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Report of the Joint Comhairle na n-Ospideal/ Department of Health Review Group on Orthopaedic Services in the South Eastern Health Board area.

Contents

March, 1992.

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SECTION - 1 INTRODUCTION.

1.1. At the request of the Department of Health, a joint Comhairle na n-Ospideal/Department of Health Review Group was established in June 1991 to undertake a comprehensive review of orthopaedic services in the South Eastern Health Board area. The impetus for the review was a request from the South Eastern Health Board for a second post of Consultant Orthopaedic Surgeon to be based at Waterford Regional Hospital/Kilcreene Orthopaedic Hospital mainly to facilitate the provision of an elective orthopaedic service for the people of Waterford.

1.2. The membership of the Review Group comprised four representatives of Comhairle na n-Ospideal i.e.

Dr. G. Hurley (Chairman of Review Group)

Mr. F. Kenny

Mr. M. Walsh

Mr. G.P. Martin (Chief Officer)

and two nominees of the Department of Health i.e.

Mr. D. Devitt, Assistant Secretary

Dr. N. Tierney, Chief Medical Officer.

Mr. T. Martin, Administrator, was Secretary to the Review Group and was assisted by Ms. C. Hickey, Executive Officer.

1.3. In pursuance of its task, the Review Group at its initial meeting on 17th July, decided to gather as much detailed information as possible concerning the orthopaedic services in the South Eastern Health Board area. At the Review Group's request, the Health Board provided a dossier of information in respect of each of the five hospitals involved in the provision of orthopaedic surgery services i.e. Waterford Regional; Wexford General; Our Lady's, Cashel; St. Luke's, Kilkenny and Kilcreene Orthopaedic Hospital. The information received described how orthopaedic services (both elective and trauma) are organised in the health board area as a whole and indicated the role of each hospital in the service. Detailed information in respect of the orthopaedic service in each hospital in relation to workload; medical staff; facilities and clinical support services was supplied in August and September. As a result of further requests by the Review Group, this information was subsequently supplemented by more specific workload information and data in relation to costs.

1.4. Having analysed the information, the Review Group embarked upon an extensive consultation process. A meeting was held with the health board management team in Kilkenny and visits were made to each of the five hospitals over a two day period on the 3rd and 4th October, 1991. The Review Group had separate discussions in each hospital with appropriate consultant and other representatives; with each orthopaedic surgeon on his own; and

with the group of consultant orthopaedic surgeons with the exception of Mr. M. Flynn who was ill at the time of this visit. The Group subsequently had a separate meeting with Mr. Flynn on 28th November. During the course of the visits, submissions/extra workload information were presented by the general surgeons in Kilkenny; Mr. White, Orthopaedic Surgeon, Kilkenny/Kilcreene, Mr. Glynn, Orthopaedic Surgeon Cashel/Kilcreene; the general surgeons in Wexford and Mr. O'Connell, Orthopaedic Surgeon, Wexford/Kilcreene.

1.5. Subsequent to its initial visit, the Review Group held a meeting in Corrigan House on 8th November at which it reviewed the visit, the discussions to-date and the available information. The problems being experienced were clarified and tentative solutions/recommendations were formulated. On 28th November, the Review Group revisited Kilkenny and discussed its tentative solutions in separate meetings with (i) health board management; (ii) the group of orthopaedic surgeons.

1.6. It is with great regret that we must record the untimely death of Mr. M. White, Orthopaedic Surgeon, Kilkenny/Kilcreene prior to the second visit of the Review Group.

1.7. The Review Group wishes to record its sincere appreciation to the many individuals in the South Eastern Health Board who assisted in its task by providing information/views either in writing or through discussion. These in-puts have been very useful to the Review Group in reaching the conclusions set out in this Report.

SECTION 2 - DESCRIPTION OF EXISTING SERVICES.

