Safe and Sustainable Review Response from Southampton Health Overview and Scrutiny Panel

Members of the Southampton Health Overview and Scrutiny Panel have considered the proposals for changes to Children's Congenital Cardiac Services in England. Below is our response to the initial consultation. Once the independent report on the outcome of the consultation is published in August 2011 the HOSP would wish to add to this submission.

The HOSP has chosen to respond in narrative form rather than use the response form provided. This is because it was considered that the form did not provide sufficient flexibility for our comments and concerns about the consultation form itself (see below).

Quality

The purpose of the Safe and Sustainable (SS) review is to ensure the services provided for children with congenital hearth disease are excellent. The Paediatric Cardiac Unit at Southampton University Hospitals Trust provides amongst the highest quality care in the world. It is the second best in the country, only Evelina Children's Hospital in London is rated higher. The 2010 Kennedy assessment highlighted Southampton as an exemplar of best practice in three different areas: Management of paediatric intensive care; Supporting parents with information and choice; Training and innovation.

The unit does not suffer the problems associated with smaller units indentified in the SS document. For example:

- the mortality rates in Southampton are low.
- there is established dual operating and mentoring of surgeons and a fourth surgeon will join the team in July.
- the Trust has no problem in attracting or retaining the best staff and has surgeons who are pioneers in certain surgical techniques.
- cancellation of planned surgery is not an issue.

Southampton University Hospitals NHS Trust has four children's heart surgeons (the fourth surgeon is a new appointment and starts with the Trust in July 2011). There are seven paediatric cardiologists in the service which involves more than 400 staff in total.

Additionally the unit is already part of an established Congenital Heart Network with Oxford and the system has worked well for patients. This has demonstrated that developing networks with centres that are de-designated as cardiology centres can work and this success should be built on and used as an example of best practice.

Southampton have had patients referred from other centres with complex needs e.g. from as far away as Liverpool and Ireland. The Southampton team

have pioneered work on teenagers where previous operations haven't been successful.

However the Unit only appears in one of the four proposed options for reconfiguration.

The Panel support the notion that the level of quality should be consistent across the country with all units meeting the highest standards. However, it must be acknowledged that it takes time to attract high quality staff, create leadership, build teams and meet the highest standards and will take a number of years for this to be achieved across networks. However SUHT can already evidence this and has the potential to roll this out across the network established with Oxford. This should be retained, built upon on, and learned from rather than dismantled.

Patient numbers

The SS document states that there should be a minimum volume of 400 paediatric surgical procedures for each Specialist Surgical Centre. This figure has had a huge impact on the options presented. However, there is a statement in the consultation document that; *"the scientific papers reviewed do not provide sufficient evidence to make firm recommendations regarding the cut-off point for minimum volume of activity for paediatric cardiac procedures"*. The document refers to, *"available evidence"* but does not show what that evidence is or the flexibility around the 400 figure.

There is however evidence that hospitals in Scotland for example are able to provide a high quality service with smaller volumes than 400 but that evidence is not referred to. Based on the figures in the document there are currently 3 centres with 3 or 4 surgeons that undertake 400+ operations per year and each of them rate lower that Southampton in the independent assessment of the centres led by Sir Ian Kennedy.

The data relating to the number of operations undertaken at Southampton is out of date. During 2010, Southampton performed 404 congenital heart surgery procedures, 338 of them were in children aged 16 or under. In February 2010 when surgery was suspended in Oxford, the majority of operations for its patients were performed in Southampton. This makes Southampton larger than the other centres being considered for closure.

The SS document states that around 100/125 procedures a year per surgeon is optimum. However, this makes a distinction between operating on children and adults – the same surgeons often operate on both. Also many operations require more than 1 surgeon e.g. for complex procedures. This is not taken into account in the assessment of the number of procedures performed. The other omission relates to the training of surgeons: approximately 40% of procedures will have a junior surgeon being mentored by a senior colleague. The Panel understand this is not reflected in the assessment of the number of procedures performed.

Patient Flows

The assumption that patients will travel to their nearest centre, and a consideration of existing clinical networks, has been used to deem that Bristol and Southampton are not both viable in the same configuration with the exception of the option that has been based solely on quality (which the Panel argue should be the prevailing factor). The Panel believe that the assumptions on which this is based are flawed. The analysis is based on a theoretical model of patient flows and doesn't take account of actual patient flows as they take place now, and the model does not allow for patient choice.

