

HOSPITAL SERVICES IN LANARKSHIRE FROM AUGUST 2004

INTRODUCTION

The European Working Time Directive (WTD) currently applies to all health workers with the exception of doctors in training. Staff can presently still waive their rights if they so choose, although this option seems likely to be withdrawn in the future. The WTD will progressively be applied to doctors in training from August 2004. The provisions that will apply from August 2004 are:

- ❑ A reduction in the maximum permitted average working hours per week to 58.
- ❑ A minimum daily consecutive rest period of 11 hours.
- ❑ A minimum rest break of 20 minutes when the working day exceeds 6 hours.
- ❑ A minimum rest break of 24 hours in each 7-day period (can be averaged to be a 48-hour rest in 14 days).
- ❑ A minimum 4 weeks paid annual leave.
- ❑ A maximum 8 hours work in each 24 hours for night workers (it is not yet clear if doctors will be regarded as night workers).

Points 3,4 &5 are already met or exceeded by existing junior doctor contract provisions. Point 6 can be left in abeyance meantime. The maximum average permitted working hours per week are already 56 ('on your feet' -new deal limit). However, the 'SIMAP' (Sindicato de Medicos de Assistencia Publica) and other recent judgements of the European Court mean in effect that all time spent by doctors on an employer's premises (even if sleeping) will count as "Working Time" for the purpose of the Directive.

Additionally, the SEHD has committed to implementing the 'Donaldson Report' – 'Modernising medical careers'. This introduces a much more structured training for doctors in their first two years following qualification and implementation commences in 2005. However, our plans for this are required by March 2004 so that posts can be advertised. The increased educational element of this training together with the on-call supervision requirements means that less time will be available for service commitments – particularly out of hours.

Finally, compliance with the 'new deal for junior doctors' was required by August 2003. For various reasons, this has not been fully achieved in Lanarkshire. It will not be possible to achieve compliance in some specialties without some form of service restructuring. In most specialties where compliance has been achieved, the arrangements are not robust and rotas tend to slip in and out of compliance.

COMMENTARY

For all practical purposes, SIMAP and the minimum daily 11-hour rest requirement mean that from August 2004 it will only be possible to employ trainee medical staff on “full shift” contracts.

In most Lanarkshire ‘medical’ specialities (principally General Medicine, A&E, but not Care of the Elderly), full shift working is already the norm and the requirements of the WTD in these specialities, taken in isolation, could be met by relatively modest changes. There are of course other major issues with regard to emergency medicine activity levels.

The situation in most ‘surgical’ specialties is more challenging. Many of these junior medical staff work patterns are not presently ‘full shift’. Work patterns that are not presently ‘full shift’ are not ‘full shift’ for a reason i.e. the ‘medical’ work in that particular department is of insufficient volume, frequency or immediacy to require the continuous presence of the doctor in the ward or unit.

Although it is technically possible to have compliant full shift rotas containing only 6 or 7 doctors, these require the use of locums to cover leave, and training is usually thought poor. Long-term stability is only likely to be achieved with rotas containing 8 or more doctors. Simple arithmetic indicates the probable number of such rotas that Lanarkshire can support. A principal requirement in any solution is to reduce the number of rotas to that figure.

OBJECTIVES

- 1) By August 2004, Lanarkshire Acute Hospitals have to reduce the hours of all trainee medical staff to an average of not more than 56 hours per week actually spent on hospital premises. There is a further requirement to reduce this to an average of not more than 48 hours on the premises by 2009. However, in many instances, that latter requirement is a smaller change than the one required of us within the next year. Our solution for August 2004 should therefore also meet the 48-hour requirement unless there are specific reasons why this is not possible.
- 2) Lanarkshire hospitals presently have around 46 doctors on duty overnight – excluding consultants. The new constraints described above mean that that number has to be reduced to around 25 with effect from August 2004.
- 3) Until the past few years, junior medical staff represented the traditional (and often most cost-effective) way of providing aspects of many out of hours clinical services. That position has now changed dramatically. Using trainee medical staff out of hours for tasks that do not specifically require the knowledge and skills of doctors is now prohibitively expensive. It is therefore absolutely necessary to reconsider what tasks we specifically require to be performed out of hours and who should undertake them. The most junior medical trainees - PRHOs and those in the forthcoming second ‘foundation’ year (F2) - will henceforth have posts which have a large educational & supervised practice component and relatively little service commitment. Serious consideration must be given to arranging duties which do not exceed 40 hours/week and which are wholly within the period 8am-7pm Monday-Friday for these doctors. A maximum average 48 hours work/week has to be regarded as the normal working pattern for all other trainee medical staff from August 2004 –unless there are very specific reasons for 56 hours in the short term.

