

Provision of general paediatric surgery in district general hospitals

Children constitute approximately 25% of the population in the UK and yet the NHS has not been able to give adequate priority to the process of planning for the needs of this large part of the population, particularly with regard to surgery. Children's surgery involves all nine surgical specialties and encompasses the full range of complex and more routine procedures.

On the one hand, there is the justifiable expectation that routine surgical services for children should be provided locally; on the other there is the need to make sure that surgeons' competence and practice are closely aligned (British Association of Paediatric Surgeons, 2002) and that occasional practice is avoided (Children's Surgical Forum, 2007), particularly for elective surgery.

In recent years there has been a progressive shift of activity (Cochrane and Tanner, 2007) of the more straightforward surgical procedures from the district general hospital to tertiary centres. As a paediatric surgeon, the author has seen numerous cases of children and their families having to travel a long way to undergo surgical procedures such as appendicectomy or hernia repair in a tertiary centre. Sometimes delays in finding an available bed in a specialist hospital have resulted in complications that required further surgical intervention.

It is an undeniable fact that tertiary centres are currently overloaded with less complex surgical procedures. This can result in dilution of training for specialist paediatric surgeons as the number of complex cases they undertake is reduced. It also has an adverse impact on the resources and support available to those patients who require tertiary care.

Training considerations

The shift of routine cases away from the district general hospital setting has the potential to destabilize the infrastructure of the local hospital both in terms of service and training. A generation of general

surgeons and urologists is emerging with little, if any, exposure to children's surgery. Poor succession planning means that as the current cohort of general surgeons and adult urologists who have traditionally provided this service retire, it will become increasingly difficult to provide management of general surgical conditions of childhood locally. Paediatricians are concerned that they will be unable to access an appropriate general surgical opinion in the local hospital.

The intercollegiate surgical curriculum does provide the educational infrastructure for general surgeons to become involved in the general surgery of childhood. All trainee general surgeons will have some exposure to emergency childhood conditions. In addition, there is an optional module in elective general surgery of childhood. However, as an optional module, this has not proved a popular choice for trainees, largely because there is no defined and attractive career pathway for general surgeons and urologists with an interest in treating children. In a competitive job market, trainees will clearly wish to sub-specialize in areas for which there is perceived demand. NHS providers and commissioners must give this matter priority. Advertising consultant posts in general surgery or urology with an interest in the general surgery of childhood is one method of ensuring general surgeons elect to undertake sub-specialist training in this area.

Alternative methods of delivering general surgical services for children locally do exist, whereby specialist paediatric surgeons become increasingly involved in delivering outreach operating lists and clinics. However, this will require significant expansion in the specialist paediatric surgical workforce and this is beyond current workforce planning.

Managed clinical networks

The Children's Surgical Forum has aimed to address this issue by publishing guidance and advice for commissioners and

service planners on establishing managed clinical networks (Children's Surgical Forum, 2010). They have concluded that in the current climate, the only sustainable method of ensuring the continuation of the service locally is the development of managed clinical networks. These networks will ensure the continued provision of routine surgical services for children that are close to home, safe and sustainable, while at the same time concentrating the rarer and more complex procedures in specialist centres to avoid occasional practice and ensure best outcomes.

The Children's Surgical Forum feels that managed clinical networks are the crucial component in reshaping children's surgical services in a way that will enable hospitals to share resources, services and expertise. An interconnected system of service providers will allow collaborative working, the development of common standards of care, flexible movement for clinical staff, and robust patient transfer arrangements. Expertise and resources will be drawn from the entire network, not just from tertiary centres, and children will be treated at the most appropriate hospital depending on the complexity of the case and the resources available. The network will also include the provision for appropriate continuing professional development and mentoring.

There are already very good examples of networking in several parts of the country with encouraging results, such as the Yorkshire Regional Children's Surgery and Anaesthesia Network, and the fledgling South West Paediatric Surgery Network. The author is confident that more will follow. These managed clinical networks are needed in order to overcome bureaucratic measures such as the need for repeated Criminal Record Bureau checks and honorary contract negotiations that stand in the way of the effective use of the workforce and available resources.

The Royal College of Surgeons, in collaboration with the Department of Health, has just completed a survey to complement

the guidance for commissioners by identifying the extent of general surgery of childhood practice in the regions and to explore training opportunities for general surgeons and urologists who may be interested in this rewarding area of work. The findings of this survey will be published shortly on the website of The Royal College of Surgeons of England (www.rcseng.ac.uk).

Conclusions

Undoubtedly, there is a wealth of policy available but also lack of implementation. We hope that the guidance for commissioners to establish managed clinical networks will be used as a tool to enable the development of high-quality surgical services for children. These must be safe, accessible and sustainable, and should provide the best possible experience and outcomes for patients and their families. **BJHM**

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British Association of Paediatric Surgeons (2002) *Paediatric Surgery, Standards of Care*. British Association of Paediatric Surgeons, London

Children's Surgical Forum (2007) *Delivering a First Class Service*. The Royal College of Surgeons of England, London

Children's Surgical Forum (2010) *Ensuring the Provision of General Paediatric Surgery in the District General Hospital: Guidance to Commissioners and Service Planners*. The Royal College of Surgeons of England, London

Cochrane H, Tanner S (2007) *Trends in Children's surgery 1994-2005: Evidence from Hospital Episode Statistics Data*. Department of Health, London

KEY POINTS

- There is a continuous decline in the number of general paediatric cases performed in the district general hospital.
- In a lot of units service sustainability is under question because of lack of succession planning for adult general surgeons and urologists currently providing this service.
- The Children's Surgical Forum recommends the development of managed clinical networks of care as the most effective way to provide general paediatric surgery services that are safe, high quality and accessible to patients and their families.