

Evolution of Remote and Rural Acute Services in Stranraer, Scotland

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Stranraer is a town of 13,000 people in a rural part of the extreme southwest of Scotland. It is a busy ferry port and farming community served, until ten years ago, by a small hospital staffed by a single-handed surgeon and latterly by a surgeon or physician. The constraints of limited laboratory and radiological facilities and a lack of high dependency support reduced the scope of procedures undertaken. Recruitment to the post of Consultant Surgeon was further compromised by statutory regulations permitting only those with a Completion Certificate of Surgical Training (CCST) to be appointed. Meantime, surgical training was moving rapidly towards the sub-specialities and away from the general surgery. The polymath general surgeon, ideally suited to the post, was no longer available or being trained, and medical services were provided by the local general practitioners (GPs) supported by physicians travelling to Stranraer for clinics. A general surgeon, and surgeons from other specialities such as orthopaedics, ear, nose and throat (ENT), ophthalmology, and oral and maxillofacial surgery, also had visiting clinics to see outpatients. In addition to recruitment problems at all levels for example consultants, radiographers and laboratory staff, concerns had also been expressed to the Board about standards of care, and in this regard an audit of the management of wrist fractures being one area recently highlighted.

Acute service change

In 1998, Dumfries and Galloway Health Board took the decision to change radically the delivery of acute services to Stranraer. This was introduced only after extensive consultation with the public, GPs and hospital clinicians. There were also informal discussions with the Scottish Office, the Chief Medical Officer (then Sir David Carter), and with the Royal College of Surgeons of Edinburgh. The proposal was that visiting surgeons would provide outpatient services and perform minor and intermediate surgery, and as all the sub-specialities would be involved, it was anticipated that over 80% of all surgery would still be performed in Stranraer. Only patients requiring major and complex surgery would be transferred to the main local district general hospital at Dumfries (population 32,136). There was also to be an increased involvement of physicians from the Dumfries hospital who carried out ward rounds and took responsibility for in-patients.

Accident and Emergency (A&E) services at Stranraer were to be provided by three staff-grade surgeons supported by three consultant anaesthetists and some GPs. Supervision of the department was the responsibility of the A&E consultant in Dumfries who, with his staff grade doctor, provided additional cover at Stranraer. Emergency surgery would be limited and performed according to protocols and guidelines agreed with local medical staff. This meant more patients travelling to Dumfries (76 miles from Stranraer) with added burdens on the ambulance services. With acute surgery restricted, acute medical admissions were inevitably affected increasing the potential for the transfer of acutely ill patients to Dumfries.

Wider Issues

Clinical Governance remained the responsibility of the Acute Trust responsible for providing medical services. The training of staff, both nursing and medical, involved Stranraer Hospital staff travelling for supervised activities at the Infirmary in Dumfries. Stranraer Consultant Anaesthetists also had sessions allocated for lists at the Infirmary in Dumfries. Medical staff expressed considerable reservations with regard to safety and time spent travelling on the busy road to Dumfries (two hours each way). They were also unhappy at the prospect of operating, perceiving that facilities and post-operative care, in their absence, was less than they were accustomed to in Dumfries. With the effects on their Dumfries Infirmary workload resulting from days away at Stranraer, it was inevitable that increases in staffing levels would be required.

These real concerns prompted a renewed call for a purpose-built facility in Stranraer where day-case surgery and diagnostic facilities could be streamlined and more comprehensive. This would also allow an increase in the catchment area and the population served, further reducing pressure on the Infirmary site. The benefit for patients was elective treatment by consultants specialising in their condition closer to home in modern up-to-date facilities.

Evolution of Services

With a relatively small workload shared among four resident surgeons (three staff grades and one associate specialist) and the visiting consultants, it was not surprising that there was a steady haemorrhage of personnel. Recruitment of suitably qualified replacements proved impossible and, by August 2003, the last staff grade surgeon had gone. The major contributor to surgical activity, the Dumfries Infirmary Department of General Surgery, thereafter manned the service twice-weekly with a consultant, accompanied by a junior surgeon, operating, teaching, running clinics and performing endoscopies. As a result, total theatre activity increased from a mean of 1,250 cases annually in the late 1990s, to 1,500 currently.

All of these elective patients are accommodated in a trolley-based day-case facility in the former surgical ward. Pre-anaesthetic assessment is carried out on all patients by nurses working to protocol and supervised by a consultant anaesthetist. Overnight stay, if required, is provided in the adjacent medical ward now staffed by seven hospital practitioners, all experienced doctors with backgrounds in A&E, general practice, immediate and rural care.

A&E services are now provided by the core of hospital practitioners, supplemented by GPs. Supervision and additional cover is provided by the A&E Consultant at Dumfries and his associate specialist. Emergency activity in Stranraer reduced. In 1994/95, 169 cases were dealt with as surgical emergencies in Stranraer but, by 2002/03, only 23 received such treatment. Presently, working to tight protocols, some patients, minor head injuries for example, are admitted and observed overnight. They remain the responsibility of the doctors in Stranraer and not of Dumfries-based consultants.

Transfers of emergencies to Dumfries, previously in the order of 40 patients a year, have risen to approximately 120. The total number of transfers from Stranraer to Dumfries was 740 in the year to the end of March 2005, the majority of those being medical patients and those undergoing investigations unavailable in the west of the region. This reflects the pressures put on the Scottish Ambulance Service providing facilities for remote communities.

The Future

The pattern of working is still evolving to meet changing needs. It has been subject to ongoing surveys of patient satisfaction, always high, and has determined the basis of a new hospital facility currently under construction in Stranraer. This ambulatory care and diagnostic service will continue to provide the people in the west of the region with a quality service near their homes.