



SOCIETY OF BRITISH NEUROLOGICAL SURGEONS

**Report
on
SAFE NEUROSURGERY 2004" CONFERENCE**

Friday 11th June 2004

**Held in the
MOYNIHAN ROOM
at**

**The Royal College of Surgeons
35-43 Lincoln's Inn Fields
London
WC2A 3PE**

PROGRAMME

10.00 - 10.25 am	Registration and Refreshments
10.25 - 10.30 am	Opening Remarks Mr David Hardy, President SBNS
10.30 - 11.00 am	Managed Clinical Networks For Neurosurgical Services Professor Garth Cruickshank, Consultant Neurosurgeon <i>Queen Elizabeth Neuroscience Centre, Birmingham</i>
11.00 - 11.30 am	National Service Framework – Implications for Service Delivery Mr David Hardy, President SBNS
11.30 - 12 noon	Consultant Workforce Requirements For Neurosurgery Mr James Palmer, Consultant Neurosurgeon, <i>Derriford Hospital, Plymouth</i>
12 noon - 12.45 pm	LUNCH
12.45 - 1.15 pm	The Role of the National Clinical Assessment Authority (NCAA) Dr Umesh Prabhu, Consultant Paediatrician, Bury
1.15 - 1.45 pm	Future Training in Neurosurgery and Inter-relationship with Service Delivery Mr James Steers, Vice-President, SBNS
1.45 – 2.30 pm	Review and Discussion

INTRODUCTION

The President Mr David Hardy welcomed the delegates and explained that the purpose of this annual conference was to highlight the key issues relating to Neurosurgical Services to those involved in its organisation and management. Currently, reconfiguration of services, workforce numbers and new proposals for training of Neurosurgeons in line with modernising medical careers were important issues, which would significantly influence the delivery of Neurosurgical, care over the next few years.

MANAGED CLINICAL NETWORKS FOR NEUROSURGICAL SERVICES

Professor Garth Cruickshank – Clinical Director West Midlands Neurosurgical Network

(also see Appendix 1 for slides)

http://www.sbns.org.uk/members/minutes/Appendix_1_Managed_Clinical_Networks_1.ppt

Collaboration between provider Trusts in supplying a neurosurgical service implies that there will be better choice, a more comprehensive range of services and best use of resources and manpower. This should lead to a higher quality, responsive and more robust service, both now and into the future. Commissioners have been encouraged through collaborative specialised service commissioning arrangements, to seek a clearer picture of what they are funding and how this may be achieved more cost effectively, especially where the same service is purchased from several Trusts. Recent reviews of service organisation as well as looming threats from manpower issues, acute versus elective competition, and capacity mis-planning have created an agenda of difficult management issues controllable only by a network of neurosurgical units working together. This talk aims to identify the major issues in developing managed clinical networks, and illustrate approaches to these issues from the West Midlands experience.

A network must have a defining point of reference particularly because it has to span a wide range of professional experience. A common focus of understanding is crucial. In the West Midlands we have chosen the production of quality indicators of service and clinical outcome as markers of a quality patient service. What is best for the patient? This forms the strategic agenda that guides the network executive.

The network management executive has been jointly funded from the Neurosurgery Trusts and the West Midlands Commissioners. It is accountable to the West Midlands Strategic Commissioning Group and was established in 2003. It is chaired by one of three CEO, s, and run by a Clinical Lead, and a Network Manager. A formal Network Board meets monthly with managerial clinical, and nursing representatives, with a representative from the regional commissioners for neurosurgery and is chaired by members of the network executive. Although the Network does not formally commission neurosurgery, a monthly meeting is held with the PCT,s with the Network Manager and Clinical Lead to discuss contracted performance and assist in the strategic planning of the service. Within the Network Board each unit is able to express their concerns, and the mix of professionals ensures that all viewpoints are heard. Specific work plans that form the operational agenda have been formulated and each member singly or in cross unit groups report back to the meeting on progress. A research officer and an IT manager support the Network.

To be able to drive the system forward we have spent much time in obtaining full support from the three Trust CEO,s to underwrite the activities of the Network management board. The clinical lead works closely with the network manager who together regularly visits network personnel, PCT and allied DGH's to 'network'. Close attention is put into understanding the implications of new issues, such as 'Payment by Results and the effect of tariffs on commissioning, and unit infrastructure funding.

