

**HAMPSHIRE COUNTY COUNCIL**

**Report**

<b>Committee:</b>	Health Overview and Scrutiny Committee
<b>Date of Meeting:</b>	26 July 2011
<b>Report Title:</b>	Proposals to Develop or Vary NHS Services
<b>Report From:</b>	Chief Executive

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**1. Summary and Purpose**

- 1.1. The purpose of this report is to alert Members to proposals from the NHS to vary or develop health services provided to people living in the area of the Committee.
- 1.2. Proposals that are considered to be substantial in nature will be subject to formal public consultation. The nature and scope of this consultation should be discussed with the Committee at the earliest opportunity.
- 1.3. The response of the Committee will take account of the Framework for Assessing Substantial Change and Variation in Health Services agreed by the Hampshire, Isle of Wight, Portsmouth and Southampton Joint Committee in November 2010. This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the Health and Social Care Act 2006 and takes account of key criteria for service reconfiguration identified by the Department of Health. The 'Framework' can be found on the website at <http://www3.hants.gov.uk/scrutinyfallsframework.pdf>
- 1.4. This Report is presented to the Committee in 2 parts:
  - *Items for action:* these set out the actions required by the Committee to respond to proposals from the NHS to substantially change or vary NHS services.
  - *Items for information:* these alert the Committee to forthcoming proposals from the NHS to vary or change services. This provides the Committee with an opportunity to determine if the proposal would be considered substantial and assess the need to establish formal joint arrangements

- 1.5. This report and recommendations provide members with an opportunity to influence and improve the delivery of health services in Hampshire and therefore support the delivery of the Corporate Strategy aim of maximising well being.

### ***Items for Action***

2. **Southern Health NHS Foundation Trust: Consultation on Older People's Mental Health services in south Hampshire.**

- 2.1. Further to decision of the HOSC to support the commencement of public consultation by Hampshire Partnership NHSFT Members will be apprised of the outcome of the consultation process. The report to the Trust Board relating to this is attached at [Appendix One](#), page 5. There are extensive supporting appendices to this paper which are available from the scrutiny office on request.

### ***Recommendations***

- 2.2. Members are advised of the next steps of the Trust in taking this work forward.

3. **Southern Health NHS Foundation Trust: Consultation on Adult Mental Health Services**

- 3.1. Southern Health NHS Foundation Trust has indicated that it intends to review adult mental health services with a particular emphasis on acute and reablement services. The business case supporting this proposal is attached at [Appendix Two](#), page 11.

- 3.2. Key issues to be considered will include:
  - How these changes will improve services for adults with mental health needs with particular regard to timeliness of response, accessibility and consistency in service provision
  - The additional support to be provided in community settings
  - How the changes will be evaluated to ensure the improvements envisaged are being delivered
  - How Adult Services and other key stakeholders have been involved in developing these plans
  - What are the implications for accessing these services OOH

- 3.3. The period of formal consultation with the HOSC will also need to be considered.

### ***Recommendation***

- 3.4. Members confirm:
  - If they are of the view that the proposals constitute a substantial change in service.
  - The time frame for any formal consultation required
  - Any additional information to be provided

4. **National Specialist Commissioning Board: Consultation on the Configuration of Children’s Heart Surgery Services.**
- 4.1. The HOSC Panel convened to look at this issue on behalf of the HOSC made an initial response to the consultation on these e services prior to the deadline of 1 July. This is attached at [Appendix Three](#), page 13 and reflects the following lines of inquiry as agreed by Members:
- The improvements in quality that will be achieved as a result of the changes proposed
  - The importance of patient choice over postcode
  - The means by which case mix and complexity have been taken into account
  - The evidence base supporting the proposals
  - The conduct and content of the consultation process.
- 4.2. Option ‘B’ , which includes Southampton, has been supported by all local Trusts and the SHAs covering the South Central, South West and South East areas. This option includes 5 of the highest scoring centres for quality of care.
- 4.3. The national team leading this work have confirmed that additional information will be sent to the HOSC in relation to the Equalities Impact Assessment, current patient flows and retrieval times for children from the Isle of Wight. The HOSC will have until October to raise any additional issues of concern with the national team. If the HOSC remains dissatisfied with the preferred option identified then referral to the Secretary of State may be considered.

*Recommendation*

- 4.4. That the Panel, working with other HOSCs as appropriate, continues to oversee the response of the national team to the recommendations and the additional information to be provide.
- 4.5. The Panel provides a briefing on progress with this work for the next HOSC.

***Items for Information***

5. **South Central SHA: Consultation on proposals to fluoridate drinking water in Southampton and South West Hampshire**
- 5.1. The response of the SHA to the queries raised by the HOSC in relation to technical feasibility and cost effectiveness of the scheme is attached at [Appendix Four](#), page 25.

*Recommendations*

- 5.2. The SHA provides the additional information relating to the capital and revenue costs of implementing the scheme.
- 5.3. The views of Southern Water about the feasibility of the proposed scheme and timescales for implementation are invited.