The majority of Oxford patients have been going to Southampton since the Oxford unit closed not just because it is nearer than Bristol or London but because they recognise the quality of service provided. The consultation document does not recognise that Southampton has replaced Oxford Radcliff as the centre for patients in the Oxford region and has not calculated potential patient numbers on that assumption.

Patients travel to the Southampton unit from both the south west and south east (e.g. Plymouth and Guildford) as well as from the north (e.g. Northampton). Ease of travel does not seem to have been considered. For example although some parts of Dorset may be theoretically closer to Bristol, in practice it is easier to travel to Southampton.

Patient choice has not been considered. It is not in line with the principles of the review that children should have to travel further for poorer quality care. Feedback from the consultation event that took place near Gatwick, who are counted as part of the London catchment, indicated that they prefer to come to Southampton. The SS review itself had rated the centres in terms of quality and this information is, rightly, widely available to parents and patients. This has the potential to impact on the centres parents choose for their child's treatment – particularly where the distance between two centres is not significant for them but one has ranked higher on quality.

The Panel believe there is enough work across the South of England and London to sustain 4 centres. Taking the activity across London, South East Coast, the South West and South Central there would be sufficient activity at Southampton if it was distributed differently to support the 4 best centres across the South. We understand that South West SHA also support option B and that the chief executive at Southampton University Hospitals NHS Foundation Trust will be receiving a letter from Sir Neil McKay (chair of the JCPCT) supporting the testing of redistributing the Brompton activity to support Option B.

Additionally population growth has not been projected at postcode level, but nationally. This fails to take into account projected regional differences in population growth. While the Panel understand that the projected population growth to 2025 will not require additional surgeons to deal with increased caseload, the distribution of the additional patients is unlikely to be evenly

distributed. According to the ONS 2008 based population projections for England published in May 2010:

"The East is projected to be the fastest growing English region over this period. The population of this region is projected to increase by 10 per cent over the decade to 2018, rising by over 0.5 million to 6.3 million. Over the same period, the population of five other regions (London, Yorkshire and The Humber, South West, East Midlands and South East) are also projected to increase by 8 per cent or more. In contrast, the North West and North East are projected to have the smallest percentage increases in population between 2008 and 2018."

This clearly shows that the greatest increase will be in those areas which are placed in the catchment of the London and southern centres. This would potential affect the patient numbers in these centres to a greater extent than those in the north.

Access and Travel Times

There are some clear errors in relation to the assumptions around access travel times on which the options have been assessed.

As has been highlighted by the review team previously, there have been significant errors in relation to retrieval times from the Isle of Wight (IOW) which is relevant to both Paediatric cardiology and surgery and PICU services. The retrieval times from the IOW have been calculated based on air travel when the reality is that Southampton's policy is to retrieve children from the Isle of Wight by road and ferry. The Panel are pleased that this issue is being reconsidered by the JCPCT and expect a full and fair review of how this will effect the options to ensure that patients from all parts of the Isle of Wight are not unfairly disadvantaged. The Panel also seek assurance that the details of this issue will be published in due course.

The Panel are also concerned that while distance to hospital was least important for parents, distance to hospital and access and retrieve times have been given such a high priority when evaluating the options. We are also concerned that travel times have not been based on actual patient flows rather than being assessed by road times from the centre of postcode areas.

Paediatric Intensive Care Unit

Option B has the least impact on the national provision of PICU services. Southampton has the 9th largest PICU in the country and has the lowest standardised PICU mortality of all the centres being considered in this process.

In the independent assessment, Southampton PICU was identified as being managed in an exemplary way (only 1 patient reported as turned away) and the throughput through PICU as excellent.

SUHT are concerned that their PICU will be adversely affected if cardiac surgery is taken away. We have heard from medical staff at SUHT that there PICU admissions will drop by 39% without cardiac patients and cardiac patients account for 44% of PICU bed days.

The South East Trauma Board have identified the importance of the Southampton Paediatric Care Unit for the care of the paediatric population in NHS South East Coast and voiced concerns about how this would be effected if paediatric cardiac surgery was removed from SUHT as have the Wessex Paediatric Intensive Care Forum (which covers the 9 hospitals that refer to SUHT PICU).