2.1. The emergence of orthopaedic surgery as a distinct specialty (and the consequent narrowing of the field of general surgery) was recognised by Comhairle na n-Ospideal in 1977 in its "Report on the Development of Orthopaedic Services". There are two distinct elements to orthopaedic surgery i.e. musculo-skeletal trauma and elective orthopaedic surgery (including joint replacements). At that time, there was a sizeable number of general surgeons in the smaller general hospitals who were trained and experienced in the management of musculo-skeletal injuries. However, separate formal training programmes for orthopaedic surgeons and general surgeons, with no overlap at higher specialist level, were then emerging. The Report anticipated that general surgeons, especially those in the younger age groups, were and would increasingly tend to regard this type of surgery as outside the scope of their training expertise. This trend has accelerated in the intervening years to the extent that nowadays, most general surgeons are reluctant to take clinical responsibility for the management of musculo-skeletal injuries. Many of the younger general surgeons have not been trained and/or do not wish to undertake orthopaedic work.

2.2. The Comhairle's 1977 Report recommended that the future organisation of orthopaedic services should be based on health board areas with the aim of developing a centralised elective orthopaedic unit in each region. It envisaged the regional elective orthopaedic unit being located in a separate facility,

preferably on the campus of a general hospital. It recommended that provision be made for consultants in orthopaedic surgery to be available to some extent at each general hospital within the health board area.

2.3. In order to cope with the trend towards specialisation which was then at an early stage of evolution, the Comhairle recommended that every regional elective orthopaedic centre should be associated with a particular general hospital and should also be responsible for providing orthopaedic services to the other general hospitals in its catchment area. Each orthopaedic surgeon from the regional centre should have a formal appointment to a particular general hospital in the catchment area involving a commitment to visit that general hospital on a regular basis (minimum of one visit per week) to conduct out-patient clinics and to provide an in-patient consultation service. The management of fracture cases would be by arrangement between the orthopaedic surgeon and the general surgeons. Under such management arrangements, the orthopaedic centre should be obliged to admit acute major fracture cases if requested by the general hospital. The orthopaedic surgeon involved could be either (i) based at the regional centre and travel on certain days to the general hospital or (ii) live in the vicinity of the general hospital and attend on certain days at the regional unit to perform elective surgery. The arrangement to be adopted could be decided locally in each case. Most health boards adopted the former arrangement. For a variety of reasons, based on local geography, demography and

available facilities, the South Eastern Health Board adopted the latter.

2.4. The regional elective orthopaedic unit in the S.E.H.B. area is at Kilcreene Orthopaedic Hospital, Kilkenny which is a separate institution on its own campus. There is one post of Consultant Orthopaedic Surgeon based at each of the four acute general hospitals at Kilkenny, Waterford, Cashel and Wexford. The posts were created on the premise that each consultant would carry out trauma orthopaedic surgery in his local hospital and travel, on a regular basis, to Kilcreene to perform elective orthopaedic surgery.

2.5. In practice, with the partial exception of Our Lady's Hospital Cashel, the orthopaedic service has not been developed on the lines or to the extent envisaged when the posts were created. The current position in each hospital is outlined in the following paragraphs.

2.6. **Wexford General Hospital**

Wexford General Hospital has 76 general surgery beds but it does not have an orthopaedic surgery department. Orthopaedic surgery is not an in-patient specialty in the hospital. Mr. O'Connell, Consultant Orthopaedic Surgeon carried out a small number of orthopaedic procedures in 1990 in Wexford Hospital. About 350 orthopaedic cases were treated under the clinical care of the two general surgeons in Wexford. All acute trauma services in Wexford

are provided by the two general surgeons who are on call for accident/emergency work. Simple fractures requiring only a closed reduction are managed by the general surgeons. About 20 of the 76 general surgical beds in Wexford are usually occupied by patients with orthopaedic problems. Major orthopaedic trauma cases from Wexford, including all fractures requiring internal fixation, are transferred, after stabilisation, to Kilcreene Hospital. They are subsequently operated on there by Mr. O'Connell (about 230 in 1990). He also performs elective operations in Kilcreene (about 160 in 1990). No orthopaedic procedures are carried out on a day basis in Wexford. Orthopaedic out-patient clinics in Wexford are held twice weekly by Mr. O'Connell. The annual cost of all orthopaedic work carried out in Wexford General Hospital is estimated by the S.E.H.B. at about £0.9 million. The new Wexford General Hospital has been built and is currently at commissioning stage. No specific provision, by way of special theatre facilities or designated beds, has been made for orthopaedic work in the new Hospital.