**6. NHS SHIP Cluster: Review of Vascular Services.**

6.1. NHS Commissioners have confirmed that options are currently being developed for configuring vascular services across the south coast. It is anticipated that this work will be completed and shared with all HOSCs affected in early autumn in order that a view can be taken on whether the changes proposed are substantial in nature.

*Recommendation*

6.2. Members are kept apprised of progress with this development.

**Section 100 D - Local Government Act 1972 - background documents**

**The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)**

Document

Location

None

**IMPACT ASSESSMENTS:**

**1. Equalities Impact Assessment:**

N/A

**2. Impact on Crime and Disorder:**

N/A

## Appendix One: Older people Mental Health Services: Outcome of Consultation Report.

Date: 16 June 2011

Author: Amanda Horsman

For: Foundation Trust Board

Subject: Executive Summary

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### 1. Purpose of report and alignment to strategic goals

*This report provides a summary of the public consultation on the proposed closures of Linden and Willow inpatient wards (functional and organic respectively) at the Tom Rudd Unit by:*

- *Outlining the background to the Trust consulting on the proposals*
- *Summarising the feedback received during the consultation period*
- *Making recommendations regarding the next steps to be taken by the Trust*

### 2. Context

**2.1** The proposed closure of two inpatient wards at the Tom Rudd Unit on the Moorgreen Hospital site reflects the strategy within the Older Peoples Mental Health Service Directorate to move from bed-based services and focus on support in the community that provides personalised care based on individual need (*OPMH 5 Year Service Strategy 2010* "Planning Together for the Future"). This also reflects the diminishing need for beds within the directorate with a significant proportion (up to a third) of beds being unoccupied at any given time. Background information is shown at appendix 1.

**2.2** Hampshire Overview and Scrutiny Committee (HOSC) were briefed in September 2010 of proposals and Southampton Scrutiny B panel on 13 January 2011 and it was agreed that further work should be carried out regarding the proposals.

**2.3** Between November 2010 and March 2011 the Older Peoples Mental Health Service Directorate carried out a significant amount of engagement work with service users/carers staff and other external stakeholders relating to the in-patient wards at the Tom Rudd Unit and the strategy for Older Peoples Mental Health Services. The Trust also held four engagement events between January and March 2010 under the banner "Planning Together for the Future" as an opportunity to engage further with the general public and discuss the service strategies and plans. The drop in events were successful in building the Trust's reputation and providing useful feedback for service development purposes. Details of this engagement are shown at appendix 2. The feedback that the Trust received from the above engagement work was included within the consultation document and was used to shape the proposals that were put forward.

- 2.4** The Trust ensured that throughout this period both the HOSC and Scrutiny B panel were kept fully informed and updated, providing both informal and formal feedback on progress at HOSC meetings held on 25 January, 29 March, 7 April and the 24<sup>th</sup> March 2011. The work completed by the Trust was acknowledged by the HOSC at their 29 March 2011 meeting where it was agreed to hold a six week formal consultation regarding the proposed changes to Tom Rudd Unit (as opposed to the maximum 12 week formal consultation period).
- 2.5** In April 2011 the consultation paper and process was agreed by the Boards of NHS Hampshire, NHS Southampton City and Southern Health NHS Foundation Trust (previously Hampshire Partnership NHS Foundation Trust).
- 2.6** Following the publication of the four key tests for service reconfiguration originally described within the revised NHS Operating Framework published 21 June 2010 (*detailed guidance since provided DoH - Service Reconfiguration 29 July 2010*), the Trust has undertaken a self assessment in order to assure itself through its engagement and consultation log that it has met the criteria.

The four tests cover:

- Support from GP Commissioners
- Clinical Evidence Base
- Strengthened Public and Patient Engagement
- Patient Choice

Details of this are shown at appendix 3

### **3 Report on the public consultation**

- 3.1** The public consultation commenced on the 9 May 2011 with five public events held on 13 May, 17 May, 18 May, 23 May and 26 May 2011. Staff were formally advised of the proposals on 9 May 2011 with meeting held for inpatient and facilities management staff on that date. This presentation is shown at appendix 4.
- 3.2** A detailed 'Timeline and Action Plan' was developed and maintained before, during and after the consultation (see appendix 5).
- 3.3** Information relating to the public events and the proposals was widely circulated across key stakeholders. These included briefings, flyers and copies of the main and summary consultation documents which detailed the methods by which feedback could be provided.
- 3.4** The five public events were well supported by Older Peoples Mental Health Service Directorate with additional attendance from Governors and Southampton and Hampshire LINKs representatives.
- 3.5** Storyboards were used detailing the proposals, and an area set aside for a presentation based on the storyboard content and then followed by a Question and Answer session. The format was generally well received.

- 3.6** The presentations worked well and generated a good number and range of questions. The presence of senior clinicians to answer questions was well received by members of the public.
- 3.7** Responses to the consultation were received in a variety of formats. The majority of feedback was received at the public events led by the Clinical Director, Director of Operations and Deputy Director of Operations from the Older Peoples Mental Health Service Directorate. Other feedback was also received via feedback forms and correspondence.