The Panel are concerned that the issues regarding the sustainability of PICUs have not been given enough consideration in the SS review.

Interdependencies

The Panel are concerned that not enough consideration has been given to the importance of having interdependent services on site.

The SUHT centre is able to offer the full range of maternity, paediatric and GUCH services co-located on a single site. The Panel have heard from both patients and doctors of the importance of this for congenital heart patients as they often have other needs and conditions, particularly those with the most complex conditions.

The framework for critical inter-dependencies report for specialised paediatric services identifies five services that require absolute co-location with cardiac surgery (paediatric cardiology, paediatric critical care, specialist paediatric anaesthesia, specialist paediatric surgery and specialised paediatric ENT). Professor Baker, the author of the framework, raised concerns at a public consultation event that the critical interdependencies had been ignored in developing the options and he had not been asked to assist in applying the framework to the options. The Panel are concerned that a full assessment of interdependencies has not been made and would like further information to be provided on how the four options proposed meet these requirements.

Grown Ups with Congenital Heart Disease

The Safe and Sustainable standards require that clear transition arrangements are in place between Specialist Surgical Centres and specialist adult units. This is already in place at SUHT as they currently treat and perform surgery on both children and adults with CHD.

Paediatric cardiac surgeons at the Southampton Centre also perform surgery for ‘grown up’ congenital heart patients however this surgery has not been included in the number of procedures performed per surgeon considered in the consultation document. Separating the two specialities would reduce the number of procedures performed and may impact on the ability to retain highly skilled staff, as well as removing the consistency appreciated by patients.

Given the importance place on transition arrangements and the feedback received from the medical profession and parents on this issue, the Panel find it difficult to understand why the children's and adults reviews are taking place separately rather than as one. No consideration seems to have been given to the benefits of having an integrated, cradle to grave, service. It is also difficult to understand how the outcome of the SS review will not have a significant impact on the GUCH review. The Panel would like this issue considered in more detail.

Complex Procedures

With the exception of the three highly specialist nationally commissioned services, no consideration appears to have been given to the most complex procedures which are not carried out at all centres.

Not every centre is currently doing the most complex surgeries, currently some centres specialise in certain procedures and publish their results as part of their CCAD return. Our understanding is that only one complex procedure - hypoplastic left heart - is audited on CCAD, with other complex procedures grouped under 'miscellaneous'. Not all centres undertake hypoplastic left heart and we assume this is the case for other complex procedures that are not audited on an individual procedure basis. We are concerned that this has been taken into account, particularly as existing expertise could be lost in the designation process. While we appreciate that new designated centres could develop specialism in complex procedures this will take time and the Panel feel there needs to be greater consideration and understanding of the current situation in order to ensure that patients do not suffer.

Consultation

Finally the Panel would like to highlight our concerns regarding the consultation itself. Members are concerned that the consultation response form was excessively long, leading and biased. There has not been any formal communication on the website, nor has it been publicised, that feedback could also be provided in written format rather than via the complicated consultation form.

The consultation document is very long and technical – although well written. The young person's summary version was not made available until the consultation was well underway.

The JCPCT have been absent from all consultation events and meetings that we have attended or been aware of. Those fielded from the regional arms of NHS SS have often struggled to answer questions and are not the decision makers. The Panel are also concerned that a third party organisation have been contracted to run the consultation and evaluate the feedback rather than those with specialist knowledge.

There has been significant interest in the SS review in Southampton. When the planned formal consultation meeting reached capacity, following several requests a further meeting was held. However, this meeting was also very popular and we were assured that further meeting would take place but as far as we are aware this did not in fact happen.

Conclusion

In conclusion the Panel feel strongly that they can only support option B. This is the only option which able to satisfy the quality criterion as five of the six centres judged to be providing the highest quality services are included as future surgical centres. Option B has centres with the best survival rates for surgery, centres which already undertake complex surgery and the option provides excellent access to patients from all parts of the country. The loss of the unit would be detrimental to the safe and sustainable delivery of a range of other paediatric services provided for the region. We believe that the given the quality, geographical distribution and patient flows the Southampton centre meets the aims of the review, and it has the strong support of the local community, patients and families.