

**Report on
General Surgery and Critical Care Configuration Meeting**

**Wishaw General Hospital
Friday 23 September 2005**

Present:

Tim Davison
Dr John Browning
Ian Ross
Susan Goldsmith
Rosemary Lyness
Dr Jane Burns
Dr Rory MacKenzie
Mr Hakim BenYounes
Mr Hector Campbell
Mr Dermot Murphy
Mr Bill Thompson
Mr Hasan Kasem
Joan James
Martin Carberry
Stephen Bowhay (Area Clinical Forum)
Hugh Sweeney (Area Partnership Forum)
Jonathan Todd
Marlene Fraser
Irene McKie
Pam Milliken
Cathy Dunn

1. Introduction to the day

Tim Davison welcomed the group to the meeting and thanked them for contributing their time. He outlined that the purpose of the meeting was to inform the Picture of Health document in relation to acute hospital configuration. It is intended to go out to consultation on A Picture of Health in January 2006. The aim of the day is to:

- Articulate a sustainable preferred configuration for anaesthetic and general surgical services
- Agree how long the current configuration of anaesthetic and general surgery services can be sustained and to set out clearly why and when the current services configuration becomes unsustainable.

2. Background

Dr John Browning set out the background to the meeting. In 2003 a paper was produced by the Acute Division Associate Medical Director, "Hospital Services after August 2004". This described changes required to meet the New Deal for Junior Doctors and introduced the concept of the Hospital Emergency Care Team. It was noted that these changes would have an impact on the workload of consultants and this has proved to be the case. Many of the drivers outlined at the time have remained the same (e.g. population changes, rising emergency admissions, workforce changes) and the impact of Modernising Medical Careers is now becoming clearer. The proposal in this paper was for overnight general surgical receiving to take place on one site only with daytime receiving continuing on all three sites. The General Surgeons did not agree this proposal and an option appraisal was undertaken in early 2004 with General Surgeons. This considered a range of options including:

- Receiving and operating on emergency surgical patients on all 3 sites
- Emergency surgical patients received at all three sites; those requiring surgery overnight transferred to a central site.
- Two permanent sites for emergency surgical receiving and operating

- One permanent site for emergency surgical receiving and operating
- One rotating site for emergency surgical receiving and operating.

At an early stage the options of one overnight site and 2 permanent sites for emergency receiving were excluded. The latter option made the assumption that ITU would continue on the third site and this led to the option being excluded, as the anaesthetic rotas required were too onerous. Of the remaining options the preferred option was the one permanent site for emergency surgical receiving and operating.

Dr J. Browning noted that the work of the General Surgeons was then reviewed in light of the wider Picture of Health programme. This includes the aim to develop local ambulatory services and has seen proposals for the reconfiguration of urology, gynaecology and haematology on to one inpatient site as well as the move of inpatient thoracic services to the Golden Jubilee. These have been clinical driven proposals. He noted that overall bed-modelling work had been completed and discussions had taken place with a range of staff on General Surgical and Anaesthetic changes.

He stressed the need to develop a clear clinical consensus on how to take forward the acute configuration and that this should be built on evidence. This meeting will be followed with a similar one looking at acute medical receiving.

3. Critical Care Models and Rota

Dr J Burns provide a presentation on critical care models and rotas (the paper on Future Options for Critical Care in Lanarkshire and the presentation are attached). She outlined that following the original option appraisal it became apparent that the anaesthetic considerations for a one or two site model for general surgical receiving were quite complex and the staffing building blocks would have to be considered in greater detail. She highlighted she had to make an assumption as part of this work that all anaesthetic staff could be distributed as required across Lanarkshire.

The presentation covered the work of the short life-working group on Critical Care. This identified that critical care (ITU) supports medical receiving and A&E and that the medical cover for ITU should be anaesthetic with potential support from critical care practitioners.

She outlined work she had completed to calculate the number of WTE medical staff required in anaesthetics and critical care in order to provide cover for a number of options for service delivery. All elements of anaesthetic services were included in this (ITU, obstetrics, emergency theatres and elective sessions). She aimed to balance the commitments of anaesthetists across these elements with 4.5 programme activities on core services per week. In line with the Kerr Report she had assumed a 1:8 on call rota.

