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Letter to the Editor

Management of emergency referrals to UK and Ireland plastic surgery units

Sir,

The volume of emergency admissions to plastic surgery has been steadily increasing over recent years. Over the past ten years the number of emergency admissions in English hospitals rose by 26% to more than 53,000 last year.[1] To deal with an increasing workload, it is necessary that systems for managing and optimising the care of referrals are highly efficient. For example, Nicholl and colleagues[2] identified lack of operating theatre time as the primary reason for delay in the management of plastic surgery emergency referrals. Rea and colleagues[3] recently recognised the increasing pressure of trauma referrals on a plastic surgery department which prompted the authors to overhaul their trauma management service. Thus important lessons can be learned from the experience of other units.

We performed a study to identify how plastic surgery units throughout the United Kingdom and Ireland manage referrals. We were interested in the variation in practice between units, and felt that dissemination of the results would interest and hopefully benefit other units.

A questionnaire was developed consisting of 20 questions, each with multiple-choice answers. The questions pertained to the management of emergency referrals from the initial phone call, through to post-operative care. A copy was sent to a Specialist Registrar (SpR) in each of the 55 plastic surgery units (listed on the BAPRAS website). It was explained that individual units would not be named in the reporting of the results.

35 out of the 55 units responded (63.6%). Two units did not receive emergency referrals. Therefore usable data was provided by 33 units, with most regions of the UK and Ireland represented. Almost 50% of units cover between 2 and 5 A&E departments. For most units (94%), hand trauma makes up the majority of referrals. Three quarters will accept referrals from nurses or nurse practitioners, and in three quarters of units the senior house officer is the first point of contact for referrals. There is a policy for all emergency referrals to be discussed with a registrar in 45% of units. The majority (85%) often receive non-urgent referrals in the middle of the night. Out of hours referrals are sometimes covered by other specialties in 39%, and the 'average unit' tends to receive between six and eight referrals each day, and three to five each night. Interestingly, with registrars taking the initial referrals, a mean of 70% of those subsequently seen are admitted, compared to a mean of 59% when senior house officers take the referrals. This seems to suggest that fewer patients are brought to the units with registrars fielding referrals. There is dedicated theatre time for plastic surgery cases in 64% of units, and for these units the mean dedicated weekly time is approximately 25 h. Increased dedicated theatre time is associated with shorter hospital stay, with 19 h per week ensuring average stay one day.

There were some limitations with the study. Undoubtedly some of the answers are 'best guesses'. In addition, 20 units did not respond, and because some respondents remained anonymous, it was not possible to identify the non-respondents for a second request to complete the form. We do feel however that the response rate (63.6%) was sufficient to be representative, enabling reasonably accurate conclusions to be drawn from the data set.

At the very least this information affords an opportunity for each unit to compare itself with the 'average'. There are certain procedural factors which are most likely generically favourable. These include plastic surgery doctors taking referrals during the night, and facilities for immediate surgical intervention. Despite the increasing volume of referrals made to our specialty, most units seem to run an effective filtering procedure, whereby appropriate referrals are seen by the plastic surgery team, and if necessary admitted. The availability of dedicated theatre time, as well as invaluable input from experienced nurses and therapists, ensures that these patients quickly receive essential operations, rehabilitation, and timely discharge.

Conflict of interest

The authors have no conflicts of interest.

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