Underpinning all issues is the need for accurate information concerning activity: diagnosis code, procedure code, delays in admission, discharge, and surgery, together with information on acute referral disposal, waiting times for admission and for MRI, etc. In particular clinical outcomes related to individual FCE's is essential data

to support discussions with PCT's. This data can be brought together on one platform for the three units and used to support business plans for resourcing. It can be used to show areas of poor performance and aid solution definition where PCT, management and Clinician can support clear proposals. Shared data and difficulties have enabled us to redistribute regional activity, with local benefits and improved control of waiting list targets. Appreciation of variable free capacity is also being exploited. The benefits of clinicians able to explain apparent patient flow anomalies to PCT,s has enabled more progressive planning of funding, and enabled manpower issues to be addressed. Networking at the person to person level has realised many benefits. For example senior nurses have realised common difficulties and have been able to share solutions particularly in the areas of staff retention and recruitment as well as in protocols for the care and management of violent patients.

A formal Service Standards review of all Units according to the SBNS document is underway across the network and will report directly to the commissioners. This will help drive up standards and ensure commissioners are placing resources against a clear plan.

Future issues concerning provision of neurosurgical services are under discussion eg management of spinal malignancy and neurovascular surgery. With the precept that we must do what is best for the patient, a clear clinical pathway can be described. In most cases referral to a specialist (multidisciplinary team) is mandatory. Such teams define protocols, organise service and carryout the specialist activity *when and where it is needed by the patient*. Where the patient is at risk from transfer this will be local, where the service is better resourced then transfer across the network may be necessary. The key issue is ready access, to a recognised specialist in part defined by membership of an MDT, to specialist imaging and to the 'choice' of appropriate treatment modality.

Managed networks must work for the stakeholders in their common goal of providing best treatment and choice for patients. The challenge is to deliver this vision by ensuring that all agreements achieve a balance of responsibility, and benefit for each stakeholder.

THE NATIONAL SERVICE FRAMEWORK – IMPLICATIONS FOR SERVICE DELIVERY

Mr David Hardy – President, SBNS Consultant Neurosurgeon Addenbrookes Hospital Cambridge.
(see also Appendix 2 for slides)

http://www.sbns.org.uk/members/minutes/Appendix_2_The_National_Service_Framework.ppt

The NSF for long-term conditions will focus almost entirely on Neurological conditions. The documents containing the recommendations of the External Reference Group recently submitted to the Secretary of State contains 12 generic 'Standards' regarding the provision of healthcare to this group of patients and covers acute care, rehabilitation and long term provision. The document is predominantly user orientated and base on an extensive scoping exercise to determine the needs of patients and carers. The next step will be the evaluation and costing of recommendations, assessing workforce and other implications and the preparation of an implementation strategy and 'tool kit' to deliver the agreed standards.

If implemented the benefit to Neurosurgical services will be profound and will include enhancement of acute services with appropriate capacity and workforce to accept prompt transfer of patients, adequate Neuro critical care facilities, telemedicine links with referring hospitals and increased capacity and better trained workforce in local hospitals to enable earlier and more efficient repatriation.

The delivery of the NSF will conform to the wider agenda of the Department of Health incorporating 'Patient Choice', 'Keeping Services Local', a 'Health service of all the Talents', 'Modernising Medical Carers' and the 'New Vision for Health and Social Care'. At the same time, monitoring of quality will be organised via the Health Care Commission and guided by the National Patient Safety Agency (NPSA).

The provision of services will be integrated to produce efficiency of care crossing traditional boundaries with new arrangements for commissioning when appropriate and probably supervised by a Partnership Board. The formation of Managed Clinical Networks is seen as central to the implementation of the NSF with multi-disciplinary teams being involved and more efficient liaison between the Neuroscience Centre and local District General Hospital services. There will be agreed protocols for referral and transfer back within such a network.

The community based services will contain Neurological teams facilitating access and re-access when needed supported by nurse led clinics and rehabilitation facilities.

District General Hospitals will be supported by Neurologically trained accident emergency and resuscitation staff as well as specialist outreach and follow up clinics with rapid access to deal with the urgent Neurological referrals.