The Royal College guidelines are that ITUs over 8 beds should have a double team and she had assumed an enhanced team for a two site option of two 9 bed ITUs. T. Davison noted that he felt that a double team would not be affordable and has formally raised an objection to the number of anaesthetic SPRs Lanarkshire receives.

It was noted that for theatres there were some difficulties getting detailed information for the current services in relation to theatre usage and occupancy. It was agreed that a system of prospective data capture was required (this can be informed by a national benchmarking project). The group agreed that even with the limitation of data that at least 2 emergency theatres would be required.

It was noted that the calculations were undertaken on 12 programme activities and that the move to 18 week waiting times had not been factored in.

She considered the demand for:

- ITU provision
- Obstetric provision

- Emergency theatre provision
- Trauma theatre provision

She considered the options of anaesthetic configuration:

- Option A - Status quo
- Option B - Single site receiving and 3 ITUs
- Option C - Two site receiving and 2 ITUs.

The conclusions were:

Option A

The status quo was not a sustainable. There would be risk issues such as recruitment and retention but the single biggest risk would be training recognition, as the training split for junior doctors would be too skewed to ITU. This would impact with the EWTD changes in 2009. Until 2009 as the junior doctors have more hours available they are able to carry out more theatre work. Critical Care Practitioners could not decrease the % of junior doctor time, as these practitioners cannot replace a doctor if there is only one covering. Recruitment of consultants will be difficult in the medium term as anaesthetic consultants are now specialising in intensive care and such consultants will not want to work in a small unit. Hence it was noted that there would be quality of care issues about sustaining these ITUs. This option however could be sustained until 2009.

Option B

For the single site receiving option the concerns related to how cases such as GI bleeder would be dealt with and how to cover the take backs for major electives. However the major risk would be that 3 out of 4 of the junior doctors rotas would be in ITU (75%), which again would affect their training status. Even with the development of Critical Care Practitioners and critical care SHOs the time spend in ITU would only decrease to 60%. Two of the ITUs would also be quite small and one (2.5 beds) would probably be unsustainable. This option would also have a serious hit on the elective programme. It was also felt that consultants would have concerns about being on call for a site that was further than 10 miles or 20 minutes travel time from their home. Hence there would be a risk of losing consultants if the option was for them to move house or be resident on call. It was noted that Option B(iii) single site receiving with 2 ITUs did not include the staffing required for a transfer team.

Option C

The two site receiving and 2 site ITU option was viewed as the most sustainable. This would mean two 9 beds ITUs. The junior doctors would still undertake 50% of their work in ITU but the ITUs would be recognised for training. This percentage could be decreased as low as 33% if Critical Care Practitioners and SHOs are available. This option would require a modest increase in consultants but it is possible that senior Associate Specialists could take up some of this workload as they can take theatre on call if there is a consultant on site. This model would be the most future proof, as it would support intensive care moving to a separate speciality. It was also noted that this would provide better quality of care intensive care and it was felt that the cost in terms of family distress of poor ITU decision-making was high.

T. Davison noted that the conclusion reached by the Anaesthetists was in line with what is emerging from other Scottish Health systems where the number of ITUs and major acute sites are being reduced.

In summary, the Anaesthetists preferred option is two sites receiving with 2 ITUs. This would provide the most sustainable and highest quality option. It would be possible to continue to support the status quo until 2009 with some transitional support for increased junior doctor hours and Critical Care Practitioners.

Overall the Surgeons agreed that they would sign up to a two-site option as a direction of travel although it was queried whether the two site option with ITUs on both sites could support one site taking emergency general surgery and one site taking major electives.

4. General Surgery and Orthopaedic Rotas

Mr H. BenYounes provided a presentation on the work undertaken by the General Surgeons to date. This was supported by papers on Rota Proposals and Site Option Summaries for General Surgery (Emergency and Elective). These are attached.

He noted the original option appraisal outcome and that this work has been reviewed in light of the anaesthetic concern about sustaining ITU on more than two sites.

The papers provided set out in detail the rota configurations and the paper on Site Option Summaries gives the implications of the options. These are:

One Emergency General Surgery Site Option

- Will meet the demands of Kerr Report to separate emergency from elective programme.
- It will develop a consistent and efficient way of managing surgical admissions for NHS Lanarkshire.
- Opportunity to form a robust 24-hour emergency cover Middle Grade experienced tier for NHS Lanarkshire.
- By centralising emergency receiving, this will allow the formation of Sub Speciality Units e.g. colorectal will be a Unit with 9 Consultants, which will lead to a higher quality of service.
- By consolidating emergency workload this will maximise training opportunities for junior medical staff.
- This is the most sustainable and flexible option which maximises staffing e.g. will reduce number of Consultants required to cover emergencies and therefore free up time for elective programme.
- Geographically there would be issues with Patient Access
- Increased intensity during the emergency week.

