REPORT FROM THE OPEN MEETING

FRIDAY 31 AUGUST 2007

GENERAL SURGERY OF CHILDHOOD

This meeting was held in the Radisson Hotel, Glasgow where over 100 delegates attended. The format was one of several presentations followed by questions and answers with subsequent breakout/small group discussion sessions. The first session discussed the care pathways and the implications in the different regions of Scotland for these care pathways. Additionally, the suggested models of care were discussed. The second breakout session repeated small group work with the groups populated on a regional basis. This session evaluated the draft report from the regional perspective.

The delegates were asked to identify omissions, contradictions, and errors in the report.

The following themes received specific comment:-

- Succession planning.
- Package of care.
- Training and education.
- Drivers for change.
- Quality assurance.
- Service models.
- Levels of care.
- Transfer arrangements.
- Care pathways.
- Recommendations.
- Remote and rural considerations.
- Others.

The following is an extract of opinion/comments/advice provided by the open meeting delegates.

Succession Planning

- Advisory appointment committees (AAC's) should ensure that when a surgeon who currently provides general surgery of childhood is replaced, that that component of his/her job plan is identified and protected in the appointment process. It is recognised that this is often only one component of the job description but failure of any candidate to meet this requirement should result in directed training if that candidate is otherwise suitable for appointment.

- If a vacancy is anticipated in GSC, proleptic appointments should be considered.

Package of Care

- A multi-specialty provision is required for GSC to function effectively and safely. The component parts of the package of care comprise General Surgery, Anaesthesia, Paediatrics, Nursing, Radiology, PAMS, Paediatric Environment. All component parts should be present before a service is endorsed as satisfactory.

Training and Education

- Identification of incentives is required to recruit general surgeons into this apparently “unpopular” specialty. If need be, these should include differential financial incentives.

- Current training programmes in special paediatric surgery in the United Kingdom are likely to over produce in the near future, so a workforce is available for regional appointments.

- A modular training package should be created to allow peri-CCT training, directed training for succession planning, and re-certification.

- Early exposure of general surgical trainees is not happening by virtue of the fact that these trainees are nearly all in urban hospitals which are not co-located with children's hospitals and which have no paediatric presence within them. There is therefore no early exposure to general surgery of childhood – which is prejudicial to recreitment into the subspecialty. Early rotation of general surgeons to paediatric surgery is required in a non-discretional manner.

- An “ST9” level should be identified for general surgery of childhood.

- CPD is different from study leave and is the responsibility of NES Scotland to ensure that all staff remain fit for purpose.

1. Drivers of Change

- General surgery of childhood lacks clear ownership. It seems to fall between the advocacy of Paediatric Surgery and General Surgery.

- Boards and regional planners must see this as an obligate service and not one that they simply choose to invest in as a low priority.

2. Quality Assurance

- The multi-disciplinary forums, which should be present in every health board region, must have quality assurance processes applied to them by QIS.

- Just as in education, prisons and other areas of public service, a quality inspectorate is required and this should review children's services.

- The recommendation of obligate presence of a paediatrician in a hospital where the general surgery of childhood is being carried out should be viewed flexibly, particularly if the anaesthetic and surgical staff have suitable competencies and there is a sufficient safety net of staff to assist them in the rare circumstance of an adverse event.

3. Service Models

- "One size does not fit all" - In that regard regional appointments will be of little value where geography is a concern (Dumfries/Yorkhill, Inverness/Aberdeen). In this situation an outreach service may well be the solution if accompanied by a local surgeon with responsibility for children.

- The use of telemedicine has been underrated and undervalued in this report. Substantial investment in this method of care has taken place and needs better awareness by all involved in providing outreach services.

- Shared regional appointments with a local lead general surgeon is the optimal service model.

- Shared appointments must have equity of loyalty and ownership.

- A supportive surgical infrastructure is required in the district general hospital for any outreach surgeon who may otherwise be somewhat isolated in their clinical function.

- Regional solutions are required to support this service and closer liaison between health boards and regional planning groups is needed.

- Multi-disciplinary forums should be an obligate component of the service and required quality assurance.

- An "elective first" model must apply everywhere. This implies that elective surgery should not be handed over to the specialist group, leaving the local surgeons with emergency care. There should be no emergency service without elective surgery being performed in-house. Elective practice must be maintained to support emergency experience.

- There is a potential for a single appointment from a specialist centre to work with multiple district general hospitals.

4. Levels of Care

- These levels must be applied flexibly.

- The level of care available varies according to the experience of the individual surgeon on call each night.

- A four tier model akin to the emergency care framework is required.

- This approach will be risky if applied too strictly. Hospitals may find a prescriptive approach intimidating and therefore work at a lower level than might otherwise be the case.

- Better definition of what is required for each level is needed.

- This is purely an organisational model and requires local interpretation and application.

- Level 3 needs split up.

5. Transfer/Transport

- The implications for families and the ambulance service could be enormous if local services are withdrawn.

- Retrieval teams could be overwhelmed by sick children who are not critically ill if local care is not provided.

- The costs of transport will be huge and outweigh the costs of any staffing solution.

- Neither retrieval teams nor local clinical teams will have the sufficient capacity to transport unwell but not critically ill children.

6. Care Pathways

- Primary Care needs to be aware of these.

- These are advisory only, and avoid making recommendations on head injuries.
- Each region should stylise the guidelines for their own needs.
- The pathway of care should start earlier.
- These fail to address assessment and diagnosis.

Recommendations

- These should be re-numbered with emphasis put on the service considerations.
- No. 7 is mandatory.
- There are two elements to recommendation 7 that should be separated.
- Multi-disciplinary forum is essential for each hospital.

Remote and Rural Considerations

- Are experienced anaesthetists sufficient for provision of care in acute and common situations, e.g. a 3-year-old with a buttock abscess requiring incision and drainage or a fracture. The obligate presence of a paediatrician in this situation is unnecessary and air /sea transfer of such cases is likewise not in the interests of child or staff.
- An outreach service is the only feasible supportive model for these hospitals.
- Telemedicine is key to supporting in-house function.

Further Considerations

- Resource and financial implications have not been referred to.
- The timescale needs better definition.
- Don't forget 12 to 16-year-olds in your conclusions.

7. Conclusion

The working party reviewed all comments and where appropriate re-drafted the report or left them as freestanding advice in this section.