ADDITIONAL FACTORS

- 1) There will be no new trainee medical staff posts created. Recent reports supported by the profession have been clear that new trainee posts may only be created to meet future demand for trained specialists, not to resolve service issues.
- 2) Government targets for waiting times have to continue to be met.
- 3) NHSQIS (formerly CSBS) standards have to be met.
- 4) There will be no new money to resolve these issues. NHS Lanarkshire already has a substantial budget deficit

OPTIONS

Sceptics might ask what would happen if we did nothing in response to the issues above.

If we did absolutely nothing, then the following could be predicted. As soon as junior doctors received their contracts for August 2004, they would likely take them to the BMA who would advise against signing them as they were illegal. At the extreme, we would have no trainee medical staff for August 2004. More likely, the SEHD would simply instruct us to comply with the law. If we nevertheless attempted to make a junior doctor work in breach of the WTD after Aug 2004, we would be vulnerable to prosecution by the Health & Safety Executive. Successful prosecution would result in a substantial fine for NHS Lanarkshire.

If on the other hand, we awarded WTD-compliant contracts to junior doctors but made no amendment to clinical services to take account of that, then in the early evening of 4 August 2004 or thereabouts, Consultants, Clinical Directors and Senior Managers would likely receive sundry phone calls asking 'who is on duty for such & such?', as around half of the expected junior medical staff would be missing.

Clearly neither of these represents a sensible course of action and in reality, 'no change' is not an option. The issues have been extensively discussed in the medical press, on the DOH websites, and more recently in the broadsheet newspapers.

The only way in which the requirements of the Directive can be met is by substantially reducing the number of out of hours (especially overnight) rotas and by increasing the number of junior doctors participating in most of the remaining ones. There are three main approaches to doing that:

- (a) Concentrate all in-patient services which have a high requirement for resident medical staff on to two hospital sites and re-designate the third hospital as an 'Ambulatory Care and Diagnostic Centre' (ACAD) co-located with inpatient facilities for patients with low requirements for resident medical staff. There are cogent arguments against doing this. It would require major alterations to recently constructed buildings, for which finance is not available and which could not be undertaken within the required time-scale. It would not maintain local access to services for many patients. This option is therefore rejected meantime, but would need to be re-considered if the preferred options below are not supported.

- (b) Continue the existing pattern of service provision, but with increased input by consultants to help replace the 'missing' trainee medical staff hours. As the majority of Consultants in Lanarkshire Acute Hospitals are likely working in excess of their contracted hours and some are believed to be infringing their own Working Time Directive requirements, it is unrealistic to ask for significantly more time commitment from the majority of existing Consultants. Expanding the consultant establishment is a possibility – and replacing trainee medical staff by consultants is an appropriate strategy for the longer term. However, this cannot be done in any significant way in the time available. Moreover, work currently undertaken by trainee medical staff does not in many instances make appropriate use of a Consultant's training and experience. In any event, there are presently significant Consultant recruitment difficulties in many specialties. This option cannot therefore represent a full solution at present, but may have a part to play in some specialties now. It will be a more important factor in the longer term.
- (c) Reduce the number of doctors in the hospitals overnight, make better use of those who remain and introduce additional specialist nurses, together with a consideration of eliminating some duplication of out of hours services provided simultaneously on all three sites (particularly those where full-shift working for trainee medical staff is not standard). We believe that this is the option likely to achieve most of what is needed in the time available. Arrangements will continue to evolve post Aug 2004, and the proposals in this paper will probably not represent a 'final' position.

