The Surgical Forum of Great Britain and Ireland
Administrative Office: The Surgical Forum Secretariat
Royal College of Physicians and Surgeons of Glasgow, 232-242 St Vincent Street, Glasgow G2 5RJ
Phone: 0141 227 3224 | Email: carolyn.capps@rcpsg.ac.uk

The Surgical Forum of Great Britain and Ireland

The future of District General Hospitals

Foreword

The *Surgical Forum* of Great Britain and Ireland, formerly known as the Senate of Surgery, is comprised of the Presidents and Vice Presidents of the four Royal Colleges and the Presidents of the 10 SAC-defined and GMC-recognised surgical specialties. The Surgical Forum is therefore a truly representative voice of surgery across the entirety of Great Britain and Ireland.

In recognition of the importance of the District General Hospital model for the provision of care in the United Kingdom and Ireland, and an increasing recognition that this model of care is coming under threat, the *Surgical Forum* agreed that it would be appropriate to hold a one-day meeting devoted exclusively to this topic. This meeting was held at the Royal College of Physicians and Surgeons of Glasgow on Monday 13th October 2014. An attendance list is attached as Appendix 1. In addition to the Presidents of the Royal Colleges and Speciality Associations, Presidents of BOTA and ASIT were represented as were the Chairmen of the ICBSE, JCIE and JCST.

A copy of the programme is attached as Appendix 2.

Following upon the presentations from the invited speakers, all attendees were given the opportunity to speak such that the view of each of the representative organisations was heard.

This document aims to provide a consensus view on the future of the District General Hospital. It is based upon the opinions expressed throughout the meeting. Preliminary drafts were distributed to all participants as well as to other interested parties in surgery. This document is therefore a representation of the opinion of the surgical profession throughout the UK and Ireland.

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Summary

There was agreement that:

1. That quality of patient care must not be compromised under any circumstances.

2. That the District 'General' Hospital will survive in some form or other for the foreseeable future and is likely to take part in a network of general hospitals, providing emergency and elective care.

3. That the United Kingdom and Ireland *currently* have too many hospitals attempting to provide both emergency and a wide range of elective care. There needs to be a reappraisal of the function of many of these hospitals to help achieve optimum patient care. The Forum was of the view that the NHS does not have too many beds, but that their function can often be redefined.

4. The surgical profession recognises the need to take a lead in reconfiguration such that it advises politicians and commissioning groups as to what they feel is optimal reconfiguration on the basis of providing best quality care for patients.

5. The Forum was unanimous in deploring what it termed 'vested interest groups' in attempting to keep unsafe or non-viable local services open where this is counter to achieving good clinical care.

6. Every hospital that existed in 1948 cannot provide everything in 2014. The solutions include reconfiguration, scope of practice, skill mix, integration of health and social care, better use of IT and modern technology, and blurring of primary and secondary care interfaces.

7. It is imperative that the growing problems with emergency care are addressed. This is where the greatest variations in outcome already exist and this needs to be addressed as a matter of urgency. General hospitals that do not have the facilities or staff to provide quality emergency care should, under most circumstances, cease taking emergencies.

8. There is increasing awareness that the demands of the emergency service are having an adverse effect on many hospitals' ability to provide elective specialist care. Cancellation of planned procedures is not only poor quality care but is also very costly and inefficient.

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Background

1. What society can afford is totally dependent upon the success or otherwise of the UK economy. Public spending in the foreseeable future is likely to be constrained and there will continue to be a massive deficit in NHS spending. NHS inflation is running at 7 to 8% per year, largely secondary to increased nurse numbers but also demography. It is an inescapable fact that financial resource for the NHS will remain tight for the foreseeable future.

2. Patients and communities value local hospitals highly. However, there is increasing concern that smaller acute providers operate at too small a scale to be financially sustainable while providing quality care.

3. Whilst the hospital setting is a prerequisite for the provision of most specialised surgical services, we recognise that numerically the volume of work performed in primary care is much greater. In 2009 there were approximately 300 million general practice consultations, of which only around 1 in 20 GP consultations resulted in referral to secondary care. This should be seen in the context that between 2002/3 and 2006/7 expenditure on general practice services grew from £4.9 billion (7.5% of total NHS expenditure) to £7.9 billion (7.9%). In other words, the vast majority of patient encounters with the medical profession occurs in general practice and accounts for less than 10% of the NHS budget[1].