2.7. Waterford General Hospital

There is an orthopaedic trauma department (1 theatre and 31 beds) in Waterford Regional Hospital. No elective work is carried out there. The workload comprises trauma procedures only. The general surgeons are not involved and feel that they should not be required to be involved with orthopaedic trauma except in relation to patients with multiple trauma. An elective orthopaedic service for Waterford patients has not been available

at either Waterford or Kilcreene for the last few years. Prior to that, patients requiring elective procedures were operated on in Kilcreene. There are two fracture out-patient clinics held each week. About 800 trauma operations were carried out in 1990 including over 100 day cases. The present medical staff in the orthopaedic unit comprises one Consultant Orthopaedic Surgeon (Mr. M. Flynn), two Registrars and two S.H.O's. No patients are transferred from Waterford Regional to Kilcreene. The revenue cost of the orthopaedic unit is estimated by the S.E.H.B. at about £1 million per annum. The new Waterford Regional Hospital is currently being built and is due to be completed in 1993. It will contain 31 new beds for orthopaedic trauma and will have the use of one and a half theatres including clean-air facilities necessary for trauma work.

2.8. Our Lady's Surgical Hospital Cashel

The two general surgeons are on call for accident/emergency work including orthopaedic trauma at Our Lady's Surgical Hospital, Cashel. A large portion of the orthopaedic trauma is referred by them to Mr. Glynn, the Orthopaedic Surgeon. Mr. Glynn carried out about 300 (100 major) orthopaedic trauma procedures in Cashel in 1990. Because of insufficient and inadequate facilities, Mr. Glynn transfers complex trauma to Kilcreene to be subsequently operated on there by him (about 110 in 1990). Patients requiring elective orthopaedic surgery are treated by him in Kilcreene (about 150 in 1990). There is one elective orthopaedic clinic and one fracture clinic per week in Cashel. The medical staff in the

orthopaedic department comprises the consultant orthopaedic surgeon and one S.H.O. There are two theatres in the hospital, only one of which is suitable for orthopaedics. This is shared with the general surgeons. There are 85 surgical beds in the hospital, 14 of which are closed. About 10 of these beds are normally occupied by orthopaedic patients under Mr. Glynn. The annual cost of all orthopaedic work carried out by both the orthopaedic and general surgeons in Cashel is estimated by the S.E.H.B. at about £.75 million.

2.9. **St. Luke's Hospital, Kilkenny.**

In St. Luke's Hospital, Kilkenny, the two general surgeons are on call for all accident/emergency work including orthopaedic trauma. The primary management of all trauma cases is provided by the general surgeons. They dealt with most of the minor orthopaedic trauma cases including closed fractures. They referred more complex cases, including those requiring open procedures, to the Orthopaedic Surgeon (the late Mr. White) who then transferred most of them (about 400 in 1990) to Kilcreene - he did very little operative work in St. Luke's. All of the elective orthopaedic work was carried out in Kilcreene (about 200 operations in 1990). The annual cost of all orthopaedic work carried out in St. Luke's Hospital by both the orthopaedic and general surgeons is estimated by the S.E.H.B. at about £0.8 million. The planned extension to St. Luke's Hospital has recently been approved by the Minister for Health and the initial costs have been included in the capital

programme for 1992. A two year building programme is envisaged commencing in 1992.

