



## ENSURING THE PROVISION OF GENERAL PAEDIATRIC SURGERY IN THE DISTRICT GENERAL HOSPITAL

Guidance to commissioners and service planners



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## Introduction

This document provides guidance for commissioners and service planners within the NHS to ensure the continued availability of high-quality general paediatric surgery (GPS) that is easily accessible to patients. There are currently problems with the provision of this service in some parts of the UK. In many units service sustainability is also under question because of lack of succession planning for general surgeons and adult urologists currently providing this service. The guidance highlights the commitment made by The Royal College of Surgeons of England and other organisations, and provides recommendations on how those responsible for commissioning and planning children's surgical services can contribute to improving patient care by working with clinical partners to create innovative solutions.

### 1. What is GPS?

- 1.1 GPS describes non-specialised children's surgery that can be performed by specialist paediatric surgeons or by surgeons who primarily operate on adults but have expertise in paediatric surgery.
- 1.2 Most surgical procedures performed on children are elective, relatively straightforward and performed in the district general hospital (DGH). While a full list of procedures that can be included under this terminology is available through the national specialised services definitions set,<sup>1</sup> GPS commonly includes:

#### Elective

- Inguinal herniotomy
- Umbilical herniotomy
- Orchidopexy for undescended testicle
- Circumcision
- Minor soft-tissue abnormalities

#### Emergency

- Acute abdominal pain including appendicitis
- Obstructed hernias
- Acute scrotal pathology
- Minor trauma
- Abscesses

- 1.3 While the above procedures are classified as GPS, if the patient is very young, has existing comorbidities, or the receiving unit does not have medical/clinical staff with the appropriate skills to manage the patient, he or she must be treated by a unit with the appropriate competencies and skills for the particular child as agreed within the local managed network. Within this network the services of surgery, anaesthesia, paediatrics and children's nurses are interdependent.

### 2. Local provision of GPS services

- 2.1 Children account for nearly 25% of the population in the UK. They require access to routine surgical and anaesthetic care at a location that is easily accessible to them and their family and that meets the appropriate standards.<sup>2,3</sup>
- 2.2 It is vital that acute trusts have arrangements with on-site anaesthetists for resuscitation and stabilisation of seriously ill children prior to their transfer.<sup>4</sup>
- 2.3 The presence of on-site paediatricians and other children's services underpins the provision of elective GPS within the DGH.<sup>5</sup>

### 3. The most effective way to provide GPS services in the DGH: managed clinical networks of care

#### 3.1 What is a managed clinical network (MCN)?

3.1.1 We define an MCN as an interconnected system of service providers, which allows collaborative working and the development of standards of care, routes of communication and agreed thresholds for patient transfer for elective and emergency surgery.

3.1.2 The network is supported by contractual agreements that specify service requirements and outcomes and is appropriately resourced on an administrative and financial basis.

3.1.3 The network defines where services will be provided.

3.1.4 There is a multidirectional flow of services within the network.

#### 3.2 Basic principles of MCNs

3.2.1 The MCN supports a whole-team approach in planning for the care of a sick child and in paediatric emergencies. If unexpected circumstances require that staff act beyond their practised competencies, the network provides support for clinicians in making the care of the patient their first concern.<sup>6</sup>

#### Basic principles of an MCN

- Child-focused
- Elective surgery stands on its own as a good-quality service and does not underpin the emergency service
- Age thresholds at each unit will vary depending on competency of staff and resources
- Personal development plans ensure training needs are identified and met
- Competency is assessed locally
  - Training and Continuing Professional Development
  - Workload and Experience
  - Outcomes
  - Annual Appraisal

#### 3.3 Advantages of MCNs

3.3.1 MCNs of care are vital in underpinning the delivery of safe services locally and enabling units to share resources, services and expertise with other hospitals and tertiary centres in the area.

