

The Royal College of Surgeons (RCS) and Independent Sector Treatment Centres

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Introduction

The Independent Sector Treatment Centres (ISTC)* programme is the Prime Minister's initiative to help to meet his political goals for waiting lists and is specifically funded by £2 billion. It is a political imperative that RCS Council recognise and wish to influence to the benefit of patients by working with the Department of Health (DoH) in its implementation. The DoH has now announced the first 22 preferred bidders for centres around the country.

The RCS welcomes any development which expands the resources and skills available for NHS surgical patients and leads to a reduction of their waiting times for treatment. Many members of the surgical professions are however opposed to this mechanism and would prefer direct investment in traditional NHS facilities.

Over the past several months, the College has been working closely with the National Implementation Team (NIT) and has raised the following concerns, many of which have been agreed as requirements for the successful sustainable implementation of the scheme:

1. Competence and regulation of the surgeon

Surgeons must:

- Be registered with the General Medical Council and appropriately qualified for the planned clinical activity
- Have their names on the GMC Specialist Register as required by the National Care Standards Commission with which all provider units must be registered. This activity will be subsumed by the Commission for Health Audit and Inspection (CHAI) in April 2004. This requires application to The Joint Committee for Higher Surgical Training (JCHST) who are working on the resource requirements for processing such applications for submission to the Specialist Training Authority (STA) and the General Medical Council (GMC).
- Have completed training and practised in their intended field of UK practice for a time at least equivalent to that required of UK trainees prior to the award of their Certificate of Completion of Specialist Training (CCST).
- Provide peer reviewed evidence that they have carried out competently a minimum of 50 of the operative procedures concerned prior to starting work in the UK (yet to be agreed).
- Be in continuing surgical practice or provide evidence of recent retraining if returning from a career break of more than twelve months.
- Be members of a team of peers capable of providing mutual advice and support and also undergo a period of clinical and organisational induction within the environment in which they will be practising.

Standards of Practice

All Surgeons must:

- Adhere to the standards and code of practice as set out in *Good Medical Practice*, GMC May 2001, and *Good Surgical Practice*, RCS September 2002.
- Include all their work in formal audit at the local level and submit data to the appropriate national audit programmes such as the National Joint Registry, the National Cataract Surgery Survey (Royal College of Ophthalmologists) and the National Tonsillectomy Audit (Royal College of Surgeons of England).

- Share with local surgeons of the same specialty details of the techniques and materials used so as to inform those surgeons who may have to manage complications or undertake continuing care in the short or long term.
- Liaise with local surgeons to facilitate any emergency care and also for audit, multidisciplinary meetings and education of the surgical team.

There are genuine concerns about “itinerant surgeons” who may contribute to the service for only short periods of time and who will be in post for insufficient time to establish the necessary professional relationships and personal reputation with “sponsors” and their patients.

2. Arrangements for dealing with complications or co-morbidity

It has been suggested that all adverse consequences directly attributable to an operation carried out in an ISTC will be corrected by that TC if they occur within 5 years of discharge. A recharging mechanism will be put in place for any complication treated in a local NHS Trust. This extra workload across the hospital and primary care services can be calculated and agreed financially.

RCS is concerned about the implications of extra pressure on both medical and nursing staff in for example ITU and Coronary Care Facilities, the medical wards or surgical outpatient clinics. This will need to be factored into discussions for staff expansion locally and brought to the attention of Workforce Development Confederations (WDCs). The National Implementation Team of the DoH (NIT) anticipates any likely extra requirement to be low. This could only be achieved by very careful case selection for the more major procedures i.e. ‘cherry picking’. Such case selection should be acknowledged by the “sponsors” and made obvious in any subsequent comparisons with NHS Acute Trust activity.

3. Governance Arrangements

RCS and NIT are agreed that clinical governance and audit arrangements should mirror those of the NHS and be based on *Good Surgical Practice*, including appropriate appraisal. Currently independent healthcare providers are required to comply with the requirements of the National Care Standards Commission (NCSC) which will be succeeded by the Commission of Healthcare Audit and Inspection (CHAI) and judged against uniform, clear and comprehensive standards.

Meaningful governance may be difficult to achieve for some individuals as it is anticipated that many will have short term contracts to work in the UK. This problem has not yet been resolved. For those staying longer, it should be possible for them to comply with the arrangements that apply to all other surgeons caring for NHS patients. It is recommended that all visiting surgeons should be involved in local surgical audit meetings.

RCS encourages local surgeons to welcome and incorporate overseas surgeons into local professional, audit and educational events. All will be in need of stimulation and continuing professional development themselves and some are likely to bring experience and new techniques from which much can be learned as well as providing fresh and stimulating company as individuals.

4. Surgical training

The RCS is extremely concerned about the impact on training, if, as is inevitable, the fitter, less co-morbid patients requiring less technically demanding operations are ultimately to be removed from existing NHS facilities. This may deprive surgical trainees of valuable exposure to some of the more common procedures, which traditionally provide the majority of hands-on technical exposure and opportunity for training.

Current discussions suggest that many preferred bidders/providers are aware that training is a very important issue for the RCS. In order to ensure early progress with this it has been suggested that three pilot sites might be identified for training, two in orthopaedics and one for ophthalmology. Some providers are themselves keen to enter discussions on the provision of training for UK trainees. Such discussions will involve both the College and the relevant Surgical Specialty Associations through the Specialty Advisory Committees (SACs) that oversee surgical training. College approval would also be required for any overseas trainers and arrangements made with surgical training programme directors and with the “sponsors” for the creation of “training lists” with a reduced number of patients per list.