2.10. Kilcreene Orthopaedic Hospital

Kilcreene Hospital is an isolated orthopaedic hospital located on its own grounds four miles from St. Luke's General Hospital, Kilkenny. It has two theatres and 100 beds - 30 of which are currently closed. Its role was intended to be the elective orthopaedic hospital for the S.E.H.B. area pending its replacement by a new regional orthopaedic unit in Waterford Regional Hospital. However, for a variety of reasons, the workload in Kilcreene now comprises about 60% trauma and 40% elective orthopaedics. About 50% of all patients treated in Kilcreene came from Kilkenny; 30% from Wexford and 20% from Tipperary. As indicated in paragraph 2.7, for the past few years, patients have not been referred from Waterford to Kilcreene. The trauma workload arises from the practice of the orthopaedic surgeons transferring virtually all the orthopaedic trauma patients referred to them by the general surgeons in Wexford and Kilkenny to Kilcreene where they are operated on some days after the trauma has occurred. A similar pattern arises in relation to 20-30% of the trauma orthopaedic workload from Cashel. The annual revenue budget of Kilcreene Hospital is over £2.6 million of which £1.8 million relates to pay costs.

SECTION 3 - THE PROBLEMS

3.1. A general consensus emerged from the consultation process (described in paragraph 1.4) that the current level of orthopaedic services available in the south-eastern area was insufficient both in volume and comprehensiveness. The current organisation of services was regarded as unsatisfactory and inefficient. The following specific problems were identified:-

- For the past few years there has been no elective orthopaedic surgery service available at either Waterford or Kilcreene Hospitals for patients from Waterford as the volume of orthopaedic trauma at Waterford is too heavy to permit the orthopaedic surgeons to go to Kilcreene to do elective surgery.
- A significant number of patients are going outside the health board area for elective procedures mainly to Cappagh Orthopaedic Hospital, Dublin (over 300 patients per annum of whom about 80 are for hip replacements and 30 are for knee replacements) and also to Cork.
- A lot of orthopaedic trauma is not being dealt with in the hospitals of origin especially Kilkenny and Wexford and is being sent, after stabilisation by the local general surgeons, to Kilcreene to be operated on sometime afterwards by the relevant orthopaedic surgeons.
- Kilcreene Hospital, which was originally designed as a T.B. hospital, is a less than ideal environment for the proper

management of orthopaedic trauma because (i) it is physically isolated from the mainstream of acute hospital activity; (ii) the medical infrastructure (e.g. radiology and pathology) is not developed and (iii) it has no on-site physician support.

- The general surgeons at Wexford, Kilkenny and Cashel are on first call for all accident/emergencies and they refer certain types of orthopaedic cases to the orthopaedic surgeons. The orthopaedic surgeons do not participate in first-call accident/emergency duty.
- The original plan was to have one orthopaedic surgeon at each general hospital to deal on-site with orthopaedic trauma with all four undertaking elective procedures in Kilcreene. This arrangement has not worked in relation to three of the four acute hospitals and only partially worked in relation to the fourth.
- The orthopaedic surgeons argued that, in practice, a single-handed orthopaedic surgeon post is non-viable because one person cannot provide a 24 hour on-call service on his/her own. Locums are difficult to recruit and consequently reasonable time-off is a problem. There is a paucity of junior staff at St. Luke's, Kilkenny; Kilcreene and Waterford. It is difficult to attract high calibre candidates as the posts cannot be recognised for training purposes under the current single-handed consultant arrangements.
- The development of special interests is impossible in a single-handed situation. Therefore, more specialised work

must be referred out of the south-east to larger more specialised units in other areas.

- A significant amount of routine elective work is also referred out of the S.E.H.B. area.
- Orthopaedic surgery is not done on a day care basis except to a limited extent in Waterford.
- A significant amount of resources are spent on orthopaedics (c. £6 million p.a.). It should be possible to organise the orthopaedic service in such a way as to provide a more effective and efficient use of these resources.