#### 3.4 Designing and implementing an MCN

3.4.1 Planners and commissioners have a key role in facilitating the creation and sustainability of MCNs, which may need to be organised across traditional boundaries. Their leadership is essential in ensuring appropriate movement of clinicians as dictated by the organisational arrangements of the network in order to meet the needs of the child. Currently this movement

## Advantages of MCNs

### Common standards

- Safe and high-quality level of care

### Integrated service

- Pathways of care

### Service planning

- Resource allocation
- Predicting trends in patient flow
- Avoidance of inappropriate competition
- Matching capacity to demand

### Workforce planning

- Maintaining high-quality services
- Provision of care near the patient's home

### Education

- Maintaining competency
- Training to support workforce planning

### Audit

- Measuring agreed outcomes

is inhibited by the need for hospitals and trusts to seek duplication of Criminal Records Bureau checks and lengthy contractual arrangements.

- 3.4.2 The Academy of Medical Royal Colleges supports the development of an *NHS Education Passport*<sup>7</sup> that will allow clinicians (including trainees) with a substantive contract to travel between hospitals or trusts to facilitate training and continuing professional development (CPD) without unnecessary bureaucracy. This is particularly important in the context of surgery for children, when local clinicians seek to maintain skills and competencies by attending clinical sessions in neighbouring trusts.
- 3.4.3 Occasional practice is undesirable. The network will support the individual to maintain skills and competencies for safe practice. It is the employer's responsibility to ensure the clinician is able to revalidate, including the provision of appropriate resources to support CPD.
- 3.4.4 The development of managed clinical networks provides the opportunity for inter-network audit and benchmarking to meet appropriate standards.<sup>2</sup>
- 3.4.5 When a network is designing its service the following factors are important in determining where a child is safely managed:
- age
  - co-morbidity
  - complexity of the surgery
  - urgency for treatment
  - available local competencies, facilities and supporting services

- 3.4.6 Clear and timely information and communication with families is an integral part of the network design.
- 3.4.7 MCNs must have an effective patient transfer system. Within the patient pathway care may be delivered on more than one site, with the overriding principle that it is provided by competent staff as close to the patient's home as possible.
- 3.4.8 Collaborative processes between clinicians and commissioners are essential, especially when there is competition between providers to meet the child's best interests.<sup>8</sup>
- 3.4.9 The Royal College of Surgeons of England's regional professional affairs network can provide advice and support to regional commissioners on the development of managed clinical networks (<http://www.rcseng.ac.uk/regional/professional-affairs-network-1>).

#### **4. Based on the considerable evidence from successful MCNs the Children's Surgical Forum outlines the required steps to ensure the continued effectiveness of these networks.**

##### 4.1 Network leadership

- 4.1.1 There must be a recognised network clinical lead with authority and accountability – this post must be appropriately resourced.

##### 4.2 Training

- 4.2.1 The general surgical syllabus requires all general surgeons to receive training in the management of common childhood surgical emergencies during their DGH attachments. An optional module is also included for those who wish to perform common elective surgical procedures on children.
- 4.2.2 Urologists emerging from training at Certificate of Completion of Service (CCT) level are expected to be able to manage appropriately the common elective and emergency urological conditions of childhood. They are also expected to be aware of the important surgical conditions of childhood, their presentation as elective and emergency cases and the indications for urgent management by specialist colleagues. Specialist advisory committees are currently discussing the future configuration of training.
- 4.2.3 Development of general surgeons and urologists with expertise in paediatric surgery can be provided during specialist training or post-CCT proleptic appointment.
- 4.2.4 The training programme director should ensure availability of training in general paediatric surgery. By developing a network, paediatric surgical training capacity is identified.<sup>9</sup>
- 4.2.5 The network should advise on the workforce requirements, including succession planning.
- 4.2.6 Surgeons with previous training in GPS can be mentored by agreement with their local tertiary centre to bring them up to an appropriate standard to provide a continuing service in the circumstance of the retirement of a colleague who previously provided GPS services.

## Competencies<sup>10</sup>

### Generic training requirements (all clinicians)

- Resuscitation
- Child protection / safeguarding
- Communication skills

### Specialty-specific requirements acquired via:

- Mentorship (visiting/operating together)
- Relevant CPD as identified at appraisal

4.2.7 Networks must ensure that all clinical staff managing children have appropriate acute paediatric life support training as well as statutory training in child safeguarding and protection<sup>11</sup> and the management of pain.<sup>2</sup>

## 4.3 Career support

4.3.1 The Colleges, specialty associations, specialist advisory committees (SACs) and hospitals must work to promote GPS as a relevant, secure and interesting career for trainees.

