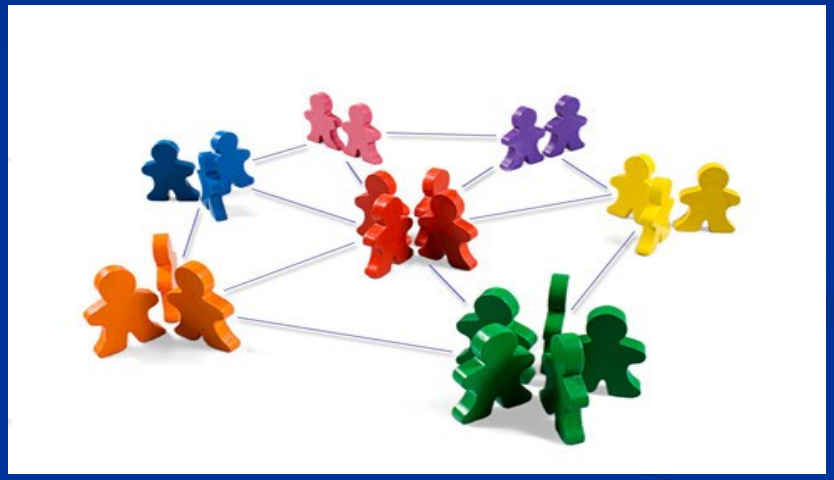
Paediatric Surgery Provider Networks: A case study in the South West



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- "The aim of paediatric surgery is to set a standard not to create a monopoly" - Dennis Browne

- Non-specialised children's surgery and anaesthesia should be delivered through clinical provider networks (RCS, CSF)

The Bottom Line

- Insufficient capacity in Tertiary Paediatric Surgery Centres to cope with ALL Children's Surgery
- Not enough work in individual DGH'S to support a full time Paediatric Surgical rota
- Need DGH general surgeons and urologists to do General Paediatric Surgery (GPS) of childhood
- Need Networks for training and support

Paediatric Surgery in the Southwest today

- Southwest Paediatric Surgery Network came into being in 2010 (Clinical Director and Network Manager)
- Tertiary Paediatric Surgery Department at Bristol Royal Hospital for Children (BRHC), 4 paediatric surgeons and 3 paediatric urologists.
- 10 DGH's where general paediatric surgery of childhood is routinely performed
- No specialist paediatric surgeons in the DGH's/ Outreach clinics but no routine lists
- BRHC is always the fall back

Key Principles of Setting up the Network

- Ensure involvement of clinical staff across the region in decision making – surgeons, paediatricians, anaesthetists, nurses and managers.
- Change must be for benefit of the patient
- Objective should be the provision of safe, high quality surgery as close to home as possible (The Children's NSF – Every Child Matters 2004, NHS Next Stage Review, CSF, NHS Operating Framework 2010/2011)

Aims of Paediatric Surgery Network

- Strengthen collaboration between DGH's and BRHC
- Ensure timely succession planning for surgeons in DGH's
- Audit the work in both tertiary centre and DGH's to ensure high standards of care
- Invest in appropriate training of future surgeons/anaesthetists
- Support CPD and revalidation
- Share good practice, sustain vulnerable services, standardise care, improve access and make best use of scarce specialist expertise

Surgeons

- Shift of patients from DGH to tertiary centres (Pye – Survey of GPS provision 2008)
- Superspecialisation among adult surgeons – no interest in GPS
- Very busy adult surgical practices – no time for GPS
- Inadequate succession planning
- Poor job advertising

Buy in by Executive/Surgeons/local Commissioners in DGH's

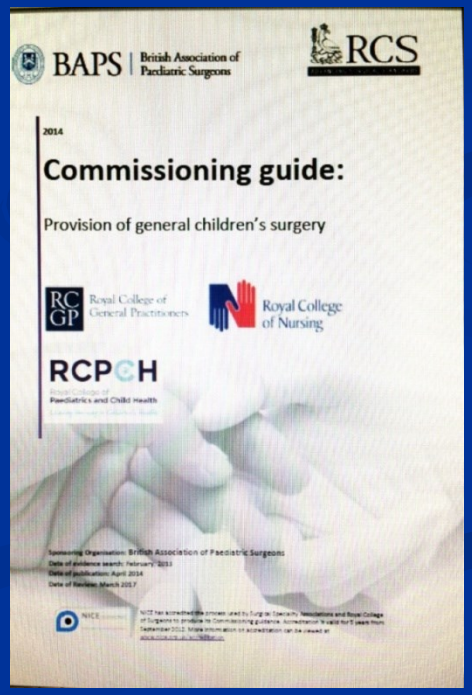
- Paediatric surgery is a low volume, low priority service - it is a vulnerable service that needs protecting
- Need for the hospital executive/managers/commissioners to understand what GPS is
- Need linked up commissioning ensuring an overall view of the service - both specialised and non-specialised paediatric surgery as well as regional and national views

Commissioners

- Difficult to get access to local commissioners
- Most do not understand GPS
- Want to save money by cutting services

CCG's

- Share responsibility with local DGH's for local children
- Engage with Networks
- Support the local hospitals in achieving the standards and commission them to do the GPS



What do we want ?

- An open and transparent debate between NHS policymakers, the public, commissioners and clinicians about what is practical and affordable

- Address this by a combined initiative including the RCS, the Specialty Associations, the Commissioners and the regional networks

- National agreement to avoid post code lottery

Solutions and Problems

1. **Move all Paediatric Surgery to Tertiary Centre**

    1. Low volume speciality
    2. Dilute index workload of paediatric surgeons with GPS risks poorer outcomes
    3. Long distances for some patients away from family support
    4. No capacity in Tertiary Centres
    5. Problem for time critical conditions e.g. acute scrotum

2. **Send all elective GPS to tertiary centre/Paediatric Surgeon in DGH**

    1. if take away elective GPS from general surgeons and anaesthetists they will de-skill and emergency GPS will suffer.

3. Employ a Paediatric Surgeon in DGH

1. Not sufficient GPS per centre to keep them busy
2. Unable to do index cases as no resources
3. Deskill general surgeons who are then reluctant to do the emergency GPS

Advantages of Paediatric Surgery Networks

- Low volume therefore a small component of workload in a DGH – require support
- Ensure adequate training of smaller pool of general surgeons and anaesthetists through the networks and specialist associations
- All staff maintain the required skills- surgeons, anaesthetists, nurses etc. – appraisal
- Tertiary Centre not diluted/swamped by GPS, better outcomes for specialised index cases
- Local care for patients/easier access for families
- No problem with time critical GPS
- More capacity in Tertiary centre for specialised cases

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