3.2. Kilcreene Hospital is a stand alone orthopaedic hospital. Its role was originally envisaged as being solely an elective orthopaedic hospital but for a variety of reasons, the workload is now about 60% trauma and 40% elective. The general view of all those consulted was that performing trauma orthopaedics in an isolated elective orthopaedic hospital was not ideal. Modern orthopaedic opinion indicates that elective orthopaedics should desirably be on the campus of an acute general hospital. Kilcreene's major deficits are its physical isolation from a general hospital; it lacks on-site physician presence to deal with medical problems especially with elderly patients; there is no proper radiology department; there is no pathology laboratory; patients with post-operative problems have to be transferred to St. Luke's; and there is no paediatric orthopaedic service.

3.3. It was the unanimous view of those consulted that all serious trauma should be treated in a general hospital environment where

the on-site presence of orthopaedic surgeons, general surgeons and physicians as well as on-site anaesthesia, radiology, pathology and intensive care facilities would be available. Moreover, orthopaedic trauma will be managed by orthopaedic surgeons in the future. However, it must be accepted that this would not, in the short-term, apply in all cases as long as there were some general surgeons, experienced in orthopaedics, who were willing to continue doing some orthopaedic work. The training of the present generation of general surgeons does not include formal training in orthopaedic surgery.

SECTION 4 - CONSIDERATIONS FOR FUTURE DEVELOPMENT.

(A) Population Catchment for Orthopaedics

4.1. Various views were expressed in relation to the official catchment population via-a-vis the actual catchment population. On the assumption that the S.E.H.B. area was a viable entity with little leakage to other areas, the population of 383,000 would justify 7 consultant orthopaedic surgeons (based on modern norms of one per 50,000 population) compared to the current establishment of 4. It was argued by some that the natural flow of patients from West Waterford and parts of South Tipperary was to Cork; from other parts of South Tipperary was to Limerick; from parts of Carlow and north Wexford was to Dublin. Consequently the natural catchment population in respect of regional services for Waterford Regional Hospital might be closer to 300,000.

(B) ELECTIVE ORTHOPAEDICS

4.2. There was unanimous agreement among all those consulted on the desirability of one elective orthopaedic unit in the S.E.H.B. area and that this unit should be sited on the campus of Waterford Regional Hospital where there would be easy access to a wide range of consultants as well as modern radiology including C.T. facilities and pathology laboratory. It was noted that this was the agreed policy of the Department, the Comhairle and the S.E.H.B. for many years but the elective unit had been deleted from the current building programme of the new Waterford Regional Hospital for financial reasons.

4.3. For many years, the continued use of Kilcreene has been seen as an interim measure pending the provision of a new elective unit in Waterford.

4.4. The existing orthopaedic trauma unit at Waterford Regional Hospital is in a separate building on the campus and it comprises 31 beds and one theatre which is equipped with partial clean air facilities. A decision has not yet been made on the future use of this particular building subsequent to the transfer of the orthopaedic trauma service into the newly constructed buildings which will constitute the new Waterford Regional Hospital. A suite of 8 theatres is being provided in the new block which includes one dedicated theatre for orthopaedic trauma plus a further theatre which will be shared with E.N.T. surgery. The future use of the 8th theatre has not yet been decided.

4.5. There was general agreement among those consulted on the desirability of incorporating the elective orthopaedic unit for the south-east in the new Waterford Regional Hospital. If this cannot be achieved for financial reasons, an alternative solution would be to up-grade the existing orthopaedic building when it is vacated and enjoin it with a nearby medical ward (which is also due to be vacated) by means of constructing two new clean air theatres between the two buildings. It was suggested that the resultant combined unit, with two clean air theatres, would be of sufficient scale to cope with the elective orthopaedic requirements of the S.E.H.B. area as a whole. While this alternative was suggested, nevertheless, it was viewed by all

concerned as a less preferable though less costly option. There was general agreement among those consulted that it would be preferable to incorporate the elective unit in the new block in Waterford Regional Hospital even though it might be more expensive and may take longer to achieve.