The specialist Neuroscience Centres will be based on a viable catchments population with sufficient capacity, workforce and resources including Neuro Critical Care and capable of providing a comprehensive range of sub-specialty expertise within the local network.

Low volume conditions will be dealt with in supra regional or other services underpinned by efficient integration into the local Neuroscience networks. There will be robust audit and governance standards and resources for research, training and education. In addition, there will be information systems in place to enable patient and carer involvement and choice with key workers identified as points of contact. The main objective is to develop a service with a single care plan encompassing all requirements modifiable as necessary and extending for the whole course of the condition.

CONSULTANT WORKFORCE REQUIREMENT FOR NEUROSURGERY

Mr James Palmer Consultant Neurosurgeon Derriford Hospital Plymouth

(see also appendices, 3,4,5,6 for a colour copy of the handout provided to delegates slides and appendix 7 for the sides)

http://www.sbns.org.uk/members/minutes/Appendix_3_How_Many_Neurosurgeons.pdf

http://www.sbns.org.uk/members/minutes/Appendix_4_Performance_vs_safe_neurosurgery_2000.pdf

http://www.sbns.org.uk/members/minutes/Appendix_5_How_many_consultants_plymouth.pdf

http://www.sbns.org.uk/members/minutes/Appendix_6_Performance_vs_demand_model.pdf

http://www.sbns.org.uk/members/minutes/Appendix_7_How_many_neurosurgeons.ppt

The New Consultant Contract has defined hours of work and volume of service delivery more accurately. Consultant time can therefore be used as a tool for planning the workforce required to deliver a given work load in relation to outpatient clinics, operations and inpatient care. The approach taken by Mr Palmer has been to develop a system which can be applied by individual Neurosurgical Units to calculate the number of Consultants required to deliver the workload according to local circumstance. The number will vary depending on the Programme Activities contracted by each individual Consultant in the Unit.

Discussion

Managed Clinical Networks

The impact of Foundation Hospital Status within a network cannot be predicted at present. One of the main drivers which has encouraged Commissioners to consider a Managed Clinical Network is the adverse impact on elective work when safe protocols are set up to deliver emergency services with a result in increase in waiting time for routine appointments and operations.

The impending changes which necessitate the formation of Clinical Networks with no other realistic option. Networks when managed properly will produce a more logical and time based service commitment and better professional satisfaction including the ability to facilitate sub-specialty development.

Nation Service Framework

There is no clearly identified funding to deliver the NSF. However, patient groups are extremely powerful politically and will probably influence the recommendations of the NSF to be delivered. Nevertheless there is still a risk that the recommendations may be watered down but this is less likely to affect the acute end of treatment.

Consultant Workforce

- The EWTD has been legally binding on Trusts for the Consultant Workforce since 1998 but has not been effectively implemented.
- Consultant will need to be prepared to face the challenges of a two tier on call cover in certain locations and circumstances.
- The implementation of sub-specialty on call rotas has not become an issue as yet but if this were to occur the workforce required would be greater and the methodology recommended by Mr Palmer can be used to estimate the workforce.

ROLE OF NATIONAL CLINICAL ASSESSMENT AUTHORITY (NCAA)

Dr Umesh Prabhu Consultant Paediatrician ant Bury General Hospital

(see appendix 8)

http://www.sbns.org.uk/members/minutes/Appendix_8_NCAA.ppt

Opinion polls seeking public confidence in Doctors and Nurses delivering a good service have confirmed overwhelming trust in these categories of the Health Care Workforce. Nevertheless, mistakes can still occur despite dedicated service and are due to system failures or genuine human error. Approximately 10% of hospital inpatient episodes are associated with adverse clinical events and litigation regarding health care has increased. The GMC deals with approximately 4,000 complaints regarding professional practice annually.

Similarly, referrals to the NCAA have also increased invariably reflecting system failure despite dedicated workforce.

The NCAA plays a dual role in supporting the NHS Trusts to protect patients and also to support doctors who work within the NHS. The causes of individual failures relate either to clinical capability, poor health or behaviour problems. The majority of colleagues referred are in psychiatry or General Surgery and between the ages of 40-55 years. Issues relating to clinical capability are identified in approximately 27% of referrals.