DISCUSSION & PROPOSALS

There are therefore two main themes in the proposals:

- i) The formation of overnight 'hospital emergency care teams'
- ii) Consideration of overnight arrangements in surgical specialties

These will now be considered in detail:

i) Overnight Hospital Emergency Care Teams

The medical care of attendees at A&E, new medical admissions, new admissions in general surgery and orthopaedics who are not for early surgery, and all the other adult patients in the hospital will be undertaken between 2100 – 0900 every day of the week by a newly formed 'hospital emergency care team' (HECT), comprising 4/5 medical and 2 nursing members. The team may need administrative/clerical and other support. The arrangements for patient management between 0900 – 2100 each day will remain largely unaltered save perhaps for formalising some Saturday & Sunday practices. The duties and work of these HECTs will clearly need to merge seamlessly with daytime practices and rotas in all specialties. The teams will likely require some supplementation to take account of peaks in A&E activity in the late evening/early hours on some days. The new GMS (primary care) contract comes into force on 1st April 2004. It is likely that Primary Care 'out of hours' centres will be located in close proximity to the 3 A&E departments. In that event, consideration will be given to integrating any GP presence with the 'hospital emergency care team' in order to maximise the use of available staffing, provide a seamless service and make best use of training opportunities. These changes will provide an opportunity to focus attention on those patients who need it most & hence improve the standard of care we provide. Wider adoption of scoring systems (e.g. MEWS) will be a part of that, as will elimination of unnecessary duplication of process (e.g. asking patients the same questions over & over again). Clearer and more formal 'management plans' are needed for all patients. Further enhancement of some aspects of our I.T. provision is also required.

The Nurses would have a wider role and a more advanced set of competencies than existing ward nursing staff. They would be new, additional posts. Their competencies would include patient examination and assessment, venous cannulation, ALS training, male & female urinary catheterisation, recording and interpretation of ECGs, advanced device training, and diagnostic test and prescribing rights. They would be permanent members of the team, but would also work in various emergency care areas by day. None of the team doctors would be a 'foundation' trainee. All would therefore have a minimum two-years post-graduate experience once the F2 year is introduced. The doctors would remain in their base specialties as at present, and form part of the team on an intermittent or block basis. Required core competencies need to be developed for the medical team members. Whilst none of the medical team members would be a foundation trainee, it might be appropriate for such doctors to have time-limited involvement with the team in an entirely supernumerary/training capacity. The team doctors might be derived as follows:

- 1 from general medicine
- 1 from A&E
- 1 from ITU (with ITU as primary duty), and

- 1 from A&E or general medicine, and/or
- 1 from the surgical specialties

The exact team composition might vary from site to site and be determined locally.

It has proved difficult to get reliable information about the precise contribution made to service provision by doctors in training in Lanarkshire. Historically, work has often been found or created for those available, rather than the staffing requirements for a defined service quantified. It is therefore difficult to be definite about what would happen if some of the juniors presently available in any specialty were no longer there. There is thus a need for all specialties to look in detail at 'what is being done – and why'.

Trainee medical staff participating in hospital emergency care teams must be very clear that they are on duty for all the patients in the hospital and not just for those in their own specialties. If this were not understood, it would be necessary to reduce the number of trainees in a specialty to the minimum needed to provide their own service, with the balance being re-designated to 'A&E'-type emergency posts. The proposal for the exact composition of each hospital's emergency team has been deliberately left slightly open so that each hospital may consider what would suit it best.

ii) Overnight arrangements in surgical specialties

The present work-patterns of trainee medical staff in surgical specialties clearly indicate that it is these specialties that will suffer the greatest consequences from the introduction of the WTD and the other requirements. Excluding Consultants, Lanarkshire presently has 8 'general surgeons', 6 'orthopaedic surgeons', 5 'obstetricians/gynaecologists' and 7 'anaesthetists' on duty overnight. These numbers are not sustainable after Aug 2004. Change of some kind in the way that we provide emergency services in surgical specialties is therefore inevitable. It is difficult to see beyond the possibility of either some reduction in the number of sites on which (or times at which) services are provided, or increased involvement of Consultant Surgeons and Anaesthetists out of hours to maintain the existing arrangements. The new Consultant contract would provide the way of appropriately recognising that latter situation.