4. Surgery itself comprises a minority of inpatient spells in hospital. Figure 1 (from Monitor, Smaller acute providers) illustrates that general medical admissions account for the majority of 'inpatient spells' in England. Nevertheless, as can be seen from this Figure, surgical admissions, if all specialties are combined, amounts to about 25% of all inpatient spells. Individual surgical specialities however comprise a very small part of the total. The largest surgical specialties, General Surgery and Trauma and Orthopaedics, account for about 15% of all admissions[2].

5. The majority of surgical inpatient episodes relate to the management of the acute admission, not the management of planned specialist surgical procedures. All surgeons are specialists by virtue of the fact that they practice surgery. But the great majority of surgeons irrespective of designated speciality interest remain generalists by virtue of the continued need to provide for the emergency admission. This constitutes far and away the bulk of surgical practice.

6. Therefore, the primary aim of a 'general' hospital from a surgical perspective must be to provide care for the emergency admission.

7. Quality care close to the community must be an additional goal wherever possible; this will be increasingly important as demography changes and the population ages.

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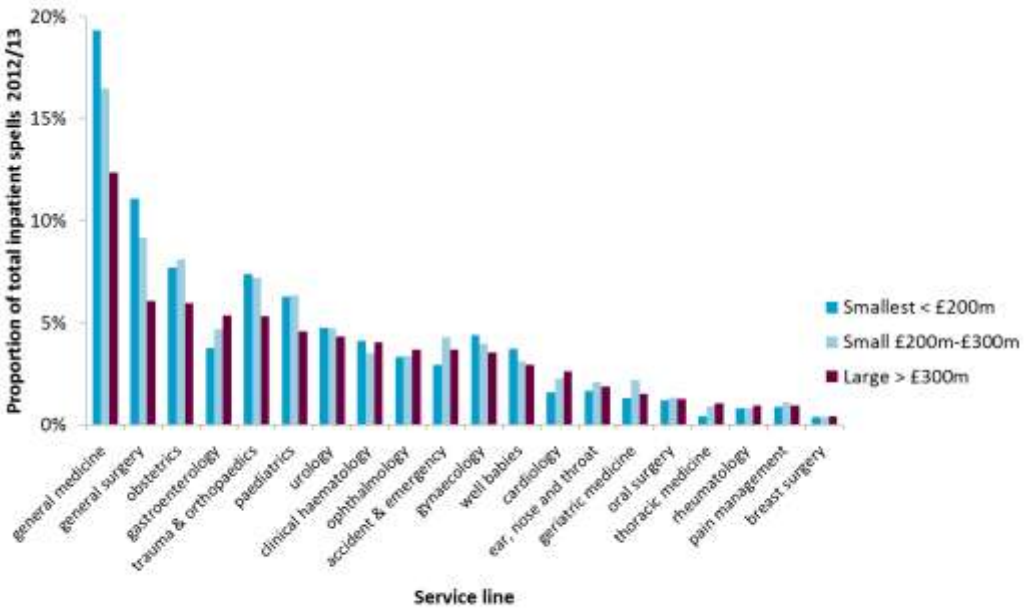

8. A frequently unrecognised consequence of the failure of General Hospitals to provide adequate emergency care is the impact this has on the provision of optimal tertiary care. If beds are occupied by emergency patients, then very often complex super-specialised elective care suffers (Dalton Review[3]).

9. The financial viability of many hospitals will be determined by the presence or otherwise of private finance initiatives. These have often left hospitals with a substantial debt which will impact upon their ability to provide a range of services in the future.

10. Beds: if admission rates to hospital continue to increase, the growing and ageing population alone means that the NHS will require an additional 6.5 million bed days by 2022. This is equivalent to 17,000 beds or 22 new hospitals with 800 beds each.

11. Reconfiguration of hospitals may be a political priority but there is no evidence that the NHS can cope with fewer beds. It is now recognised that closing beds in the past 20 years was probably inappropriate particularly because of changing demography. In reality we probably did not have as many beds as we thought. We still need hospitals for acute care. Community care will not be effective for all.