(c) - ORTHOPAEDIC TRAUMA

4.6. There was general agreement that the current organisation and practice of orthopaedic trauma should be changed. The continued use of Kilcreene as a trauma centre was generally regarded as not being an option for the future.

4.7. The problems emanating from the current organisation and practice of orthopaedic trauma are equally serious but more difficult to resolve than elective orthopaedics given the medical, medico-legal and social difficulties involved. In the first instance, consideration was given to the possibility of continuing with locally-based orthopaedic trauma services. This would involve doubling the number of orthopaedic surgeons at each of the four acute general hospitals; providing an appropriate number of non-consultant orthopaedic staff; and designating orthopaedic beds and theatre time at each hospital. This was generally recognised as a very expensive way of delivering an orthopaedic trauma service since it would inherently require duplication of staff and facilities at four centres. This scenario was the preferred choice of the non-orthopaedic consultant staff at Wexford Hospital. The two general surgeons in Wexford indicated that they

would make 26 of their current complement of 76 beds available for orthopaedics, if this solution was implemented. A de-centralised solution was also the preferred choice of some of the consultant staff at Cashel, so long as a properly staffed orthopaedic unit with its own theatre was provided.

4.8 Against the concept of de-centralisation the following arguments were advanced by the orthopaedic surgeons and others:-

- In the not too distant future, the existence of two-consultant teams would become as unacceptable and non-viable as single-handed situations are currently. In a two-consultant unit, only one would be available for much of the time due to holidays, sick leave, study leave and time spent at the elective unit.

- The development of a reasonable level of sub-specialisation would not be possible.

- The problem of recruiting non-consultant staff would not be solved as posts would not be recognised for training.

- To overcome the above problems, a team of at least three consultant orthopaedic surgeons would be necessary. It was argued that the concept of four hospitals in the south-east, each with three orthopaedic surgeons would be excessive in terms of workload and the range of other pressing needs in the health board area.

4.9 The concept of centralising all major orthopaedic trauma (i.e. ambulance cases) in Waterford Regional Hospital was considered. In this scenario, a centre of excellence staffed by 6 orthopaedic surgeons was envisaged. Sub-specialisation and a reasonable on-call rota would be possible. High calibre N.C.H.D. staff would be attracted as the centre would be recognised for training at both general and higher specialist levels. The full range of diagnostic and medical back-up facilities and consultant expertise would be available on-site. 31 beds and the use of one dedicated and one shared theatre for orthopaedic trauma are planned for the new Waterford Regional Hospital due for completion in 1993. On the question of the feasibility of a single regional centre, the orthopaedic surgeons accepted that a minimum of 60 trauma plus 60 elective beds, as well as day beds, would be sufficient to enable a complement of 6 orthopaedic surgeons to function effectively as a team based at Waterford Regional Hospital. It was pointed out that the advent of day surgery had reduced bed requirements for the specialty. It was agreed that, ideally, two orthopaedic trauma theatres and two elective orthopaedic theatres would be required in this scenario. It has been confirmed by the South Eastern Health Board that a high proportion (approximately 70%) of the population of the health board area including the towns of Clonmel, Kilkenny and Wexford live within about 30 miles of Waterford. It was pointed out that ophthalmic and E.N.T. surgery in the south-east are already centralised in Waterford and these services work well. It was noted that there will be a net increase of 100 beds in the new hospital - 470 in toto - and this complement would provide flexibility in terms of specialty allocation. It was appreciated

that competing demands for these beds will need to be reconciled and prioritised in order to achieve the necessary 60 beds for a centralised regional orthopaedic unit.