However, NHS Lanarkshire still has to meet the government's targets for waiting times, so it is not therefore possible to commit an undue proportion of resources to maintaining 3 parallel emergency services in the surgical specialties. Ultimately, the number of sites for overnight surgical emergency services will be determined by the collective will and attitude of the relevant Consultants. If the Consultants clearly wish to support the continuation of 3 overnight sites and are willing to participate fully in such arrangements in a way which is affordable and which permits elective activity targets to continue to be met, then that should be possible. If any of those elements are missing, then rationalisation will be necessary.

Previous studies have clearly shown that the utilisation of operating theatres overnight is now very low (less than 10% on each site). Whilst this is an appropriate response to successive CEPD reports, overnight theatre staffing has not fully mirrored this downward trend, and it does mean that Lanarkshire is using scarce and expensive resources inefficiently. Appendix 1 shows the number of operating theatre patients in the three hospitals during the month of March 2003 (and April 2002) who had surgery which:

- (a) started after midnight
- (b) finished after midnight
- (c) started after 2100hrs, and
- (d) finished after 2100hrs.

The numbers of patients whose operations 'finished after 2100' largely reflect theatre activity earlier in the day rather than true peaks of evening emergencies. A recent publication by the Association of Anaesthetists opined that 'Only cases that cannot be delayed for good clinical reasons should be operated on at night e.g. after 2100'. It is evident that if operating theatres were closed in two hospitals between e.g. 2100hrs and 0800hrs and patients requiring surgery during that time were transferred to centralised facilities at the third hospital, the expected number of patients who would need transferred for surgery would average less than 2 patients per day from each of those hospitals. These numbers would be reduced by improving daytime theatre utilisation. The impact on surgical bed occupancy on each of the three sites would therefore be small, although it would clearly be essential that a centralised surgical emergency site always had beds available for that purpose. Even if there were precautionary transfer of 1 additional patient for every patient actually transferred and operated, the overall impact on bed numbers and occupancy would still be very modest. Similarly, the impact on critical care facilities would be small, amounting to an average of less than one additional critical care patient from each site per week requiring post-operative ITU care following transfer. Policy would require to be developed concerning 'repatriation' of post-operative and any un-operated patients to their original hospital sites if this suggestion were implemented.

The majority of 'emergency admissions' in surgical specialties do not require immediate surgery within the first eight to twelve hours following admission. Such patients could continue to be admitted on all three sites throughout the 24-hour period and only those assessed as requiring surgery which could not be completed before 2100 hours or safely delayed until after 0800 the next day being transferred to a centralised site for that. Inter-site PACS functionality will be reviewed. Telemedicine may have a role to play. Duties for all of the medical staff in general surgery, orthopaedics, gynaecology and anaesthetics would be reorganised in order to provide centralised specialty emergency teams and there would be no medical presence in these specialties (other than in the emergency team) on the two non-centralised sites between 2100 and 0800. No change would be proposed to existing daytime arrangements save for a review of CEPD / trauma theatres on all 3 sites including early evening and weekend daytime working.

Many would naturally have concern regarding the management of those emergencies that arise in-house in the absence of overnight theatre availability on-site. Such conditions would include post-operative haemorrhages, haematomas, and wound & anastamotic dehiscences. It would be necessary to put robust protocols in place for the management of these conditions and it is accepted that a very few of them would require to be managed on-site without transfer. Suitable arrangements would need to be made to permit that.

The essence of such changes would be that henceforth, Lanarkshire would provide one integrated area-based out of hours emergency service in each of general surgery, orthopaedics, gynaecology and anaesthesia rather than three parallel hospital-based ones. In some specialties, it might be appropriate to consider the possibility of Consultants being 1st & 2nd on-call for the county, as opposed to having one Consultant on-call for each hospital. This could reduce the frequency of some consultant on-call duties. There would be a need for further discussion of the principles which would underpin arrangements for Consultant responsibility for emergency patients in these changed circumstances. This might be related to 'team' as opposed to 'individual' responsibility.