12. No discussion about the provision of surgical services can proceed without recognition of the need to provide quality care for acute medical admissions. Surgical care cannot exist in isolation.

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What is a DGH?

- In 1948 there was a clear distinction between so-called 'Teaching Hospitals' and District General Hospitals. This distinction was simply based upon those hospitals which were affiliated to a medical school and were thereby termed 'Teaching'. A similar distinction existed between teaching and non-teaching hospitals in Ireland. The District General Hospital was one which provided a range of facilities, but was not affiliated to a medical school. This distinction has now become irrelevant. All hospitals now teach. Many hospitals, originally termed 'General Hospitals', have become very large hospitals and cannot and should not be considered second best to a Teaching Hospital.

- It would be useful to abandon the terms 'Teaching' and 'District General'. The term 'DGH' has pejorative connotations and is now misleading to the public. Similarly, many Trust Boards in recent years have affixed the term 'teaching' or 'university' to their hospital names presumably because Trust Boards consider this lends a veneer of presumed excellence.

- We would commend the term 'General Hospital'. Such a hospital would be expected to take emergency patients 24 hours a day, 365 days a year. Many specialist hospitals (providing elective care for a defined specialty) are not by definition 'general'. Similarly, the term 'community' or 'cottage' conveys to the public the concept that a hospital is not providing all 24 hour services.

- A 'General' hospital (formerly DGH) cannot be easily defined by size (number of beds), catchment population, geographic situation or range of services. Neither can it be defined by operating revenue (income). In its recent report entitled 'Smaller acute providers', Monitor defined 'smaller' as providers with an operating revenue (income) of under £300 million in the 2012/13 financial year[2]. This threshold was chosen to capture Foundation Trusts with a very low or negative operating surplus in 2012/13. This group was further split into those with operating revenue under £200 million (smallest) and those with an operating revenue of between £200 and £300 million (small). Together these represent 75 (over half) of the acute non-specialist providers operating in the NHS in England today and one-third of all inpatient episodes.

- Hospitals in the UK tend to be larger than those in the rest of Europe. The hospitals we consider smaller would be seen as relatively large in other countries. Table 1 sets out some features of English acute providers and summarises some of the differences between the characteristics of smaller and larger acute providers in the NHS in England[2].

- Since 1948 the delivery of acute emergency care has changed across the UK and Ireland. Many small hospitals have joined with their neighbours to form larger units capable of providing an enhanced level of emergency care and allowing the development of specialist practice. In some areas the need for larger volumes of patients to provide the platform for acute specialist interventions has been in the medical specialties, examples being acute stroke and myocardial infarction. Often the need for larger specialist surgical teams has been the main driver of these changes.

- The consistent achievement of high-quality emergency hospital care, with access to specialist interventions for all, will continue to drive reorganisation of the hospital service.

Table 1: Provider characteristics by operating revenue category, 2012/13 [2]

		<£200m	£200m - £300m	>£300m
Number of providers	Total in each category (based on 2012/13 operating revenue)	30	45	67
Provider characteristics	Average operating revenue, 2012/13	£166m	£250m	£523m
	Average number of sites	1	1.2	2.1
	Average number of beds (provider total general and acute beds), 2012/13	396	548	953
	Average number of service specialties, 2012/13*	24	27	35
	Average number of inpatient spells (to nearest thousand), 2012/13	58,000	81,000	148,000
	Average number of FTE consultants employed	113	164	346
	Inpatient spells per FTE consultant**	513	494	428
Location characteristics	Average distance from (next) nearest hospital with A&E	26.8km	23.0km	21.0km
	Average distance from nearest major trauma centre	46.1km	48.6km	32.4km
	Average inpatient catchment population 2012/13 (to nearest thousand)	195,000	275,000	470,000
	Average % of inpatients from an urban (ONS) area 2012/13	72%	83%	83%
	Average % of inpatients aged 65 and older or under 5, 2007-13	29%	29%	26%

FTE= full time equivalent; ONS=Office for National Statistics.
Source: HES 2012/13, APR 2012/13, FIMS 2012/13, ONS

* As measured by the number of NHS Hospital and Community Health Service (HCHS) Workforce Statistics grade consultants with distinct occupation codes (distinct CCSTs for publication) in post at providers in September 2013. Source: Health and Social Care Information Centre (HSCIC), Provisional NHS Hospital & Community Health Service monthly workforce statistics. HSCIC extract from Electronic Staffing Record (ESR).

