

Response to RCS Standards for Non-Specialist Emergency Surgical Care of Children 2015 Consultation Document

A statement from



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About ASiT

The Association of Surgeons in Training (ASiT) is a professional body and registered charity working to promote excellence in surgical training for the benefit of junior doctors and patients alike. With a membership of over 2700 surgical trainees from all 10 surgical specialties, the Association provides support at both regional and national levels throughout the United Kingdom and Republic of Ireland. Originally founded in 1976, ASiT is independent of the National Health Service (NHS), Surgical Royal Colleges, and specialty associations. Governed by an elected Executive and Council, the Association is run by trainees for trainees.

Background

There has been a shift in paediatric surgery away from District General Hospitals (DGH) and towards tertiary centres. [1] This has a profound impact on provision of surgical services and surgical training. Children often have different needs to adult patients, in terms of their medical and surgical management, as well as distinct psychosocial issues. Many surgical specialties include a mixture of both paediatric and adult surgery. [2] In particular, several surgical specialties may be involved in the emergency care of children by non-paediatric specialties. [2] However, some surgical specialties such as otolaryngology or trauma and orthopaedics, may be classified as paediatric specialists in their own right.

Delivery of safe surgical care for children requires excellence in surgical training to equip surgeons with skills to manage the paediatric population. [3-4]. The approach to surgical care of children differs between the DGH and tertiary setting, although similar overall outcomes can be achieved. [5]

Several factors have had a detrimental effect on training including the European Working Time Regulation, making hours available for training a precious commodity. [6] In addition, centralisation of paediatric care to high volume centres has concentrated experience for paediatric trainees, but has reduced exposure of non-paediatric general surgeons to sick children. [1] Therefore, delivery of training to paediatric surgeons, and to non-paediatric surgeons is a challenge. It is important that children with surgical conditions have access to appropriately trained staff and are treated in a safe environment suitable for their needs. [4] This may involve initial assessment in a non-paediatric centre and referral to a facility with greater resources for definitive care. However, more commonly performed emergency paediatric surgical care, such as scrotal exploration for presumed testicular torsion, which requires prompt intervention, may be best delivered locally, where skills permit. [7]

We welcome the efforts of the Royal College of Surgeons of England to improve paediatric patient safety by setting standards for paediatric surgical care.

Response to Recommendations

Surgical care of the sick child is an important patient safety issue. ASiT welcomes the document as an effort to improve standards in paediatric surgical care.

- We welcome the inclusion of the entire patient journey in the consideration of care of the surgical paediatric patient.
- We welcome the emphasis on anaesthesia, paediatric and allied health professional training and skills. Adequate surgical training alone is not sufficient to provide safe emergency surgical care to children. Anaesthetic and paediatric expertise and input is essential in the care of the surgically sick child patient.
- We welcome the assertion that all staff assessing and treating young people must retain competency in the skills of resuscitation and management, and that all those who undertake resuscitation and transfer are appropriately trained. Resuscitation training could be delivered in a network setting reflecting the level of need of the local DGHs.
- We welcome the guidance that all hospitals have the required resuscitation equipment, as well as 24-hour access to services.
- We welcome the call for audit, including that of transfer pathways. Audit is key to improving outcomes and maintaining high standards. Audit of outcomes should be instigated to address care pathways in place and identify areas where improvement is needed. Currently, a national audit of the acute scrotum in childhood is underway via the trainee research collaborative network, which may inform care pathway planning. Trainee research

collaboratives are useful resources in implementing regional or national audits. Use of the collaborative network in performing audit may assist in collection of data that may inform strategic planning of paediatric surgical services.

- We suggest that audit of surgical training be included in the audit process. Exposure to paediatric cases and level of comfort and competency with paediatric emergency surgery should be assessed to identify correctable deficits in surgical training.
- We welcome the call for educational arrangements between DGH's and tertiary paediatric centres to facilitate continual professional development and refresher courses.
- We welcome the recommendation that emergency surgical care be provided within a network of both secondary and tertiary care providers. Clear protocols and pathways for transfer of the critically unwell child are important.
- For those cases deemed suitable to be managed at a DGH level (e.g. testicular torsion), the surgical specialty taking responsibility for the care of the child must be clarified at an institutional level, not be negotiated between consultants or trainees on an ad hoc basis. The availability of anaesthetic support must also be made clear in Trust policy. If these resources are not available, a clear transfer protocol must be available. It is unacceptable for trainees to be performing procedures, which their supervising consultant does not undertake. In the absence of each of these, patient safety is compromised.
- Adequate pre and inter hospital resources are essential to allow prompt and efficient transfer of a sick paediatric patient once the decision has been made to transfer to a centre more appropriate to their needs.

- We agree that basic skills in paediatric surgical care should be a requirement for CCT in many surgical specialties. Some curricula already have paediatric skills as an integral component for CCT, e.g. trauma and orthopaedics or otolaryngology, while others may require adjustment to reflect this. [9]
- However, curricula should avoid making attainment of paediatric skills a "tick box" exercise. For general surgery and urology trainees, many trainees will ultimately work in hospitals with no paediatric surgery or paediatric emergencies. A specific paediatric surgical rotation in the latter years of training for this group of trainees is an inefficient use of their already reduced working time, and takes away training opportunities from colleagues. Delivery of basic paediatric surgical training to non-paediatric surgeons may be delivered through a modular-based approach or dedicated theatre lists that fit within other sub-specialty rotations. A taught course or bootcamp on paediatric emergency surgical care, may also be an efficient method to deliver training in basic paediatric emergency surgical care in a standardized fashion to non-paediatric surgical trainees. This may be appropriate as a means to fulfill CCT requirements.
- We welcome that a named Consultant be in charge of the care of the patient at all times. We note that the recommendation is that during a transfer the care remains under the transferring Consultant until the receiving Consultant has seen the patient. We suggest that this be amended to "the receiving Consultant, at the point when the patient is first reviewed by the surgical team at the receiving hospital". If a trainee sees the patient, they should have appropriate Consultant cover- we do not feel that a Consultant in the transferring hospital is appropriate cover for a trainee seeing the patient in the receiving hospital.

- We welcome the call for paediatric involvement in surgically unwell paediatric patients. We feel the arbitrary time interval of 14 hours prior to assessment by the paediatric Consultant is a relatively long time and that this should be amended to "or sooner if requested by the surgical team". It is important that children with surgical problems have prompt access to senior paediatric care and input as required.
- We note the document states that a Consultant should review hospital inpatients, at least once every 24 hours, 7 days a week. While we welcome Consultant input, for well patients it may be appropriate for a surgical senior decision maker (trainee or Consultant) to see the patient- for example, a well post-operative appendicectomy patient. Depending on the child's needs, a paediatric senior decision maker may also be required.
- We welcome the call for adequate supervision of trainees, but emphasize that senior trainees must progress to an appropriate level of independence for their stage
- Training in surgical care of children should include surgical courses and bootcamps, paediatric emergency care and resuscitation training We feel that training in the care of sick children should be provided at no additional cost to the trainee. Surgical trainees face considerable expenses, both at undergraduate and postgraduate level. [10-12] It is important that trainees do not bear the cost burden of improving paediatric care. Children must not be denied access to appropriately trained staff because of financial constraints.

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Further reading

ASiT has published a number of statements that are available at

<http://www.asit.org/resources/articles>