Any consideration of centralising any element of emergency surgery is constrained by actions already taken and under consideration with regard to centralising other aspects of services. For example, all ENT in-patients are already at Monklands. Similarly, all in-patient maternity services for Lanarkshire are provided at Wishaw. The group conducting the Review of Child Health for Lanarkshire has recommended that all in-patient paediatric activity, both elective and emergency, should now be formally centralised at Wishaw and that this should include all in-patient child surgery not presently located there. These 24/7 services both require immediate and separate on-site anaesthesia and other services. The nature of clinical risk in all matters obstetric and paediatric dictates the need for particularly robust arrangements in those areas. This makes any contemplation of a 'rotational' surgical receiving unit difficult.

BRIEF CONSIDERATION OF INDIVIDUAL SPECIALTIES & DEPARTMENTS

A. Intensive Care

It is a moot point whether Lanarkshire can or should continue to support 3 separate general Intensive Therapy Units (ITUs). At present, however, withdrawal of level 3 critical care (=ITU) from any of the sites would be contentious and unpopular with staff. As suggested above therefore, each of the 3 present ITUs would continue to be supported meantime with resident duty medical staff 24/7. The precise staffing arrangements may vary between sites. The ITU duty doctor will have that as his/her first duty, but overnight there will be a commitment to the hospital emergency care team.

B. Gynaecology

Appendix 1 includes some gynaecology patients. The numbers of emergency admissions in gynaecology are significantly less than in general surgery and orthopaedics. The requirements of the Working Time Directive can be complied with for gynaecology by withdrawing resident SHOs on 2 sites and centralising emergency gynaecology admissions. The overnight medical staffing for a centralised gynaecology service is inextricably linked with that required for obstetrics and these two specialties have to be considered together. A paper has recently been circulated within the Lanarkshire Obstetric/Gynaecology community regarding options for the future configuration of all gynaecology services. If change is to be made, it would be appropriate for it to take place at the same time as other changes (summer 2004).

C. Urology

A paper previously submitted to the Clinical Strategy Group proposed centralising urology in-patients (both elective and emergency) at Monklands. If change is to be made, it would be appropriate for it to take place at the same time as other changes (summer 2004). That paper proposed a separate urology junior medical staff rota. The need for that beyond 2100 hrs now needs to be critically examined. Protocols would need to be drawn up for the management of urology patients requiring surgery outwith 2100-0800.

D. Vascular Surgery

It has been intended to centralise vascular surgery inpatients on one site for several years now, but there has been a difficulty in identifying a centralised site as there have been conflicting pressures. If there is to be a centralised emergency theatre site, it might be appropriate to consider centralising vascular surgery there. If change is to be made, it would be appropriate for it to take place at the same time as other changes (summer 2004).

E. ENT Surgery

ENT surgery has had in-patient activity centralised at Monklands for several years. There are already protocols available concerning the management of ENT emergencies presenting at the other sites. Protocols would need to be drawn up for the management of ENT patients requiring surgery outwith 2100-0800. Junior medical staffing is under consideration in conjunction with neighbouring health boards.

F. Thoracic Surgery

The need for separate overnight junior medical staffing beyond 2100 hrs needs to be critically examined. Protocols need to be drawn up for the management of thoracic patients requiring surgery after 2100 hrs. Discussions may take place to consider the possibility of centralising thoracic surgery on a West of Scotland basis.

G. Maxillofacial Surgery

This has been a centralised service at Monklands for many years. Most emergency patients are transferred to Monklands for surgery. Occasional patients with other (multiple) injuries are operated on the other sites. These arrangements will probably need little change. Protocols would need to be drawn up for the management of maxillofacial patients requiring surgery outwith 2100-0800. Junior medical staffing is under consideration in conjunction with neighbouring health boards.

H. Ophthalmology

Overnight medical staffing requirements need to be critically examined. Protocols need to be drawn up for the management of ophthalmology patients requiring surgery after 2100 hrs.