** This does not take account of the differing levels of research and development or other activities undertaken by consultants, which may make these figures less comparable between different sized trusts.

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- There was agreement that if a hospital is to take emergency patients, then it needs to meet recommended standards of care as defined by NCEPOD[4], ASGBI[5] and RCS England (termed by some as 'London Standards')[6, 7]. These include:

  All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital (this standard applies particularly to general surgery and orthopaedics and trauma).

  All patients admitted acutely to be continually assessed using the National Early Warning System (NEWS).

  When on-take, consultants and their teams are to be completely freed from any other clinical duties or elective commitments.

  This would entail 24-hour staffing of A&E units, 24-hour staffing of emergency theatre, an Intensive Care Unit, 24-hour availability of CT scanning and endoscopy, interventional radiology and adequate rotas to cover acute medicine, acute general surgery and acute trauma and orthopaedics as an absolute minimum.

  All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making:

  - Critical – imaging and reporting within 1 hour
  - Urgent – imaging and reporting within 12 hours
  - All non-urgent – within 24 hours

  Type 1 emergency departments are a consultant-led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

- The Forum agreed that if the above minimum standards are not available, then a hospital should not be expected to take emergency patients on a regular basis. This would necessitate alternative arrangements for emergencies. By default it then means that these hospitals would have to develop alternative functions to that of a General Hospital.

- The requirements of a General Hospital may not include the need to provide all surgical specialties. Some will be concentrated in the large hospitals, such as maxillofacial surgery, and others such as paediatric surgery favour a solution based on the provision of networks.

- All were agreed that there is no universal solution to what constitutes an appropriate General Hospital. The understandable ambition of patients, their carers and politicians to have local access should be considered alongside the need to provide high-quality emergency and elective care. This does challenge the current geographical distribution of hospital care in the UK and Ireland**.**

- The aim must be safe care delivered to meet local needs. The patient voice should be involved at an early stage in any discussions.

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Training the next generation of surgeons and the smaller hospital

- The 'General' Hospital that provides emergency care must be in the forefront of surgical training.

- There is an urgent need to address the problem of incentivising young doctors to work in smaller General Hospitals

- It is recognised that often the very best training occurs in smaller hospitals.

- There was agreement that the principles of the Greenaway Shape of Training Report were fundamental to future provision of care[8]. In particular it was agreed that following training and acquisition of a Certificate of Specialist Training these doctors should not come off the on-call rota. In other words, all surgeons trained to the level of CCT should maintain a commitment to emergency patients for much of their professional lives. It was not appropriate for those with CCTs to abrogate their responsibilities to emergency care[8, 9].

- It is recognised that independent treatment centres can have a detrimental effect on training by removing elective surgery, particularly day case procedures, and undermining the critical mass to provide dedicated wards in NHS hospitals. In ENT, for example, 86% of routine elective activity is undertaken as day case surgery.

- We ignore at our peril staff grade and associate specialist (SAS) doctors. These constitute a large part of the surgical workforce. There is no standardised career structure for these individuals. They often feel they are working in dead-end jobs without recognition[10, 11]. Many 'General' hospitals are dependent on these grades of surgeon for provision of service. As training numbers for surgical trainees are to be reduced this situation is likely to continue.

- The Forum has previously written about the hierarchical structure of training in the United Kingdom and the detrimental consequences of a slavish obsession with the role of Consultant as being the only senior doctor in the service. We need more flexibility at the endpoint of training and a recognition that not all doctors will do the same job for the entirety of their career. Such flexibility in training is important, not only because of feminisation of the workforce but also because of a realisation that surgeons do not wish to work in the same manner as their predecessors[10, 11].

- It is recognised that some surgeons have no wish to train and should not be under any obligation to do so. This, however, should be the exception. Under normal circumstances all consultants would be expected to contribute to training.