Some themes to emerge included:

- Support for closing under utilised beds within the directorate
  - Agreement for developing our community services and moving away from bed-based provision
  - Some concerns relating to services being cut back by other agencies and the potential impact on carers and relatives
  - The difficulties for some patients and their carers of travelling to the Western Community Hospital
- 3.8** At its 24 May 2010 meeting the HOSC received a progress report on the consultation period.
- 3.9** The Trust analysis of the formal consultation has been externally validated by Hampshire LINKs and a report produced. This report is shown at appendix 8.

#### **4 Key issues, risks, opportunities and actions**

As detailed in appendix 6 feedback was received from a variety of sources including responses from members of the public and local councils. This feedback was collated and highlighted some emerging themes which were described in the analysis and forwarded to Hampshire LINKs for validation. Notwithstanding Hampshire LINKs' recommendation the Trust has noted the following concerns and proposed to strengthen the existing arrangements as described below.

##### **4.1 Improved understanding of mental health issues in primary care and acute care**

The Older Persons Mental Service Directorate has good existing links with GPs and will look to strengthen these further. Each surgery in the Southampton and the South West Hampshire area has a designated psychiatrist and community mental health team to work with. The Older Persons Mental Service Directorate has already run some training events for GPs and will continue to do this through 2011 in order to raise awareness of mental health needs in older people.

The Directorate has recently increased psychiatric liaison into Royal Hampshire County Hospital, Winchester, and will look to increase liaison into Southampton General Hospital as part of these plans. The Directorate is also planning a series of educational events to be held across acute hospitals during 2011.

#### **4.2 Better information for service users and carers**

The Directorate has recently updated all its information for service users and carers and this is given out to people when they attend for appointments. The Trust website has also recently been updated.

#### **4.3 The need for people to remain independent for as long as possible with support from family and friends to achieve that**

People told the Directorate that they wish to stay living in their own homes as long as possible, however there is a need to ensure that service users and their carers are supported for this to happen. Clinical staff in the directorate work closely with carers, paid carers and Hampshire County Council Adult Services as well as a range of voluntary organisations and try to ensure that individuals are signposted to all the care support that can be provided for them.

#### **4.4 Concern for those who would need transport from rural areas**

It is acknowledged that there will be an additional travelling burden for some patients and their carers and family members who will have to travel greater distances as a result of the proposed ward closures. Not all of these individuals have their own transport and would rely on public transport. The numbers of individuals who would be affected negatively by the changes is very small and the Directorate plans to work with members of Eastleigh Borough Council to develop a travel plan to support these individuals. It is acknowledged that a significant amount of care is provided to individuals within their own homes. An additional clinic has been set up at Blackfield Surgery in Eastleigh Southern Parishes where a consultant psychiatrist holds a monthly clinic. Outpatients clinics and memory clinics will continue to be held at the Tom Rudd Unit and Newtown House Eastleigh. There are plans to provide additional memory clinics in or in the vicinity of the Western Community Hospital.

#### **4.5 Concern for carers**

The Older Persons Mental Service Directorate values the role that carers and families perform in the care of patients; our staff will ensure that carer assessments continue to play an important role in ensuring that carers' needs are identified alongside those of the service user. As part of developing good practice the clinical teams within the service involve carers as part of care planning. There are carers' groups that are well established across the whole Directorate and in particular carers of people with memory problems have special groups that can be attended to meet their specific questions and needs, as part of 'Memory Matters' courses.

#### **4.6 The need for public awareness and reducing stigma**

It is acknowledged that there are significant number of individuals living in the community who have either memory problems or functional mental health problems who have not had a formal diagnosis. Public awareness has increased since the publication of the National Dementia Strategy and the Directorate has noticed an increase in referrals for memory assessments. Southern Health NHS Foundation Trust has a "Time To Change" campaign manager. The "Time To Change" is a national campaign which aims to reduce stigma around mental health.

#### **4.7 Health use of the Moorgreen Hospital Site**

Many individuals have been concerned about the removal of services from the Tom Rudd Unit site. A significant amount of money has been spent on upgrading the Tom Rudd Unit where the Community Mental Health Team for East Southampton is based and the Memory assessment clinic is also based there. There are no plans to move these services away from the Tom Rudd Unit site. Proposals are underway to reutilise some of the vacant ward space to develop an inpatient learning disabilities unit.

#### **4.8 Development of a group to oversee changes**

A time linked reference group will be established to incorporate key stakeholders to oversee changes.