4.10 The orthopaedic surgeons consulted were unanimously of the view that a single centre at Waterford would be in the best interests of patient care. They envisaged and were agreeable that their posts should be restructured to be based at Waterford Regional Hospital as part of a regional service for the health board area. They envisaged providing one elective orthopaedic out-patient clinic per week at each of the other three general hospitals. If orthopaedic services were centralised in Waterford, the team of orthopaedic surgeons would, between them, share the on-call duty on a rota basis. An orthopaedic trauma patient would, therefore, be admitted under the orthopaedic surgeon on duty rather than under the orthopaedic surgeon primarily responsible for the patients area of residence. They argued that, in the interests of continuity of care/follow-up, fracture clinics would have to be confined to the centralised unit to which patients would have to travel to be seen by the orthopaedic surgeon who had treated them.

(D) - GENERAL TRAUMA

4.11 In the event of all orthopaedics being centralised at Waterford, two points of view were advanced in relation to the organisation of trauma services generally:-

(i) It was suggested that major trauma cases (orthopaedic, soft-tissue and multiple trauma) should be admitted initially to the local general hospital where the patients would be assessed, resuscitated and stabilised by the general surgeons and anaesthetists. If a general surgical operation was warranted, this would be done locally. Patients needing orthopaedic services would, subsequently be transferred to the central orthopaedic unit for orthopaedic surgery. The general surgeons were of the view that only they can properly triage trauma patients.

(ii) A number of those consulted felt that a better medical solution would be for all major trauma to be admitted directly to a single regional trauma centre where all the necessary general surgical and orthopaedic expertise with full back-up services would be on-site to cater comprehensively for the needs of the patient.

It was acknowledged that there was no simple answer to how minor orthopaedic trauma should be dealt with in the local general hospitals, if major orthopaedics was to be centralised at Waterford.

(E) - PARTIAL/PHASED CENTRALISATION

4.12 Consideration was also given to partial and/or possibly phased centralisation of orthopaedics i.e. initially in two centres (Waterford and Kilkenny) and, depending on how it evolved,

eventually one centre. The general surgeons in Kilkenny were in favour of this possibility. They felt that the proposed complement of three theatres in the expanded St. Luke's Hospital would be sufficient to cater for general surgery, obstetrics/gynaecology and orthopaedic surgery involving three consultant orthopaedic surgeons. They envisaged 24-30 orthopaedic beds being required. There are 54 general surgical beds plus 6 day beds in St. Luke's Hospital. The general surgeons said they would give up their involvement in orthopaedics when three orthopaedic surgeons were on-site. Concern was expressed by many of those consulted that a smaller unit in Kilkenny could be perceived as not being on a par with the centre in Waterford Regional Hospital as the major infrastructure would be provided at the latter both in terms of consultant staff, diagnostic facilities and theatres. In their view, resources on the same scale would not be duplicated in Kilkenny.

SECTION 5 - RECOMMENDATIONS

5.1. Having taken into account the views of all those consulted; the present organisation of orthopaedic services; the existing network of general hospitals including their roles and location; developments in orthopaedic and general surgery; the Review Group recommends that orthopaedic services in the South Eastern Health Board area should in future be organised as set out in the following paragraphs.

5.2. The Review Group considers, that in the best interest of patient care, elective orthopaedics in the S.E.H.B. region should be centralised in Waterford Regional Hospital which is being developed as the flagship hospital and tertiary referral centre for the health board area. Major capital investment is currently underway there. As the building programme is completed, and as finances permit, the Hospital should be staffed appropriately to meet the regional role envisaged for it.

5.3. The Review Group is convinced that the best interests of patient care would also be served by all major orthopaedic trauma in the south-eastern region being transported directly to Waterford Regional Hospital where the patients should be managed by the team of orthopaedic surgeons to be based there. It is envisaged that non-ambulance cases, including those requiring minor orthopaedic procedures, will continue to be treated in their own local hospital as long as the general surgeons in these hospitals are willing to accept clinical responsibility for their management.

5.4. The implementation of these recommendations will result, in the future, in the cessation of all orthopaedics at Kilcreene Hospital.

