many of these patients are not fit or
appropriate for transfer in such circumstances. To have a complex elective service somewhere and to transfer cases with complications somewhere else would not be acceptable.

Any relocation of the emergency GS service would therefore have to be accompanied by a relocation of large amounts of the GS elective service for those consultants who would stay on the on call GS rota. This would have to be accompanied by the adequate provision of appropriate theatres resources, endoscopy facilities and critical care capacity. None of this has currently been planned or costed.

In my opinion to deliver the elective RTT, cancer targets and emergency GS service there needs to be a redesign of the vascular surgical and breast surgical service, a conversion of some of those consultant salaries to GS consultants who do on call and an expansion of the consultant GS workforce. This will allow a mainly consultant delivered GS service. Some consultant GS expansion is also inevitable as it is not acceptable for other GS consultants in colorectal and upper GI surgery to have their subspecialty work denigrated for the emergency GS service whilst other specialties such as breast are allowed to become pure specialist whilst they currently hold a GS CCST. The extra number of consultants needed to do this is relatively few and is likely to be much cheaper than moving all the services and reproviding the necessary facilities. This also needs to be properly costed.

To date none of the suggested proposals have been properly examined in the detail necessary or costed out. The fundamental reason for the Trust wanting to change things appears to be financial despite what else may be said. If it is not this then it must be philosophical dogma, politics, personal opinion and vested interest rather than based on fact and evidence of best practise in surgery.

If man power and junior staff is limited then by far the cheapest option in terms of salaries, and the one likely to deliver the most comprehensive emergency and specialist services in a sustainable model is a single site for all emergency surgical services and complex elective surgery with 2 lateral sites doing limited GS on call and elective day case surgery only. In such a model a central site somewhere would be the best option.

Thank you very much for taking my views into account in your report. We look forward to receiving it.

Andrew Maw
Appendix 13
Results of Survey of Substantive General Surgery Consultants

"Survey Summary.xls"  Q7_Text.xls  Q8_Text.xls  Q14_Text.xls
Acutely ill patients in hospital

Recognition of and response to acute illness in adults in hospital

NICE clinical guideline 50
Developed by the Centre for Clinical Practice at NICE