### **5 Recommendation**

**The Trust Board is asked to note the contents of this paper and, based on the feedback received during the consultation process, approve the recommendation to proceed to close Willow and Linden Wards on the Tom Rudd Unit on a permanent basis. This will be subject to the actions set out in section 4 of this paper and any further actions identified by Hampshire LINKs.**



## Appendix Two: The Case for Change – Adult Mental Health Service Redesign

V4/ 15.07.11  
HOSC - CASE FOR CHANGE

Southern Health   
NHS Foundation Trust

### ADULT MENTAL HEALTH SERVICE REDESIGN

DRAFT CASE FOR CHANGE

**Implementing the Joint Commissioning Strategies for Adult Mental Health in Hampshire**

For presentation to the Hampshire Overview & Scrutiny Committee on 26 July 2011

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## **Appendix Three. Children's Heart Surgery reconfiguration. HOSC Panel Response to consultation- 17 June 2011**

Dear Sir Neil

I am responding on behalf of Hampshire HOSC to the consultation on Children's Congenital Heart Services. Given that it has taken over a decade to reach this point our observation is that the overarching objectives of this exercise – to improve the quality of these services for children and ensure they are safe and sustainable in the future - has been lost in an adversarial and divisive consultation exercise which has focused predominantly on defending the process and not the on delivering the desired outcome.

We agree that it is important for children's heart surgery to be undertaken to the highest standards of quality of care, and wholeheartedly support the view of Professor Sir Ian Kennedy that 'mediocrity must not be our benchmark for the future'. It is therefore deeply disappointing that this is the outcome that we are in danger of delivering unless there is a change in focus from those leading this process. Professional and stakeholder consensus in relation to the five principles identified has, in our opinion, been lost in the emphasis given to an option appraisal process that has set unit against unit and clinician against clinician. Assessments of service quality have been put to one side in a process that places emphasis on travel times and the assumption that parents will go to the nearest centre- except where it appears to be more convenient to assume they will go elsewhere.

The flaws in the approach adopted have been highlighted by many. The adverse impact of these proposals on a wide range of other clinical services as well as the research and training implications for those centres that are not designated have yet to be considered. The adversarial climate this process has fostered is of no credit to those concerned. The responses to issues raised by clinicians, parents and other stakeholders seems to reflect a preoccupation by those driving 'Safe and Sustainable' with defending the process against legal challenge rather than securing the prize of better quality care for these patients. This is not acceptable or in the interests of the patients affected.

The consultation process has exposed a number of issues that, in our view, will have a material impact on the options open for reconfiguring these services. These are summarised below and considered in more depth in our more detailed response at Annexe One. They have yet to be addressed or discussed with stakeholders. Without this work being completed and robustly tested we believe there is a real risk to a range of acute paediatric services and a potential disruption to critical/ intensive care networks that are vital when these patients are in greatest need. Key areas that will have a material impact on the viability of the options presented are:

- Quality of care has not been given appropriate weighting in the option appraisal process despite being the priority for patients and clinicians. The options presented give priority to access and retrieval times even though stakeholders agreed these are the least important factors.

- The requirement for the co-location of paediatric cardiac surgery with other essential children's services, as identified in the evidence, has not been appropriately considered in the option appraisal process
- The variability in the way in which travel times have been assessed and patient populations 'allocated' to a specific centre (not consistently their nearest)
- The impact on PICU, PIC networks and PIC retrieval and the implications for these services across the south coast area. This must include retrieval of patients from the Isle of Wight: this was not considered in the option appraisal process.
- The implications for services that currently provide seamless, integrated care for patients with congenital heart problems from before birth through to adulthood.
- The management of complex or rare conditions.
- Current patient flows and choice.
- The impact on existing and future services for GUCH patients.
- The impact of the proposals on existing training posts for junior medical staff and national/international research.
- The potential loss of specialist consultant expertise that has international recognition.

We do not understand why the extensive preparatory work that underpinned the launch of the consultation failed to identify and address these concerns.

The feedback we have received from key stakeholders and parents is that there is a need for this process to continue despite the problems identified, primarily because it has taken 10 years to get to this point and change is needed. As a HOSC we have therefore reluctantly come to the view that we will support it proceeding, but only if the specific points set out in our detailed response attached at Annexe One are satisfactorily addressed. In supporting the outcome of this process we are clear that we:

- will not support any decision that cannot demonstrate that quality of care (and not postcode) has determined the configuration of surgical centres for the future;
- will need to understand the wider impact of these changes on other critical paediatric clinical networks (particularly PICU). It will not be acceptable for these crucial networks to be put at risk as a result of any changes made;
- are not prepared to tolerate a continuation of some of the behaviours and misuse of information to support one position over another that we have observed (and brought to the attention of the secretariat) as this process has rolled forward.

As the options currently stand only Option B is 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. It also has the potential to minimise the impact on PICU services and is the only option that meets retrieval time standards for the residents of the Isle of Wight, a significant omission in the other three options identified.

It is therefore the view of the Hampshire HOSC that option 'B' should be supported although there is a considerable amount of further work to be undertaken if this process is to move to an acceptable conclusion.

We must also flag our deep concern about the decision making process that has underpinned the development of the options. We accept and support the common sense behind a joint committee of PCTs acting as a decision making body where services are provided on a national or supra-regional basis. It is however essential that there is clarity about the accountability of any such body back to individual PCT Boards and the public as well as transparency in its deliberations. We have requested additional information from the Safe and Sustainable team in relation to this issue.

