Emergency Children’s Surgery

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Emergency General Surgery of Childhood

- Appendicitis, pyloric stenosis, acute scrotum, abscesses, minor trauma, incarcerated hernias

- Major trauma - managed by MTC

- Specialist emergency paediatric surgery – refer to tertiary centre unless time critical e.g. major haemorrhage
Shift of GPS from DGH to tertiary centres (48% DGH’s doing emergency GPS 2010)

- Inadequate exposure to GPS in training/lack confidence
- Superspecialisation – reduced exposure/deskilling
- Very busy high volume adult practices
- Inadequate succession planning
- Poor job advertising - no mention of GPS in job descriptions
- No ownership of paediatric surgical cases – cared for on paediatric wards by paediatricians
The aim of paediatric surgery is to set a standard not to create a monopoly” - Dennis Browne

We do NOT want to do all children’s surgery

Insufficient capacity in tertiary centres

NOT in patients/families best interests - far from home, time critical

Non-specialised children’s surgery and anaesthesia should be delivered through clinical provider networks (RCS, CSF)

Paediatric surgery in the DGH is a low volume, low priority service that needs protecting
How can you protect General Surgery of Childhood?

- Collaboration with others in your organisation (paediatricians, anaesthetists, managers, nurses)
- Collaboration with tertiary Paediatric Surgery Department
- Different models
Retaining the service model for paediatric surgery (a “hub & spoke” model) but strengthen it by the creation of a Paediatric Surgical Network.
Geography of the Southwest

Population 5 million from 2013 census data

850-900 000 are under 16
Paediatric Surgery in the Southwest

- Southwest Paediatric Surgery Network came into being in 2010 (Clinical Director and Network Manager)

- Developed local Standards of Care for Paediatric Surgery together

- Paediatric Surgery Department at Bristol Royal Hospital for Children (BRHC) (Hub)

- 10 DGH’s (Spokes) where general paediatric surgery of childhood (elective and emergency) is routinely performed

- Specialist paediatric surgeons do not routinely operate in the DGH’s

- BRHC is always the fall back
2 surgeons and/or urologists per DGH with an interest in general paediatric surgery, a paediatric list every fortnight, children’s outpatient clinics, an appropriately trained workforce, strong links with paediatricians and appropriate anaesthetic support

**BUT**

still an issue for emergency surgery when surgeons with paediatric interest not available/on call
Solutions and Problems

1. Move all Paediatric Surgery to Tertiary Centre
   1. Low volume speciality
   2. Dilute index workload of paediatric surgeons with GPS risks poorer outcomes
   3. Long distances for some patients away from family support
   4. No capacity in Tertiary Centres
   5. Problem for time critical conditions e.g. acute scrotum

2. Send all elective GPS to tertiary centre/Paediatric Surgeon in DGH
   1. if take away elective GPS from general surgeons and anaesthetists they will de-skill and emergency GPS will suffer.
3. Employ a Paediatric Surgeon in DGH

1. Unable to do index cases as no resources
2. Deskill general surgeons who are then reluctant to do the emergency GPS
3. Not sufficient GPS per centre to keep them busy

4. Train general surgeons to do emergency paediatric surgery
Proposal for new mutually beneficial training scheme

Problems:

- General Surgery trainees – inadequate exposure to paediatric surgery
- Paediatric Surgery Trainees – low volume, highly specialised cases with limited opportunity to rapidly develop basic surgical skills

SOLUTION

- Crossover training as part of new Shape of Training
Crossover training

- Some general surgical trainees spend 6 months in latter years of their training in Paediatric Surgery which will allow focused exposure to GPS - both elective and emergency cases

- Paediatric surgery trainees spend first 2 years of training in General Surgery developing basic surgical skills prior to starting specialist training in paediatric surgery

- 1 PS :: 4 GS (increasing the number of general surgeons to do GPS and improving surgical confidence of paediatric surgeon)
Emergency Children's Surgery in DGH within Paediatric Network

- Ensure adequate training of emergency general surgeons and anaesthetists
- Networks offers opportunities for CPD, multidisciplinary discussion and case review
- All staff maintain the skills - surgeons, anaesthetists, nurses etc.
- Local care for patients/easier access for families
- No problem with time critical GPS
- More capacity in Tertiary centre for specialised cases
- Tertiary Centre not diluted/swamped by GPS > better outcomes for specialised index cases
CCG’s

- Responsibility to local population
- Engage with Network
- Support the local hospitals in achieving the standards and commission them to do the GPS
Future for Children’s emergency surgery

- Combined initiative by the RCS, the Specialty Associations and the regional networks with support from the SCN’s

- Invest in appropriate training

- Robust support and CPD for surgeons doing emergency GPS through the networks
Conclusion

Do not forsake the children

Let's work together to ensure high quality care close to home where possible