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Primary Care: the gatekeeper role

- The success and the survival of the NHS since 1948 has in large part been a consequence of the gatekeeper role performed by General Practitioners in Primary Care. They have been responsible for approximately 90% of all patient contact and this they achieve whilst consuming less than 8% of the NHS budget.

- Historically General Practitioners have been prepared to make clinical decisions on the basis of history and examination, and have not routinely referred all patients for investigation. This 'attitude to risk' has been fundamental to the success of the NHS and has kept a check on unrealistic patient expectations. There is however significant concern that this historical attitude of General Practitioners, which has been to avoid investigation except where absolutely necessary, is changing. The modern General Practitioner is more likely to refer to Secondary Care and more likely to request investigations. Inevitably this will fuel patient expectations and increase demand on the service.

- Repeated exhortations in the media or by politicians to improve services particularly with regards to cancer care will also further add to patient expectations and the belief that all cancers should be identified quickly and not to do so represents a failure of the system. Such an approach from the media and politicians will lead to more overburdening of the system. The genuine will be delayed because the system will be dealing with the worried well.

- It is now generally accepted that 40% of attendees at Accident and Emergency Departments don't need to be there. Their ailments could be dealt with in Primary Care. The reasons for such a large cohort of patients being in A&E are multi-factorial. One is, as stated above, patient expectation. Another may be the availability of general practice consultation. If the NHS is to survive then this question needs urgent attention.

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Politics, health and social care

- The Forum broadly welcomed the recent statement from Simon Stevens in the document entitled 'The NHS Five year Forward view'. All acknowledge the need for efficiency savings and the need to evolve innovative solutions to reducing hospital admissions. In particular the Forum welcomed the following suggestions:
    - Large GP practices employing hospital doctors to provide extra services, including diagnostics, chemotherapy and hospital outpatient appointments
    - In areas where GP services are under strain, hospitals could be encouraged to open their own surgeries
    - Smaller hospitals to work as part of larger chains, sharing back-office and management services
    - Larger hospitals to open franchises at smaller sites,
    - Hospitals to provide care direct to care homes to prevent emergency admissions.
- There was agreement that there is much to be gained by distancing the NHS from party politics. The example of the Government giving over the right to set interest rates to the Bank of England, so removing a key area of monetary policy from direct political influence, was noted. The Forum would support an analogous situation of the profession being given responsibility for recommendations on the reorganisation of hospital services. It was felt that much would be gained by the NHS not being party political.
- It was agreed that surgery as a profession needs to be more vocal, needs to demonstrate more leadership and needs to speak with one voice.
- It has been estimated that up to 25% of hospital inpatients don't need to be in hospital. This may not reflect inappropriate admission but a failure to discharge which necessitates having the right facilities available in the community. However adult social services have suffered cuts of 15% in real terms between 2009/10 and 2012/13. Failure in the hospital setting to reduce lengths of hospital stay puts extra pressure on hospital finances and affects performance of A & E where the inability to discharge patients who are already in hospital sufficiently quickly has been a factor in lengthening the time patients spend in A & E[12].
- Older patients consume 40% of healthcare expenditure. There are significant benefits to be gained by combining budgets from hospital and social care.
- The Forum recognises that many politicians and others are enthusiastic about the concept of integration of health and social care. However, there are potential drawbacks: there is no limit to the potential cost of social care and without ring-fencing hospitals may be stripped of cash. The move of Public Health to local authorities has not always been a success.

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Looking to the future

- *Community hospitals*: hospitals that do not receive emergencies on a 24 hour basis need to reinvent themselves as 'community' hospitals. This needs liaison with care homes, polyclinics and mental health offices. Consultants must work more seamlessly with General Practitioners. We would support the development of conglomerations of General Practitioners working with hospital practitioners in small community hospitals. Such a model is likely to have a major impact on reducing unnecessary admissions. Such hospitals are also likely to have a valuable role in convalescent care, rehabilitation and readjustment to independent living. These factors are in accord with the document 'The NHS Five year Forward View'.