Two Emergency General Surgery Sites Option

- Does not fully meet the requirements of the Kerr Report, as you will still have a mixture of emergency and elective activity on any 2-hospital sites.
- Opportunity to form a robust 24-hour emergency cover Middle Grade experienced tier for NHS Lanarkshire.
- Could lead to different approaches and therefore have inconsistencies in the approach in the emergency receiving for NHS Lanarkshire.
- Potential problems with capacity to cope with all emergency activity – Medical and Surgery – on 2 sites.
- Still allows some flexibility with Consultants to improve current elective activity.
- For junior medical staff training opportunities, this would be an improvement from the existing 3-site option.
- Geographically it would be easier patient access for 2 sites.
- On 2 site emergency receiving option, it is not sustainable to have a 24 hour robust experienced Middle grade rota and this would lead to less daytime activity unless 1 site will be dedicated to elective activity and the other dedicated to emergency receiving. The frequency would be 1/6. However to sustain this option, 1/8 cover would be required. This would require four additional Staff Grades, which would incur additional costs. The Staff Grade cost would be £46,053 (based on 12 sessions) total cost of £184,212. This does not include on-costs.

Three Emergency General Surgery Sites Option

- Does not fully meet the requirements of the Kerr Report as you will still have a mixture of emergency and elective activity on any 2 hospital sites
- Inefficiency in running 3 theatres out of hours on each of the hospital sites.
- Gaps in the Middle Grade cover for daytime activity. One option would be to have 2 additional Staff Grades (based on 12 sessions), one for Monklands Hospital and one for Wishaw General Hospital. The Staff Grade cost would be £46,053 x 2 (based on 12 sessions) = £92,106. Depends on the outcome of the thoracic surgery provision, it is

possible that the 5 SHO's in thoracic surgery will contribute to the senior SHO rota. If the SHO's are not available then the frequency would be 1:6. This would be difficult to sustain. Therefore additional two doctors at SHO level are required at Hairmyres Hospital. The SHO cost would be £45,627 x 2 (based mid point at band 2b) = £91,254. The total cost would be £183,360. This does not include on-costs.

- One NHS Lanarkshire rota for Middle Grade doctors would mean a difference to their current working arrangements. They currently do not work over night and to implement this would have an impact on elective activity on all 3 sites.
- Geographically this option is good for patient access.
- Training opportunities for junior medical staff would be diluted.
- The junior medical component of the team would either be in surgery or orthopaedics therefore this dilutes the experience of the team.

Mr H BenYounes noted that with the one site option the consultants would have 18 weeks out of 21 weeks for elective work where as for the two site option 16 weeks out of 21 weeks the would be available for elective work.

He noted that with the introduction of the FY2 in August 2006 there will be less experienced juniors available and they will not be able to work unsupervised at night. A solution to the deficit this creates is required by August 2006. A proposal to address this, in line with MMC, which supports SHOs receiving more general exposure, is to combine the orthopaedic and general surgery rotas out of hours. This would provide the opportunity to match up a more experienced FY2 in one speciality with a FY1 from the other speciality out of hours. He noted that agreement for this would need to be secured from the Orthopaedic Consultants. Currently, orthopaedics have a middle grade on call 24 hour a day. During the day these staff would be based in their speciality. Dr J. Burns identified that at Hairmyres there was not overnight orthopaedic cover.

The requirement to make the case for a greater distribution of SPRs for Lanarkshire was again highlighted.

Mr H. BenYounes also noted that currently the General Surgery SPRs and Staff Grade work until 9pm at night. An option would be to have a rota of these senior staff available at night across Lanarkshire providing support to their base site and telephone support to other sites. There will be human resources issues in making this change.

Hence, the middle grades doctors would be required to work a combined rota for out of hours work in order for the status quo to remain sustainable from 2006 to 2009.

The interim continuation of the status quo will mean the continuation of the current level of consultant workload. It was noted that the age profile of the current consultants should be considered as some may only be prepared to continue working at this pace for a limited timeframe. This was felt to be an important driver for change.