If the accountability and governance arrangements supporting this process cannot be appropriately evidenced then we will be asking our PCT to reconsider the mandate it has given the JCPCT to act on its behalf. Hopefully this will not be necessary.

Please do not hesitate to contact me should you have any queries about the issues raised in this letter or the supporting Annex. We look forward to receiving the response of the JCPCT to our recommendations. It would also be helpful to have confirmation of the next steps in the decision making process of the JCPCT.

Yours sincerely

**Cllr Pat West**

**Chairman, Health Overview and Scrutiny Committee**

cc Hampshire County Councillors  
Hampshire MPs  
Simon Jupp, Director, South Central Specialist  
Commissioning Group  
Jeremy Glyde, Safe and Sustainable Secretariat  
Mark Hackett, Chief Executive, Southampton University  
Hospitals Trust  
Debbie Fleming, Chief Executive, SHIP PCT Cluster  
Jonathan Montgomery, Chairman, NHS Hampshire  
Andrea Young, Chief Executive, South Central SHA

## Annexe One

The specific points we wish to raise in relation to the consultation on the options for reconfiguring children's congenital heart services are set out below:

### Conduct and Content of the Consultation Process

1. We have already drawn the attention of your secretariat to a number of concerns that we have about the conduct and content of the consultation process. Specific points include:
  - The consultation document is long and overly complex. Additionally the document contains a number of factual errors, inaccuracies and omissions that are material to the options for change identified. The Safe and Sustainable team have been alerted to these errors but no amendments have been issued.
  - The response form is limited in its scope for comment. In our view it is designed more to ease the process of evaluation than secure meaningful feedback. There is no clarity about the way in which issues raised or alternative options identified will be evaluated or tested for cogency. We do not accept the suggestion that this work can simply be outsourced to a third party who - no matter how experienced - will not have the depth of clinical and professional expertise required to understand the complex care pathways that children's services need to have in place.
  - Limits were placed on the numbers attending public meetings in our area and requests that more were arranged were declined. Despite an assurance that more events would be arranged we are not aware of any taking place.
  - There is no clarity about the next steps to be taken in terms of transparent consideration of the additional evidence received and how this will be taken into account when the JCPCT makes its final decision.
  - Delivery of the configuration tests. We are keen to understand how NHS London had quality assured the process against the Secretary of State for Health's 4 configuration tests as the consultation is not yet complete. It would be helpful to have the quality assurance assessment that NHS London undertook in relation to this. We do not take referral lightly and, should this be necessary, would wish to take all evidence into account when we come to a view on the extent to which the process followed meets the 4 tests. The views of GPs are important but the impact of the proposals on patient choice is a particular concern given the emphasis on networks referring to centres in their area. It would also be helpful if you could answer the question we posed in relation to the Co-operation and Competition Panel as their views would be relevant to our deliberations.

**Recommendation 1:** the HOSC is provided with the assessment undertaken by NHS London in relation to the '4 tests' for reconfiguration of services within 4 weeks of receipt of this letter.

**Recommendation 2:** the HOSC is provided with the views of the Co-operation and Competition Panel on these proposals, or the reasons why this is not necessary, within 4 weeks of receipt of this letter.

2. We would also wish to be clear why you have not provided the information we have requested in relation to the budget set aside to support this work. Whilst it may not be material to the consultation per se we are of the view that it is important background to the process. We do not wish to resort to using the Freedom of Information Act to access this information but will do so if necessary.

**Recommendation 3:** the HOSC is provided with the breakdown of the budget available to support this work and how this has been allocated to date. If it is not possible to provide us with this information, please confirm why it is exempt from disclosure.

### **Evidence Base**

3. Whilst the literature review supporting this work found an association between greater volume and outcome it was clear that specific thresholds for procedures undertaken on a centre or individual surgeon basis were not considered appropriate. Additionally the relevant evidence that is available is based on an integrated model of congenital heart services and therefore looks across adult and children's surgery. The thresholds outlined in the consultation document are only based on children's heart surgery. The SCG response acknowledges that the thresholds for surgery are based on professional consensus rather than evidence, but does not address the issue of assessment of those services where an integrated model of care means that surgeons are operating across children's and adult services. The model of care developed for children's congenital heart services has merit but needs to be flexible enough to accommodate other ways of working where quality of care and service can be demonstrated.
4. Where adult and children's cardiac services are delivered separately through children's and adult hospitals these services are likely to be least affected by the changes suggested. Those centres delivering a life-long pathway of care (the integrated 'cradle to grave' model) will be impacted on far more significantly if designation as a children's cardiac surgical centre is lost, as acknowledged in your response to our questions. We are of the view that the inability of the current process to acknowledge progress made with integrated services is a major weakness in the case for change that has been put forward. We would suggest that it is not appropriate to exclude consideration of GUCH services in those areas where the same surgeons are operating on child and adult patients. This not only adversely skews the assessment of the performance of the surgeons involved (in terms of number of procedures performed) but fails to take account of the benefits that have been achieved for congenital heart patients through an integrated model of care that is passionately supported by the clinicians and patients involved. We do not believe this to be in the interests of the children or the adults so affected.
5. It is also a fact that the outcome of the work on paediatric cardiac surgery will materially impact on the options for configuring GUCH services. This is not appropriately addressed in the consultation document. Our belief is that account needs to be taken of the needs of GUCH patients and the range of