4.3.2 This could include:

- Advertising consultant appointments for general surgeons, urologists and anaesthetists to provide GPS at the DGH.
- Having regional advisors consider the need for GPS expertise via the advisory appointment committee process.
- Arranging post-CCT proleptic appointments (with funding for training) to ensure GPS services can continue safely.
- Providing opportunities for DGH surgeons and anaesthetists to access appropriate CPD and mentorship in order to maintain the skills required to support the paediatric component of their practice.

## 5. Consequences of failing to address this issue

- 5.1 If preventative steps are not taken now, there will be a substantial deficiency of general surgeons and urologists capable of providing a safe local GPS service in the near future. This would go against the NHS stated policy to deliver care as close to the patient's home as possible.<sup>12</sup>
- 5.2 Failure to address this issue will mean that, in some regions, GPS work will need to be undertaken by specialist paediatric surgeons and paediatric urologists conducting outreach care as part of a network. In order to manage this on a large scale, there will need to be a significant and immediate expansion of specialist paediatric surgeons and paediatric urologists.

## 6. Example care pathways

- 6.1 Example care pathways have been adapted from the Scottish model for delivery of GPS services to facilitate service planning. These are available online at:  
[http://www.rcseng.ac.uk/service\\_delivery/children2019s-surgical-forum](http://www.rcseng.ac.uk/service_delivery/children2019s-surgical-forum).

- 6.2 These pathways are not overly prescriptive and are provided to aid discussion between commissioners, providers, service planners and patients. Each locality will have a different solution and this must be understood and agreed by all stakeholders.
- 6.3 In all care pathways there will be sites with emergency departments receiving children that will not have overnight paediatric inpatient services and no paediatrician on site. Involving paediatricians out of hours would be potentially by telephone or video link, provided this is an agreed service specification within the managed network.

## 7. Further information

The Children's Surgical Forum provides information to support the planning and commissioning of children's services. This information can be found on the forum's web site:

[http://www.rcseng.ac.uk/service\\_delivery/children2019s-surgical-forum](http://www.rcseng.ac.uk/service_delivery/children2019s-surgical-forum)

Any specific queries can be directed to the forum secretariat:

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The Welsh Assembly Government provides guidance on children and young persons' management through the Children and Young People's Strategy Division (CYSPD): <http://wales.gov.uk>

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1. National Specialised Commissioning Group. *Specialised Services National Definitions Set*, 3rd edn. *Specialised Services for Children – Definition No. 23*. London: NSCG; 2010.
2. Children's Surgical Forum. *Surgery for Children: Delivering a First Class Service*. London: RCS; 2007.
3. Department for Education and Skills, Department of Health. *National Service Framework for Children, Young People and Maternity Services. Core Standards. Change for Children – Every Child Matters*. London: DH; October 2004.
4. Royal College of Anaesthetists. Guidance on the provision of paediatric anaesthetic services'. Chapter 8. in *Guidelines for the Provision of Anaesthetic Services*. London: RCA; April 2010.
5. Department of Health. *Commissioning Safe and Sustainable Specialised Paediatric Services: A Framework of Critical Inter-Dependencies*. London: DH; September 2008.
6. Department of Health. *The acutely or critically sick or injured child in the district general hospital: A team response*. London: DH; Devenber 2005 [Tanner report].
7. The term *NHS Education Passport* refers to clinicians who wish to work short term across NHS trusts to ensure efficient and timely delivery of service to patients and optimal training and CPD opportunities for clinicians. It should not be confused with the *NHS Staff Passport*, which is meant to provide guidance on employment standards for non-clinical staff who face permanent transfer.
8. British Association of Paediatric Surgery. *Survey of Regional Networks for the Provision of General Paediatric Surgery in the UK*. London: BAPS; 2008.
9. The RCS is currently undertaking a survey of training capacity and networking opportunities, to be published in September 2010.
10. Competency frameworks for paediatricians are available online at:  
<http://www.rcpch.ac.uk/Training/Competency-Frameworks>
11. Appropriate levels of safeguarding training are described in the intercollegiate guidance, *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff*, (a revised version of this document is due to be published in 2010).
12. Department of Health. *The NHS operating framework for England 2010/11*. London: DH; December 2009.