- *Networks:* there is no doubt that there needs to be a move towards 'networks' of hospitals. This term is preferable to 'hub' and 'spoke' which is slightly pejorative. Networks are successful if there are good interrelationships between hospitals and that these different hospitals are served by good, efficient and cheap transport systems. The advantage of a network is that it facilitates good appointments. Individuals are more likely to apply for such posts as they will not feel insecure about the future of a single institution.

  It was recognised that the problems in creating a network system relate to the purchaser/provider split and the constraints placed upon General Practitioners with Choose and Book initiatives and commissioning. The Forum urges politicians to address these issues such that conglomerates of hospitals can work together for a common good.

  There are obstacles to an integrated and collaborative approach across the healthcare sectors and between providers. One factor that sometimes adversely effects integration is the existing purchaser (commissioner)/provider split and the establishment of independent Foundation Trusts.

- *Skill mix*: there needs to be a radical change in skill mix. What used to be done by qualified medical practitioners can often be done by other non-medically qualified personnel at much reduced cost.

- *Technology:* there needs to be much improved use of technology, whether this is in the form of electronic communication with patients, or whether it relates to the provision of information and education. There is no reason, for example, why internet-based videos could not be produced in place of patient consent forms and information leaflets.

- *Discharge liaison staff*: there is good evidence to demonstrate that individuals should be appointed in all hospitals with specific responsibility for discharge. Such a discharge liaison individual has been shown to facilitate early discharge and reduce readmissions.

- *Standardising surgical care*: there is good evidence from the American literature that smaller hospitals can adopt standardised packages of care that minimise unnecessary investigations[13]. A contrast can be made between hospitals providing a wide range of investigations and ancillary care (termed 'solution shops') and those practicing what is termed a 'focussed factory' model of care. The solution shop approach leads to wide

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variations in care, which results in increased costs and reduced quality. In contrast, the focussed factory model is characterised by a uniform approach to care. An example is enhanced recovery protocols after surgery. These are associated with significant reductions in hospital stay and their widespread adoption should be actively encouraged.

A proven advantage of 'standardised' care packages in the UK are enhanced recovery protocols. It is now accepted that these are associated with improved quality of care, reduced durations of hospital stay without increased morbidity or readmission. Enhanced recovery protocols are in essence simply standardisation of optimal pre-, peri-, and post-operative care. The GIRFT initiative by the British Orthopaedic Association follows similar lines[14].

- *Reconfiguration discussion*: the Forum was unanimous that personal vested interest in the maintenance of hospitals is intolerable. However, the surgical profession has a legitimate opinion as to which hospitals should and should not provide emergency surgical care**.**

  The Forum were agreed that it would be appropriate for clinicians to voice concerns about the viability or otherwise of small hospitals, and make recommendations to politicians as to which hospitals should be reconfigured, closed, or have their function significantly changed. The Surgical Forum, together with our colleagues from other specialties, could help in such discussions, recognising that they are often very challenging for local communities, clinicians and politicians.

  At all stages, involving lay and patient groups will be helpful.

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Conclusions

1. The term 'District General Hospital' might be best replaced with 'General Hospital', recognising that such hospitals may be in our city centres or in other less densely populated areas.

2. General Hospitals should be able to provide minimum standards of emergency care and this will mean that reconfiguration of the current hospital service is inevitable.

3. We recognise that discussion of such reconfiguration is often challenging for the public, politicians and clinicians.

4. We believe that the medical profession can, and should, provide leadership to help properly inform these discussions.

5. We consider that primary and secondary care providers should be encouraged to work together to achieve an NHS in which as much care as practical is provided in a community setting, while accepting that some care does need to be centralised to achieve best clinical outcomes.

6. Reconfiguration of our hospital services will help continue the improvement of high-quality clinical services across the UK and Ireland.