An additional driver for change for the General Surgeons would be the opportunity to separate elective from emergency work. Surgical specialisation is also a driver and an elective site would enable specialities to target their elective work. This would be possible for some specialities such as breast surgery to be on a site without an ITU and this could include 23-hour surgery. The General Surgeons felt that this benefit would be increased if one of the sites with an ITU were for major electives only. This would avoid the current competition for beds with emergency patients.

Dr J. Browning noted that under a 2 site option where both sites had General Surgery receiving it would be possible to separate elective and emergency activity if the capacity for emergencies was set correctly and there was ringfencing. This would be support by the third site undertaking day cases.

I. McKie said that the bed modelling work undertaken so far has considered average bed occupancy rather than bed establishment to model the new configuration. The bed requirement would also need to be set slightly higher to take into account peaks in demand. The requirement to meet the targets for reduced waiting times would also need to be factored in as well as the issue that the current occupancy level is higher than is desirable and the intention to convert emergency care where possible to planned care.

5. Plenary on the Agreed Preferred Option

The meeting agreed:

The preferred future option for General Surgery and Critical Care was a two-site option. Within this option there are two sub options:

- Two sites with both emergency receiving and major electives. These sites would be similar to each other except that one site would have obstetrics and paediatrics. There would also be some specialities with inpatient beds on only one site in line with the proposals for urology and gynaecology. The Anaesthetists favoured this sub option, as the balance of services across sites would give the optimum rota configuration and sustainability of ITUs.
- One site providing General Surgery emergency receiving and the other site major electives. The General Surgeons favoured this sub option as it facilitated the separation of emergency and elective activity.

The Status Quo was agreed to be sustainable until 2009. This would require additional support for Anaesthetics in relation to increasing junior doctors hours and development of Critical Care Practitioners. For General Surgery a combine middle grade rota with orthopaedics would be required from 2006 as would some additional support and change in working practices for staff grades and SPRs. These would be time-limited solutions

It was noted that a configuration of two major sites with ITUs and a third site without an ITU would be a major change including potential major capital considerations. This may mean that the desired timetable of 2009 would be difficult to achieve. The achievement of the timetable would be supported if the maximum level of services could be provided at the third site, thus reducing the bed capacity required on the major sites.

6. Services on the Third Site

Consideration took place of the services, which could be provided, on the third non-major site. These services would not have on site access to an ITU.

These were agreed as:

- All day surgery including an expansion for 23 hour day surgery
- Ophthalmology
- Some elective general surgery (breast, hernia)
- Orthopaedic – some inpatient
- Some geriatric assessment
- Rehabilitation
- Psychiatry
- Palliative care beds
- Haemodialysis

In doing this several principles were noted:

- I. Diagnostic and day cases will be available on three sites
- II. Consultants should work across no more than two sites
- III. Access to services on all three sites should be retained far as possible for the local populations.

7. Clinical Advantages and Disadvantages of Options

The group considered the clinical advantages and disadvantages of the options. The options considered were the Status Quo, the preferred option of two major sites with ITU and medical receiving on both sites and the option of two major sites with ITU and medical receiving on all three sites. These are listed in Appendix 1.

8. Site Options

The group considered the advantages and disadvantages of each of the current NHS Lanarkshire acute hospitals being either a major site with ITU and the third site without an ITU. These are listed in Appendix 2.

9. Timeline

A timeline for actions required in the lead up to 2009 was set out:

Date	Timeline
September - October 2005	Develop options
October - November 2005	Appraisal of the options
November 2005	Options completed (Start business case, sites pros and cons identified)
December 2005	Picture of Health Paper to the Board
January – April 2006	Formal Consultation of A Picture of Health
January – April 2006	Formal option appraisal
May 2006	Outcome of option appraisal and consultation to Health Board
May 2006	Submission to Minister for approval
August 2006	<i>FY2 combined surgery / trauma rotas</i>
September 2006	Decision from Minister
September 2006 – May 2007	<i>? Scottish Election</i>
August 2007	<i>Run through Grade Thoracic moving Anaesthetic Hours decreasing</i>
August 2007- August 2009	<i>Commence training of critical care practitioners - implementation</i>
December 2007	<i>Waiting times – maximum 4hr target 24hr Hip fracture audit 18 weeks Cancer waiting times 16 weeks ophthalmology 16 week CHD</i>
February 2009	<i>Target date for implementation</i>
August 2009	<i>New Configuration operational</i>

