

Interviews on Emergency and Trauma Surgery
April - May 2005
Summary

Results based on 33 interviews out of a possible 68 permanent posts. 21 Anaesthetists (3 Hairmyres, 9 Monklands, 9 Monklands), 8 General Surgeons (5 H, 3W) and 4 Orthopaedic consultants (2H, 2M).

Total distribution: 10 Hairmyres, 11 Monklands, and 12 Wishaw.

1. Givens

Having considered all of the 'givens' above, do you think it is possible to maintain the "status quo" for emergency general surgery / trauma surgery / HDU / ITU?

If not, what are the reasons why the service needs to change? Does this change have to be achieved within a specific timescale?

Generally agreed the givens. Comments made: thoracic (problems in Glasgow), do not accept that consultants cannot be recruited and disagreed with WT targets.

1b. Status Quo Sustainable

7	- sustainable
20	- not sustainable
6	- don't know, or case not been made

2. Alternatives for Speciality

Alternatively, what Emergency Service would it be possible to sustain in your own speciality on three sites simultaneously? What would be the consequences of doing that?

Anaesthetics	4	- no change
	9	- need to reconfigure services
	1	- don't know
GS	1	- no change
	3	- need to reconfigure services
Orth		need guaranteed theatre and more consultants
Some did not answer		

3. Most Workable Option

Can you describe what you think would be the most workable option for emergency general surgery?

Anaesthetists	9	- one centralised site
	5	- two sites
	2	- status quo
	2	- one or two sites
	4	- don't know
GS	2	- one centralised
	2	- two centralised
	3	- status quo
Orth	4	- status quo

4. Differences OOH

For this option would there be any differences between within and out of hours?

Comments made:

- Monklands 23 hours site for day surgery
- Need the ability to take patients back to surgery on same site (most common comment)
- 24 hour centralised site (with 2 theatres)
- Consultants will need to come in more often and stay longer OOH
- CEPOD surgery work the next day on local site
- May need a specialist “flying squad” for OOH for non centralised sites
- Rotate centralised receiving
- Non centralised site would have reduced staffing during the day
- Have a fully fledged service 24/7 on two sites
- Increase access for emergency work within hours

5. Admit Direct to Centralise Site

**If there is a “central site” for emergency general surgery should patients initially be directed to their nearest hospital or direct to the “central” site?
Do you foresee any problems with either initial referral to local hospital and transfer or direct referral to any “central” site?**

27	- admit direct
3	- admit to local for assessment
3	- don't know

Issues:

- Define what emergency is
- Need appropriate staffing and support on centralised site
- Issue of bed capacity on centralised site
- Transfer of patients is never at zero risk, do not transfer unless stable
- Concern about need to escort and additional demand on shock team
- Need to work with GPs and ambulance service as well as patient education
- Need to avoid duplication of assessment.

6. Admit and Transfer

Similar to 5.

7. Other Specialties Required on Centralised Site

**If emergency general surgery were centralised on 1 or 2 sites, are there any other specialties that would need to mirror this arrangement?
If so, what other specialties would need to separate emergency and elective and co-locate with emergency general surgery?**

Vascular, anaesthetics, ITU and HDU (raised by most respondents)

Range of other services suggested including:

- Full range
- Dialysis
- Urology
- Gynaecology
- Renal
- Orthopaedics
- General medicine
- Paediatrics

- ENT
- Upper GI Bleeds
- Maternity

8. Which Hospital

Are there clear reasons which would make one or two hospitals more suitable for provision of Emergency Services than the third?

If one site only:

- 20 - Wishaw
 - 3 - Hairmyres
 - 1 - Monklands
 - 4 - Don't know / No view
- Some did not answer as had not accepted centralisation.

If two sites, the second would be:

- 1 - Wishaw
- 4 - Hairmyres
- 3 - Monklands

9. Issues for ITU and HDU

What are the issues with regard to ITU & HDU?

- 1 - No change
- 14 - Need to remain on non centralised site (for medical and complex electives)
- 19 - Need to expand the centralised site
- 2 - If ACAD on one site then do not need ITU or HDU
- 2 - Don't know

10. Issues for A&E

What are the issues with regard to A&E?

Range of responses given:

- Increased demand on receiving site
- Public need to know where to go easily
- Trauma centralised and minor injuries on other two sites (6 respondents)
- If A&E remains open on local sites then need the ability to operate in an emergency.
- A&E and HECT staff will need to transfer patients for surgical expertise (4 respondents)
- Ideally close non centralised sites A&Es
- 3 A&E stay open
- Reduce to 2 A&Es
- ACAD with no A&E for one site.

11. Issues for Elective Surgery

What are the issues with regard to elective surgery?

Range of responses given:

- Hairmyres could take elective work from other sites
- Expand date surgery
- 23 hour model for day surgery should be used at Monklands
- OOH care for complex cases would need to be provide
- Need to move off the centralised site (most frequent comment)
- Need to clarify the "spectrum of urgents"
- Centralisation for anaesthetics would lead to a reduction in ability to do elective work

- Separate electives and emergency cases (in order to ensure access to ITU, HDU and to avoid cancellations)
- Need capacity to reopen theatres for electives for patients who need to return to theatres OOH
- Concern about spilt site working (particularly from surgeons)

12. Supporting Arrangements

Are there any other supporting arrangements that would need to mirror emergency general surgery?

Most common – labs, radiology (especially interventional), pharmacy, ITU, HDU
 Others – AHPs, ECG, Cardiology, Improved transfer arrangements, blood transfusion, paediatrics, geriatrics, more juniors, plaster clinics.

13. Impact on Emergency Medical

Do you have a view on how such changes would impact on emergency medical receiving?

- 6 - Not sure
- 2 - Concern about access to anaesthetics advice on non centralised site
- 7 - Increased demand on the centralised site
- 11 - Concern about lack of access to GS on non centralised site
- 1 - Centralised site close earlier to med admissions
- 1 - Not a big impact.

14. Any other factors

Any other factors to take into account?

Issues raised:

- Many staff will retire soon, need to make posts attractive for recruitment
- Concerns about patient transfer arrangements
- Staff travelling between sites should be avoided
- Cannot see “carrots” to offer people – staff openly talking about leaving
- Not convinced by the option appraisal process carried out with general surgeons
- Has anyone asked patients currently using services
- Centralisation may make ITUs unviable
- Want to keep a balance workload (emergency, elective, day and inpatients)
- What about changes that might take place in bordering health systems
- Anxious that a decision should be taken soon and that this should be decisive and be for the longer term
- Concern about providing emergency care on one site and having elective ill patients on another site.

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