I. Anaesthesia

The overnight medical staffing required in Anaesthesia follows from the above. A robust 24/7 on-site Obstetric Anaesthesia Service is essential, and a 24/7 general emergency anaesthesia service would be required on any centralised theatre site (CEPOD/trauma by day). Emergency Anaesthesia services on non-centralised sites would be required during the agreed hours of theatre availability. As noted earlier, the pattern of future service provision will be strongly influenced by the views of the Consultants.

J. Other specialties & Departments

E.g. Radiology, Laboratories, Pharmacy, AHPs. There will undoubtedly be some implications for other specialties and departments in the paragraphs above, but we do not think that these are likely to represent significant change from the present arrangements.

EXAMPLES OF POSSIBLE FUTURE PATIENT ARRANGEMENTS - IF EMERGENCY SURGERY WERE CENTRALISED OVERNIGHT

- 1) A 17 year old boy is seen in at Hairmyres A&E dept at 2030 hrs. He has typical signs & symptoms of appendicitis. His surgery could not be completed at Hairmyres before 2100 hrs and it is considered that it would not be reasonable to delay the commencement of his operation until 0900 the following morning. He therefore has IV fluids commenced, is given a dose of antibiotic, given analgesia, and transferred to WGH for surgery that evening by normal ambulance.
- 2) An 87 year old lady is brought to Hairmyres A&E dept at 2100 hrs. She has fallen, and clinical examination and X-rays are consistent with a fractured neck of femur. Her surgery can be safely delayed until the following morning. Her admission notes are completed by the A&E doctor and CXR & ECG are undertaken there. Blood samples are taken. IV fluids are commenced, and analgesia provided. She is admitted to the ward. She is seen by the orthopaedic SpR and by the trauma anaesthetist at 0800 the following morning and surgery takes place at 1030 hrs.
- 3) A 34 year old man is seen in Monklands A&E dept at 2300 hrs. His X Rays show an ankle fracture. His X-rays are reviewed on PACS by the Orthopaedic SpR on duty at Wishaw. He determines that surgery can be safely delayed until the following morning. The patient is therefore admitted to the ward at Monklands, given analgesia, and is seen by the orthopaedic SpR and by the trauma anaesthetist at 0800 the following morning. Surgery takes place at 0930 hrs.
- 4) A 25-year-old man is brought to Monklands A&E dept by ambulance following a road traffic accident. He has multiple rib fractures with a pneumothorax, several other bony injuries and requires a laparotomy. His initial treatment is observed via a video link by the duty Consultant surgeon at Wishaw. Following fluid resuscitation, insertion of chest drains, tracheal intubation & ventilation and immobilisation of fractures, he undergoes 'ITU transfer' directly to theatre at Wishaw. [This scenario can obviously be avoided by appropriately involving the ambulance service. Discussion would be required on the risks and benefits of doing that.]

- 5) A 70-year-old man in the surgical wards at Monklands, who is 3 days post hemicolectomy, complains of shortness of breath. His urinary output is poor, but apart from a modest tachycardia and slight hypotension, his vital signs are otherwise stable. He is seen initially by one of the nurse members of the 'hospital emergency care team'. She measures his SpO₂, which is low, so she commences oxygen therapy. She performs an ECG that is computer-reported as showing sinus tachycardia and lateral ischaemia. She listens to his chest and hears some crepitations in both lung bases. She takes bloods for FBC, U&E and blood gases. She then speaks with the emergency team leader to advise him of her suspected diagnosis of mild left ventricular failure.

NUMBERS OF JUNIOR DOCTORS

The total number of trainee medical staff in Lanarkshire is unlikely to change significantly as a result of these proposals. A small number of posts may require to be re-designated. This might particularly be the case where additional trainee posts have been created solely or mainly to permit the formation of 'compliant' rotas in specialties which would have some functions centralised. Moreover, some posts will have to be earmarked for the second year of foundation training. Specialties which would have some functions centralised would require to commit staff both to a centralised rota and to the hospital emergency care teams. The alternative would be to re-designate some posts between specialties. The Postgraduate Dean will need to be consulted on the proposals. Numbers of doctors presently on duty on each site after midnight are shown in appendix 2.