models of care that support them, not least because there are implications for both quality of care and sustainability for congenital heart services in the future that cannot be easily separated. We do not believe that this runs counter to the objectives set out in the review of paediatric services. Greater flexibility simply needs to be built into the outcome of this consultation process to allow consideration to be given to the models of care that are based on integrated services and a phased approach to the provision of both children's and adults congenital heart services. It has taken a decade for the outcomes of the Kennedy Review to be implemented. Services have evolved over that period of time and where there is evidence of safe, sustainable and high quality care these should not be penalised or destabilised.

6. The initial SCG response to our questions acknowledges that there is not a clinical reason for separating adult and children's services on the basis of the number of surgical activities. Whilst we accept the point that the initial response to the Bristol Inquiry in 2001 was quite properly focused on children's services we believe it is important to take into account the evolution of differing models of care over the last decade.

**Recommendation 4:** that further work is done to accommodate an integrated model of care in the future configuration of children's heart surgery. This will enable GUCH patients to be reflected in any assessment of the capacity of surgical centres to reach the desired number of procedures. This work could then be factored into the implementation of the outcome of this consultation process.

7. The consultation document appears to take account of some clinical interdependencies, but not others, even though these are clearly set out in the standards. Our understanding is that children with a congenital heart condition often have other medical needs and these may vary significantly. The document entitled 'Commissioning Safe and Sustainable Specialised Paediatric Services – A Framework of Critical Inter-Dependencies' states "to ensure the provision of safe services, four core services (ENT airway, specialised paediatric surgery, paediatric critical care and specialised paediatric anaesthetics) would become the common core of any specialist paediatric centre or network.
8. If it is accepted that co-location is defined as either 'on the same hospital site or on a neighbouring hospital site such that access is as though it was on the same site' then it is clear that not all current centres are able to meet these standards. The 2010 Kennedy assessment was very clear that not all centres were able to meet the standards for co-location and in some instances had no plans to address this issue. The comment from the national team that the achievement of the standards is aspirational is misleading - any centre would be able to meet the standards given sufficient resource and time. We accept that all centres will need to refine and develop their ability to meet and exceed the standards but the degree of variation across the centres found by the 2010 Kennedy assessments was significant- hence the point about the benchmark for the future not being mediocrity but exemplary practice.
9. At the Oxford consultation event, Professor Edward Baker, the Medical Director at the Oxford Radcliffe Hospital and Chair of the project group that developed the 'Framework of Critical Inter-Dependencies' addressed the expert panel by stating that the critical interdependencies from the framework had been included in the standards but this was not reflected in the

subsequent evaluation. He was clear that this is not acceptable and needs to be addressed as a matter of urgency.

**Recommendation 5:** that the national team confirms and publishes (with details of individual centre's compliance of these standards) the weightings that have been applied to co-location, and how this informed the option appraisal process.

**Recommendation 6:** Professor Baker, with appropriate clinical and JCPCT support, is asked to assess the options, taking into account the framework and highlighting the interdependency issues that need to be addressed with each.

10. We are concerned that the clinical and equity risks associated with these proposals have not been adequately evaluated, particularly with regard to impact on PICU networks/retrieval and the unwillingness of the JCPCT to reconsider the options taking account of the retrieval times for patients from the Isle of Wight. Frontline clinicians have commented at length and far more eloquently than we are able to about the risks to PICU, particularly with regard to PIC retrieval.

11. Your response to our questions confirms that 'further assessment of risks associated with the potential impact on PICUs is required and is part of the consultation'. When will this information be available and who is leading this work? We feel that this is material to the assessment of the options presented and it is not acceptable to ask any centre (or indeed commissioner) to sign up to a change that may have such a profound and unintended impact on other services. This is not a network that can be put at risk.

**Recommendation 7:** the national team, working with lead representatives from PIC networks, reviews and publishes the anticipated impact of the changes outlined in the options on PIC networks, individual PICUs and retrieval networks. This work should be factored into any decision about the final form of the configuration of these services

12. Priority, and apparently significant weighting in the option appraisal process, is given to the need to align children's heart surgery with three national services (ECMO, heart transplants and complex tracheal surgery) even though three of the options will require some relocation of these services. We are still not clear what the interdependencies between these services are in terms of their impact on the options identified or why weighting was given to them in the option appraisal process.

**Recommendation 8:** that there is a clear statement setting out the interrelationships between children's congenital heart services and national paediatric services. Where appropriate these should be incorporated into service standards.