5.5. Centralisation of both elective and major orthopaedic trauma at Waterford Regional Hospital will facilitate the development of a centre of excellence of orthopaedic practice in the south-east. The Review Group envisages that the centre would be staffed by six orthopaedic surgeons. A centralised orthopaedic service would provide a 24 hour service for major orthopaedic trauma producing a higher standard of care than is possible under the existing organisation of services. A higher standard of orthopaedic surgery, and consequently patient care, will result from a larger throughput of patients requiring regular practice of a wider spectrum of orthopaedic skills. Sub-specialisation would be facilitated leading to a better service for patients and better job satisfaction for the orthopaedic surgeons. Back-up consultant expertise and diagnostic facilities in anaesthesia, radiology and pathology, already on site, would be available. However, additional consultant appointments in these and other specialties (e.g. rheumatology) are likely to be required, not solely for a central orthopaedic service, but also as part of the overall development of Waterford as the regional hospital for the south-east. A major orthopaedic unit as envisaged would be recognised for training purposes and would attract high calibre staff. Such a unit is also likely to be more cost-efficient as duplication of orthopaedic facilities would be avoided and shorter bed stay would be achievable. The availability of a locally-based elective

orthopaedic service for Waterford patients would significantly reduce the number of patients going outside the region for elective orthopaedic treatment. The South-Eastern Health Board has estimated that their current expenditure on local orthopaedic services amounts to about £6 million per annum. The Review Group is conscious of the fact that this does not mean that, if orthopaedic services were centralised in Waterford Regional Hospital as recommended above, all of this money would be transferable to Waterford. A significant proportion of the money currently spent in Wexford, St. Luke's, Kilkenny and Our Lady's, Cashel is inherently part of the staffing and infrastructure which would continue to be required to cope with the surgical work that will continue to be carried out in these hospitals.

5.6. The Review Group recognises that there are a number of potential disadvantages to centralisation (e.g the possible adverse effects on the other hospitals in the region). In order to minimise such disadvantages and to minimise extra travel impositions on patients, the Review Group recommends that regular and frequent consultant orthopaedic in-put should be made to each of the three general hospitals by the consultant orthopaedic staff based at Waterford. This in-put would be on the following basis at each hospital:-

(a) two orthopaedic clinics (at least one of which would be a fracture clinic) per week to be conducted by a designated consultant orthopaedic surgeon

(b) in conjunction with the clinics, a ward consultation service should be provided for in-patients at the request of locally-based consultants.

(c) the designated consultant orthopaedic surgeon should be responsible for providing an advisory service on orthopaedic level related problems to the staff of the local general hospital.

While the above services would normally be provided by the designated consultant, the orthopaedic team as a whole should share collective responsibility for supporting each other in ensuring, within reason, continuity of the above services to each of the local general hospitals in the absence of the designated consultant, whether on sick leave, holiday leave or otherwise.

5.7. To avail of the enhanced orthopaedic services recommended by the Review Group some patients will have to travel greater distances than is currently the case. A re-organisation of the ambulance services will be essential for the successful functioning of the future orthopaedic services. This re-organisation should have, as a major objective, the minimisation of additional travel impositions on patients as well as the effecient transporting of trauma cases from the scene of accidents to the regional centre.

5.8. The implementation of the Review Groups recommendations, will require an early decision to be reached on the designation of about 60 beds for orthopaedic trauma from within the total bed

complement of the new Waterford Regional Hospital due for completion in 1993. Such a decision will enable the new central orthopaedic trauma service to commence with the opening of the new Hospital.

5.9. The transfer of elective orthopaedics from Kilcreene Hospital to Waterford will require the provision of additional facilities as set out in paragraph 4.5. above. Pending, the emergence of such facilities, it is envisaged that all elective orthopaedics for the region will continue at Kilcreene Hospital including a service for Waterford patients.

5.10 The Review Group has concluded that the clear medical benefit to patients and the economic advantages in centralising orthopaedic services outlined earlier far outweigh the potential disadvantages. The Review Group is convinced that the opportunity now exists to dramatically improve the orthopaedic service for the people of the south-east by centralising both the trauma and elective services in Waterford Regional Hospital.