CLINICAL GOVERNANCE AND CLINICAL RISK

All models of service provision contain some element of risk for patients, staff and health authorities. The existing model of service provision is certainly not risk-free. Although the suggested models for the future clearly have some risks that differ from those in the present model, it is our judgement that the overall risk in our proposals would be no greater, and probably less, than that in the present model.

CONSULTATION

Comments on this paper are now invited from all professional groupings and individual staff members. We see the thoughts outlined above as striking the best balance between meeting the requirements of the Directive and providing local access to services for Lanarkshire residents. Local access is clearly more important for frequent and recurrent ailments rather than once-in-a-lifetime occurrences. There is nothing unique in the proposals: all are in current use in other places.

NHS Lanarkshire does have to comply with the requirements of the European Working Time Directive in less than one year from now. 'No change' is not an option. It is freely accepted that any proposal, which is perceived in any way to 'diminish' a hospital will not be popular. However, expressions of opposition to these proposals will not be particularly helpful in themselves. Similarly, un-evidenced 'shroud-waving' is of little value. It has to be clearly understood that failure to support the preferred options and work constructively towards their implementation (or to produce fully workable alternatives) is not a 'vote for no change' and 'maintenance of the status quo'. It is rather to force re-consideration of options presently rejected. The comments sought are therefore:

- a) Is this overall a reasonable 'direction of travel'?
- b) How committed are surgeons and anaesthetists to the maintenance of 3 overnight emergency surgery facilities – or would they prefer rationalisation as suggested?
- c) Those concerned with facets not touched on within this paper and which might require specific consideration or particular additional measures put in place,
- d) Those relating to points within the paper – especially where reference is made to the need for further consideration/examination/protocols/attitudes etc, or
- e) Fully workable alternative proposals which can form an integrated part of the NHS Lanarkshire strategy for meeting the requirements of the Working Time Directive, and not just a solution for a particular speciality, department or hospital in isolation.

The last day for receipt of comments on this paper is 30 November 2003. We will hold local consultation meetings - including one for the Trust as a whole on 14 November (for which invitations will be sent separately).

Tjn 16/10/03

consultation paper

NUMBERS OF THEATRE PATIENTS

appendix 1

MARCH 2003 (APRIL 2002)

	Column 1 Patients started after midnight	Column 2 Patients finished after Midnight (Excl. Col.1)	Column 3 Patients started after 2100hrs (Excl. Cols.1&2)	Column 4 Patients finished after 2100hrs (Excl. Cols 1, 2 & 3)	Column 5 Grand Total Patients finishing after 2100hrs
MONKLANDS	7 (6)	5 (3)	3 (6)	18 (11)	=33 [4 ITU + 2 HDU] (=26)
WISHAW (Non- Obstetric)	7 (7)	2 (5)	5 (12)	16 (16)	=30 [6 ITU/HDU] (=40)
HAIRMYRES	6 (4)	13 (2)	13 (3)	18 (13)	=50 (=22)

Appendix 2

Doctors on duty after midnight at present

	Hairyres	Wishaw	Monklands	Comments	Totals
Med JHO	1	1	1		3
Med SHO*	1	1	2*	*inc COTE	4
COTE SHO	1	1	-		2
Surg JHO	1	1	1		3
Surg SHO*	2	1	2		5
A&E SHO	1	1	1		3
A&E SHO*	1*	1	1	* till 2am	2+
Orth SHO	1	1	1		3
Orth SHO*	1*	1*	1*	*? At home	3
Gyn SHO	1	1	1		3
Ob/gyn SHO*	-	2*	1	*1 at home/all	2
Anae SHO	1	1	1		3
Anae SHO*	1	2*	1	*1 MK-orig.	4
Ophth SHO*	1*	-	-	*? At home	1
ENT SHO	-	-	1		1
ENT SHO*	-	-	1*	*? At home	1
Thor SHO	1	-	-		1
Oral SHO*	-	-	reg. service.		N/a
TOTALS	14+	15	15		44+

SHO* = SHO/SHO3/ S-G or A-S

'Surg' includes urology

Ignores paediatrics & psychiatry presently in LPCT