13. In addition to children's congenital heart surgery it is proposed that interventional cardiology is also moved to the surgical centres. There is no information on the consequential impact this may have on other services provided at the hospitals affected but your response to our questions is clear this may be the case. Again this would seem to be a material issue to the discussions about the options. When and how will this work be taken forward?

**Recommendation 9:** that the national team, working with appropriate clinical specialists, reviews and publishes an evaluation of the impact of the options on interventional cardiology services.

### **Quality of Service**

14. It is deeply disappointing that more information is not available regarding the mortality and the quality of care across those centres currently providing paediatric cardiology services. Our understanding is that:
  - 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.
15. The 2010 Kennedy assessment highlighted Southampton as an exemplar of best practice in three different areas yet this has not been considered by the national team in the option appraisal process.
16. We believe it is misleading to suggest that all centres should be considered because they have the potential to meet the standards. The wide variation in the ability of the existing centres to meet the standards demonstrates the difference between mediocrity and exemplary practice!
17. The JCPCT appears to have set the quality assessment undertaken by Kennedy in 2010 to one side in order to prioritise the designation of centres by a predetermined activity threshold and without taking account of current patient flows or complexity of procedure. This is deeply unhelpful.
18. Parents and professionals both give priority to quality of service, and consider access or distance to a facility the lowest priority. The option appraisal process has given greatest weight to geography to support access and retrieval times. This has run counter to the principles set out in the documentation and in our view has contributed to a loss of patient and professional confidence in the process.
19. The original Kennedy review was very specific that ease of access should not be a factor in considering where paediatric cardiac surgery is carried out. No credible reason for setting this to one side has been given in taking forward the option appraisal process. Your response that this reflected the views of stakeholders is contradicted in both the document and the feedback we have heard from parents. We are not convinced that the priority accorded travel and access in short listing the options is supported or supportable and that the emphasis placed on these factors during the various methodological gymnastics that comprised the option appraisal process is misjudged. The models based on postcodes take no account of current patient flows and the assertion that allocations are based on the 'strict application of patients attending the nearest centre' (as stated in the pre consultation business case) has been applied inconsistently across the north and south of the country but

there is not rationale for this apparent discrepancy. Taken with the other concerns that have been identified in the option appraisal process we are of the view that the principles set out on pages 13-14 of the consultation document have been badly undermined.

20. The process has been further devalued by the fact that you did not take travel times or retrieval into account for the Isle of Wight and have steadfastly refused to publish any information on the impact that this additional information could have on the options presented despite that fact that this was drawn to your attention early in the consultation process. We strongly challenge your assertion that this information will not be made available until the JCPCT makes its final decision as it could have a material impact on other stakeholders views on the best option.

**Recommendation 10:** that the national team publishes the reasons for there being a variation in the application of the assumption that 'patient will travel to the nearest centre' across the north and south of the country and when this was agreed by the JCPCT.

**Recommendation 11:** that the report on the impact of the inclusion of the Isle of Wight in the assessment of travel and retrieval times is published immediately. If there is any reason why this information cannot be published as requested by the HOSC this shall be communicated in writing within 4 weeks of the receipt of this letter.

21. The absence of robust comparators of quality, outcome and mortality for these services is a significant weakness given that we are 10 years on from the original Kennedy report. We note that Southampton has been collecting this data for a number of years, making it possible to demonstrate a single centre's performance but not to compare this data.
22. The comments that you make with regard to the quality of service that will be achieved as a result of the changes proposed are laudable but will take a number of years to demonstrate across networks. SUHT can already evidence this and has the potential to roll this out across the network established with Oxford. Rather than building on this work three of the four options discard the progress made. Again we are at a loss to understand how this can be justified. Your comments about the importance of leadership in the clinical networks is key but fails to take into account the point about the need for respect and collaboration necessary to make these work effectively - this consultation process has been so adversarial that this good will has been significantly compromised.

### **Case mix and complexity**

23. We were deeply alarmed by your responses to us in relation to case mix and complexity. The original Kennedy report states that there should be just two centres nationally caring for the most complex or rarest heart conditions, yet there is no reference to this in the consultation document or the pre-consultation business case.
24. 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.

25. The feedback you have provided to us in relation to this is at odds with what we have heard from stakeholders, parents and practising clinicians. We heard for example at our evidence day that some centres with no previous track record in more complex procedures are now undertaking these- although this is not currently audited via CCAD. This cannot be a desirable consequence of this process and must constitute 'occasional practice'? The inference in your response to our questions to less than 100 procedures constituting 'occasional practice' it would be helpful to understand how you define this.

**Recommendation 12:** that the HOSC is provided with a definition of what is meant by 'occasional practice' and confirmation of the steps that have been taken to ensure that only those with the appropriate expertise perform rare or complex surgery.