As an alternative, it has been suggested that recognised trainers in local NHS hospitals might be seconded to ISTCs for one or two lists per week. It is likely that these arrangements for training will not form part of the primary contract for service but they should be registered early for future detailed negotiation and agreement as a form of secondary contract.

5. Impact on income flow

This is a matter for local Trusts to arrange with PCTs and SHAs. There appears to have been little discussion about this impact on forward capital and service development at Trust level from year 2 onwards. The PCTs clearly are not able to commit themselves for the full 5 year period as their financial plans are based on a 3 year planning cycle.

RCS is concerned that such independent service developments will compete for limited PCT funds and will impede the development of NHS Trust surgical services locally.

6. Concurrent healthcare developments in a locality

RCS takes the view that although the introduction of ISTCs has the potential to enhance the availability of surgical services for patients, other developments in healthcare provision must also be taken into strategic consideration. It is particularly important to integrate the implications of the European Working Time Directive for both consultant staff (enacted October 1998) and for trainees (with effect from August 2004) and to consider the concurrent proposals for Foundation Hospitals, NHS DTCs, *Keeping the NHS local; a new direction of travel*, the *Changing Workforce Programme* and other political initiatives.

7. Balance of surgical practice

Currently there is a mix of patients with relatively straightforward and more complex conditions admitted to the wards and listed for surgical procedures. This is necessary to maximise the use of operating time by the introduction of less time consuming and more predictable (anaesthetic and surgical) procedures in the construction of lists and also to lighten and spread the load on the ward teams as well as to utilise the available beds in as efficient a manner as possible.

Removal of patients with less complicated conditions and predictable lengths of stay would create more pressure on service delivery as well as having a deleterious effect on training in the existing local NHS acute hospital.

The existing NHS acute hospitals are not staffed or financially resourced to cope with such changes in the intensity of practice at the present time

8. Risk adjusted financial arrangements

Currently RCS is engaged with the NIT in discussions to ensure that contracts are not based on average cost per procedure and that the Health Resource Groups (HRGs) used are risk adjusted to truly reflect the age, co-morbidity and other factors that may lead to prolonged length of stay and intensity of care. This is essential to ensure that the current local NHS

providers are accorded appropriate recognition of their contribution and that any subsequent comparative analyses of throughput and cost-effectiveness are accurately adjusted to take account of surgical risk, underlying medical co-morbidity and length of stay.

It would appear that this is not the case and that the costs to the GP and PCT will be based on average costs per case. In addition there will be an additional payment to the providers from targeted funds held centrally to cover the costs of providing the facilities [capital costs spread over 5 years] and the extra costs of employing staff from overseas. This is known as “dual funding” which may will extend for the duration of the 5 year contract. What happens at the end of this period is a matter of speculation!

9. Depletion of NHS staff

One of the early principles of the ISTC developments was that of ‘additionality’. Although it has been stated that no doctors or nurses who have worked for the NHS within the previous 6 months will be permitted to work in an ISTC, it would appear that this principle is being relaxed for certain schemes with “structured agreements” with NHS employers for secondment of staff. It is at present uncertain whether this rule will extend to physiotherapists, radiographers and operating department practitioners (ODPs). It would appear that other hospital staff such as healthcare assistants (HCAs), porters, cleaners and ancillary staff will not be included in the “additionality” restrictions.

RCS is very concerned that staff should not be poached, as any key staff shortage can adversely affect the quality of care that is received by surgical patients in the local NHS hospital and lead to inefficient use of capacity, which may in many cases only recently have been expanded

This should be a matter for intense discussion with intended providers. Any secondment arrangements for NHS staff to ISTCs must be monitored. This might for example take the form of consultants using time not contractually committed to the NHS (either part time or maximum part time), nursing staff, radiographers etc, who again might be seconded for sessions in an ISTC. How this affects the principle of ‘additionality’ has yet to be determined. Such secondment of staff must be acceptable, not only to the employing NHS Trust but to surgical, nursing and other colleagues employed in that Trust as there is a major risk of causing disharmony. Any deleterious effects must be identified and pointed out to the PCTs and SHAs.

10. Patients’ rights

RCS is concerned to ensure that patients are given full and accurate information and free choice about the options available to them for their care including details of the clinical outcomes of surgeons and others who will be carrying out potentially life threatening procedures and caring for them in hospitals which may have limited onsite staff and facilities to cope particularly with complications or crises. Responsibility for patients exercising this freedom of choice will rest with the referring general practitioner (GP), but patients must not be coerced in to agreeing to go to a new and possibly untried hospital for treatment.

RCS is concerned that PCTs or individual GPs may be pressurised to direct patients to an ISTC in order to fulfil a predetermined service level agreement (SLA), contracted and therefore paid for.

RCS wishes to emphasize that all surgeons have a duty of care to any patient following an operation wherever and whenever it has been carried out and should neither obstruct nor make unwelcome any patient unfortunate enough to have suffered an adverse consequence or complication following care in an ISTC. Equally, surgeons should not obstruct the transfer of patients from their waiting lists to care in an ISTC if this is the patient’s wish and when it is likely to result in more timely quality and safe care.

RCS points out these concerns in order to assist the negotiations leading to contract that will be taking place between PCTs, SHAs and Independent Providers over the next few months. This is in order to try to ensure that NHS patients are not only offered their surgery with less delay but to the highest quality in order to achieve the optimum long term result and by surgeons whom patients can trust to have been screened and trained to the standards that they expect.

RCS recognises that it has no direct influence on the employment of surgeons by independent sector providers but is keen to be involved in discussions between “sponsors” and providers in an endeavour to ensure the highest standards of patient care.

Charles Collins 7 October 2003