10. Future Work

A list of further work required arising from the day were agreed as:

1. Undertake a travel and transport analysis for each site
2. Prospective theatre data capture- standardised – to commence as soon as possible
3. Anaesthetic rota calculation for option 2B
4. Interim SHO solution for FY2 August 2006
5. Interim solution for Urology SHO reduction at Hairmyres and Wishaw
6. Confirm catchments population for Hospitals
7. Agree assumptions and model activity and theatre capacity
8. Quantify activity that can be converted from emergency to planned care (review cancer data base)
9. Communication Plan – arrange meets with Surgeons, Anaesthetists and Orthopaedic

In support of this communication plan a list of planned events were set out. The confirmation column identifies if the actions are in place to deliver this.

Date	Timeline	Confirmed
27 th September	Meeting with Kevin Woods Chief Executive NHS Scotland	Yes
28 th September	Meeting with Physician, A&E Consultants	Yes
7 th October	Meeting with Tom Divers	Yes
10 th October	Meeting with the Area Medical Committee	No
12 th October	Meeting with Area Clinical Forum	No
12 th October	Meeting with the NHS Board	No
14 th October	Meeting with Andy Kerr	Yes
25 th October	Hairmyres Medical Staff Association	Yes
27 th October	Wider Stakeholder Meeting	Yes
3 rd November	Monklands Medical Staff Association	No
	Wishaw Medical Staff Association	

Appendix 1: Clinical Advantages and Disadvantages of Options

Option 1 Status Quo	Option 2 2 Sites ITU- 2sites emergency medical	Option 3 2 sites ITU 3 sites medical receiving
Advantages	Advantages	Advantages
<p>Easier geographical access Minimum cross site working Maximum cross cover between specialties Few emergency transfers</p>	<p>Sustainable for anaesthetics and general surgery Maximum of two site working Two good sized ITUs Supports training Specialties concentrated on one site Recruitment Easier to have two equal sized hospitals Facilitates an Intensive care specialist only rota Specialists in ITU More consistent clinical practice (Interferes with the elective programme) Better capacity for electives Reduces waiting times</p>	<p>Better access for medical admissions Less disruption to beds and staff Surgery and Anaesthetics same as option 2</p>
Disadvantages	Disadvantages	Disadvantages
<p>Sustainability Interferes with elective programme Inefficiency Quality (ability to specialise) Labour intensive rotas Less effective training Loss of training accreditation Smaller ITU Units Recruitment</p>	<p>Still duplication Inconsistency of patient care Access reduced for patients Disruption due to change- lose staff More transfers if you concentrate subspecialties</p>	<p>No support to 3rd site for anaesthetics or general surgery High number of medical transfer Increased patient risk on the third Lack of physician support</p>

Appendix 2: Site Options

Hairmyres Elective non major site	Hairmyres ITU, Emergency GS, Major Electives	Monklands Elective non major site	Monklands ITU, Emergency GS, Major Electives	Wishaw Elective non major site	Wishaw ITU, Emergency GS, Major Electives
Advantages	Advantages	Advantages	Advantages	Advantages	Advantages
Smallest activity Adaptability Ophthalmology	Regional perspective ITU Cath lab Room to expand Space for maternity Recruitment of medical staff	Purpose built facilities (cheaper) Cheaper to expand / reconfigure	Airdrie Health Centre moves Feb 2009 Renal Communicable diseases, ENT inpatients Deprived community Regional perspective	Theatre capacity Purpose built psychiatry Relocate Wishaw Health Centre Less impact on Glasgow	Maternity Paediatrics Theatres ITU PFI (potential) Capacity
Disadvantages	Disadvantages	Disadvantages	Disadvantages	Disadvantages	Disadvantages
Move the Cath lab Increase follow to Glasgow Ageing population / increase demand for services Smallest number of theatres PFI	Too small Recruitment of nursing staff Attract activity from Glasgow	Facilities expensive to upgrade Theatre capacity Renal Communicable diseases A&E Emergencies will go to Glasgow Busiest acute site Highest mortality / morbidity	Size, infrastructure ? Space for paediatrics cath lab Regional perspective	Move maternity / paediatrics ? Too big	Psychiatry Increase cross boundary flow