The NCAA does not accept referrals from members of the public. On the other hand, Chief Executives, Medical Directors, Human Resource Directors and Clinical Directors as well as any Doctor can make the NCAA aware of concerns regarding a colleague who is not coping well in the working environment.

The NCAA has a good understanding with the GMS but no direct authority to influence its decisions. The majority of Trusts are satisfied with the performance of the NCAA. It is important to recognise that all colleagues who encounter problems within the work environment are not re-trainable.

FUTURE TRAINING IN NEUROSURGERY AND INTERRELATIONSHIP WITH SERVICE DELIVERY

Mr James Steers, Vice-President SBNS – Consultant Neurosurgeon Western General Hospital Edinburgh

(see also Appendix 9 for slides)

http://www.sbns.org.uk/members/minutes/Appendix_9_Future_Training.ppt

The training of surgeons is being affected by a number of factors including the New Deal, (56 hours per week) The programme for Modernising Medical Carers (MMC) capping training time to 8 years and the changes in clinical practice e.g. Interventional methodology superseding surgical treatment.

Similarly, the implementation of the EWTD, The New Consultant Contract, Issues of Clinical Governance and the increased time demands required for training have caused significant changes to the working pattern of a Consultant trainer.

Previously a Medical Practitioner would spend an average of 12 years after graduation before acquiring Consultant status. In the ~USA and Canada specialist training is achieved in 6 years and recently the working hours have been reduced to 80 per week in these countries. In Denmark trainees work only 37.5 hours per week but in Germany and France the compliance regarding EWTD is largely ignored in view of service as well as training demands for increased time. In the UK up to now service has been dependant on Doctors in training for both elective and out of hours work. In fact, service needs have taken precedence over service requirements. Training has been based on an apprenticeship system and assessment processes have been deficient in objectivity.

In future training will need to take precedence over service needs and the work of a trainee will be more focussed thus maximising the use of the limited number of hours available within the week. The set piece type clinical exposures will include training operating lists and clinical as well as well supervised on call commitments for emergency experience. A greater amount of Consultant Trainer time will be required in the future to underpin the proper delivery of the above training principles.

The new scheme proposed by the SBNS recognises a Foundation Programme of 2 years during which the emphasis will be on the development of generic skills. During the second Foundation year it may be possible to include a limited exposure to the Neuroscience specialties. The framework of basic surgical training will be the 'common stem' concept, which will enable trainees to understand the normal and abnormal functioning of the nervous system. There will be 3 years of basic Neuroscience training (BNT) of which the first will be a probationary or 'taster' year the purpose of which will be to provide an opportunity for the trainee and the trainer to recognise a future career path. A process of selection leading on to the second and third years of basic surgical training towards the end of which there will be an examination similar to the MRCS will follow this. This examination will test knowledge in the principles of general surgery, basic Neuroscience and of the specific sub-specialty, which the trainee intends to pursue. There will then be three years of higher surgical training underpinned by a robust competency based assessment process and the FRCS (SN) culminating in the acquisition of a Certificate of Completion of Training (CCT). To achieve the current level of Neurosurgical expertise at CCST level will probably require a further two years of post CCT training.

Consultants will need to spend more time with training. Time will need to be allocated for this purpose and built into the individual Consultant Contract. Some Consultants or even some Units may decide to opt out of the responsibilities of training and the implications of such decisions remain uncertain.

Discussion

- There was concern that the number of training posts will be less than the number of trainees. This will result in many trainees moving into the service stream and modules of experience within such posts should be recognised.
- Need to avoid creating yet another 'lost tribe' was emphasised. Ideally, all posts should have training recognition and potential.
- Separation of training and service may drive Trusts to pay less remuneration for training posts.
- It was accepted that once the new system is implemented it would be extremely difficult to reverse or to change to another system.
- A two tier on call system may become necessary. There will be implications of this to elective work. The establishment of an emergency operating theatre during normal working hours will reduce night work.

Consultants would also need to maintain skills and knowledge within an effective CPD.CME system. After CCT I a Surgeon will be expected to deliver a core emergency service working within a Team. As new competencies are required increasing independent responsibility can be undertaken.

There were 53 delegates of which 30 were Consultant Neurosurgeons (24 were either Council Members or ULO's or both), 14 Managers, 7 Commissioners and 2 from the nursing profession.

**Nihal Gurusinghe
Honorary Secretary SBNS**