26. The fact that the JCPCT is prepared to set aside current arrangements for the referral of complex cases whilst those centres that are designated 'develop a specialism in rare and complex procedures' is frankly astonishing. You have already stated that the peer audit of quality outcomes and mortality does not take place in real time, yet the JCPCT is prepared to begin this process from scratch in the designated centres. The lag this would create in terms of getting meaningful data from such a process is significant as is the potential risk to patients during this period. In our view be this would be unacceptable, especially when coupled with the feedback received at our evidence day that some centres are now attempting complex procedures in order to build their skill base. It is not clear if this 'occasional practice' is being recorded on CCAD. It is not possible to demonstrate that all current centres are able to deal with all cases equally effectively, nor have we seen any evidence that would support this premise.

27. We are not confident that the commissioning process (which has yet to be agreed) or the Network Boards (which have yet to be established) will be able to ensure that the emphasis on activity thresholds in deciding the viability of a centre does not create a scenario where achieving the numbers takes precedence over the quality of care, certainly in the short to medium term. There is also a danger that the commissioning process and network boards will be so far removed from frontline services they would not be able to address this point for a number of years.

**Recommendation 13:** that further work is undertaken by clinical networks, under the leadership of the JCPCT, to identify appropriate referral pathways for complex and rare conditions and ensure that these are reviewed and audited in an appropriate and timely manner.

### **Choice versus postcode**

28. The consultation document states that some parents may decide that their child should be treated at a different hospital – even if this means that they are travelling further. This is evidenced by the patients' flows for Southampton

General in the last year which includes patients from the south west, south east and other catchment areas. The assumptions about thresholds are based only on numbers in postcode areas. It is counterintuitive for the document to be suggesting that a service, independently assessed as being of high quality, should close in order to meet a postcode threshold that is not actually evidence based. Parents can and will exercise choice and have already indicated that quality of care **not** the distance travelled is their priority.

29. The analysis of current patient flows needs to be carefully considered and we would appreciate confirmation of when this will be available.

**Recommendation 14:** that the national team confirms when the information on current patients flows will be published.

30. Taking account of the points raised above in relation to case mix and complexity we are concerned that that clinicians in non-designated services will be under pressure to refer within a network rather than to the best/ most experienced service. Both referring clinicians and parents must be free to exercise choice in deciding the surgical centre they wish to attend, based on sound audited information about quality and capability. The development of options on the basis of post codes does not give us confidence that this will in fact be the case.

**Recommendation 15:** that the national team confirms that patients will be able to be referred to any surgical centre of their choice.



## Appendix Four: Fluoride letter to HOSC from South Central SHA



South Central Strategic Health Authority  
First Floor, Rivergate House  
Newbury Business Park  
London Road, Newbury  
Berkshire, RG14 2PZ

01635 275500  
www.southcentral.nhs.uk

10 June 2011

Cllr Pat West  
Chairman, Health Overview and Scrutiny Committee  
Room 102, Chief Executives Department  
Hampshire County Council  
The Castle  
Winchester  
Hampshire  
SO23 8UJ

Dear Cllr West *Pat,*

### **Plans to add fluoride to drinking water in Southampton and parts of south west Hampshire**

Thank you for your letter dated 11 May regarding the proposals to add fluoride to the drinking water in Southampton and south west Hampshire.

We are currently developing the implementation plan for the fluoridation scheme in discussion with Southern Water, which will include the anticipated capital and revenue costs. Once completed, we will be happy to share this information with you.

We are also working with the Department of Health to determine which bodies will be responsible for meeting these costs. I anticipate that we will have more information on this before the end of June.

Further to your comments on the cost benefit analysis, York Review and Abacus International study, please note that the relevant finding in the York Review states that 'The range in the mean difference in the proportion of caries free children is -5.0% to 64% with a median of 14.6%'. The Abacus International study, however, used published data including that from the York Review to look at the reduction in carious lesions and how many teeth would be saved, rather than how many more children would have no disease at all. These are different measures of the effectiveness of fluoridation, though both have value in demonstrating that effectiveness.

The consultation document clearly highlighted the various initiatives that NHS Southampton has carried out over recent years to improve the dental health of the local population. Even with this extra investment and effort, dental health in Southampton is still poor. Although dental initiatives have achieved some local improvements in Southampton, these targeted schemes are not able to provide the required community-wide improvements for the dental health of Southampton residents. Reviews of the scientific evidence and experience from other parts of the UK where there are water fluoridation schemes suggest that an optimal level of fluoride in the water, alongside continued dental health promotion programmes, would be the most effective way of reducing 'dental inequalities' and will help improve the health and wellbeing of people in

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Southampton. The Board of SCSHA considered this research when presented with all arguments to help inform its decision.

The proposed dosing model was recommended by WS Atkins who are specialists in water engineering. Although dosing does not happen in distribution systems elsewhere in England, WS Atkins advised that this does happen in other countries and there is no reason why it could not be done here. We hope to engage with Southern Water on any proposed changes to this recommendation during the next few months.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Andrea Young', written in a cursive style.

**Andrea Young**  
**Chief Executive**