John MacFie
November 2014

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Appendix 1

Attendees - Surgical Forum of Great Britain and Ireland
Monday 13 October 2014, 1000h, College Hall
Royal College of Physicians and Surgeons of Glasgow

Mr William Allum	Chair-Elect, Joint Committee on Surgical Training
Mr Andrew Beamish	Immediate Past President, Association of Surgeons in Training
Professor Peter Brennan	Chair, Intercollegiate Committee for Basic Surgical Examinations
Professor Timothy Briggs	Immediate Past President, British Orthopaedic Association
Mr David Burge	President, British Association of Paediatric Surgeons
Mr John Cooper	Chief Operating Officer, Royal College of Physicians & Surgeons of Glasgow
Mr Michael Davidson	Chairman of Council, British Association of Oral and Maxillofacial Surgery
Dr Frank G Dunn	President, Royal College of Physicians & Surgeons of Glasgow
Mr Ian Eardley	Chair, Joint Committee on Surgical Training
Professor Ian Finlay	Senior Medical Officer, Scottish Government
Mr Timothy Graham	President, Society for Cardiothoracic Surgery in Great Britain & Ireland
Professor James Hutchison	Vice President, Royal College of Surgeons of Edinburgh
Professor John Hyland	Vice President, Royal College of Surgeons in Ireland
Mr Mike Lavelle-Jones	Vice President, Royal College of Surgeons of Edinburgh
Professor Valerie Lund	President, British Association of Otorhinolaryngology - Head and Neck (ENTUK)
Mr Declan Magee	President, Royal College of Surgeons in Ireland
Mr Ian Martin	Immediate Past President, Federation of Surgical Specialty Associations
Miss Clare Marx	President, Royal College of Surgeons of England
Mr Hugo Mascie-Taylor	Medical Director, Monitor
Professor John MacFie	Chair, Surgical Forum of Great Britain & Ireland President, Federation of Surgical Specialty Associations

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Mr Michael McKirdy	Vice President, Royal College of Physicians & Surgeons of Glasgow
Mr Richard Nelson	Immediate Past President, Society of British Neurological Surgeons
Mr Nick Price	Lay Representative
Professor John Primrose	President, Association of Surgeons of Great Britain & Ireland
Mr Michael Reidy	British Orthopaedic Trainees Association
Professor David Richens	Chair, Joint Committee for Intercollegiate Examinations
Mr Ian Ritchie	President, Royal College of Surgeons of Edinburgh
Ms Alison Rooney	Chief Executive, Royal College of Surgeons of Edinburgh
Mr Mark Speakman	President, British Association of Urological Surgeons
Professor Terence Stephenson	Chair, Academy of Medical Royal Colleges
Dr Jackie Taylor	Vice President (Medical) Royal College of Physicians & Surgeons of Glasgow
Mr Kevin Varty	Honorary Secretary, The Vascular Society of Great Britain & Ireland
Mr David Ward	Vice President, Royal College of Surgeons of England
Mr John Abercrombie*	Council member , RCS England

**Did not attend meeting but contributed to manuscript*

The Surgical Forum of Great Britain and Ireland

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Appendix 2

Time	Programme	Chair
1000	Welcome to RCPSG Opening remarks: setting the scene	**Dr Frank Dunn, PRCPSG** **Prof. John MacFie, Chair, Surgical Forum**
	Background	
1015 - 1035	***Access v. cost v. Quality*** - Dr Hugo Mascie-Taylor, Medical Director, Monitor	
1035 – 1055	***Quality care, close to the community*** - Professor Terence Stephenson, Chairman, Academy Medical Royal Colleges	
1115 - 1135	Discussion	
1135 - 1150	Tea /coffee	
	Visions for the future of the DGH	**Mr Ian Ritchie, PRCSEd** **Miss Clare Marx, PRCSE**
1150 - 1210	***A community / physician's perspective*** - Dr Jackie Taylor, VP Medical, RCPSG	
1210 – 1230	***Implications of Greenway and 7 Day Services*** - Professor Ian Finlay, Senior Medical Officer, Scottish Government	
1230 - 1250	***"Getting it right first time"*** - Professor Tim Briggs, Immediate Past-President, BOA Consultant Orthopaedic Surgeon Joint Head of Training & Director of Strategy and External Affairs, Royal National Orthopaedic Hospital	
1250 - 1320	Discussion	
1320 - 1400	Lunch	
1400 – 1530	**Forum discussion** (to which all College and Speciality Associations Presidents will be invited to speak)	
1530 – 1545	Break	
1545 – 1615	**Summing up**	**Prof. John MacFie, Chair, Surgical Forum** **Prof. Declan Magee, PRCSI**