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**Ear, Nose and Throat Service**

**Options Appraisal**

**Version 8 - 16.05.2014**



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# Introduction

This options appraisal sets out the options being considered by commissioners for the provision of Ear, Nose and Throat (ENT) services within North and North East Lincolnshire, and the risks and benefits with each. The purpose of this paper is to provide the information required by the Council of Members from each of the Clinical Commissioning Groups, along with the Partnership Board from North East Lincolnshire Clinical Commissioning Group and the Governing Body from North Lincolnshire Clinical Commissioning Group to make a decision on a preferred option that will be taken to a public consultation in the summer of 2014.

# 2. Executive summary

## 2.1 Background information on the ENT service

Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) provides ENT services across its three sites and operates routine outreach clinics in Mablethorpe and Louth. The ENT service works in collaboration with other services, predominantly:

* NLaG Audiology service
* NLaG Speech & Language service
* Hull & East Yorkshire & United Lincolnshire Trust (dependent upon CCG of residency) via multi-disciplinary team referral

Table 1 shows activities currently undertaken at each of the NLaG sites:

#### Table 1 - Activity currently undertaken across the locations February 2013- January 2014

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Activity | DPOW (Grimsby) | SGH (Scunthorpe) | GDH (Goole) | Louth (outreach) | Mablethorpe (outreach) |
| Outpatients | √ | √ | √ | √ | √ |
| Elective | √ | √ |  |  |  |
| Daycase | √ | √ |  |  |  |
| Non-elective | √ | √ |  |  |  |

The ENT service has teams of staff on both DPOW and SGH sites that offer similar operations and procedures for the people in this area both as inpatients and outpatients. There are few vacancies within the ENT service, minimal use of locum services and the service financially operates within its budget.

The service offers an on-call and “out of hours” service, which currently rotates between the DPOW and SGH sites. Concerns have been raised by NLaG clinicians regarding the sustainability of this on-call system, which has no formal specialist coverage on both sites 24/7. The rota is managed by informal arrangements between consultants and senior doctors to cover their own patients if the on-call team are on rotation to another site. This avoids transfer of patients, but has been deemed unsustainable for the long term.

Optimal and safe emergency processes are required to ensure that the patients receive timely intervention should an emergency occur, and that normal service delivery is not compromised by temporary arrangements to provide emergency cover. Commissioners have responded to these clinical concerns and this options appraisal review sets out the options available for the service. Options will be subject to a full public consultation as part of the Healthy Lives, Healthy Futures programme in the summer of 2014.

The NLaG business case that set out the provider clinical review can be found as Appendix 1.

## Options being considered

Commissioners are reviewing a range of options to determine which is right for their health communities for the long term. This thinking takes into consideration the safety and quality aspects of the service, drawing on national and regional guidance and clinical best practice recommendations for ENT services where they are available. Considerations draw on demographic information, and take into account the impact of provision in different locations according to safety, access, deliverability and cost.

The options being considered by commissioners are:

1. Do nothing, continue to deliver ENT services as currently in operation across all sites
2. Centralise the elective and non-elective inpatient ENT service to DPOW, Grimsby
3. Centralise the elective and non-elective inpatient services to SGH, Scunthorpe
4. Decommission local service and send all surgical ENT patients to tertiary centres

## 2.3 Preferred option

The programme board have reviewed this options appraisal and undertaken an evaluation scoring exercise, taking on board feedback from the clinical community and sub groups within the HLHF programme. It is the recommendation of the programme board that option 2: centralise the service on the DPOW site is taken to a public consultation. The rationale for this recommendation is included further in this options appraisal document.

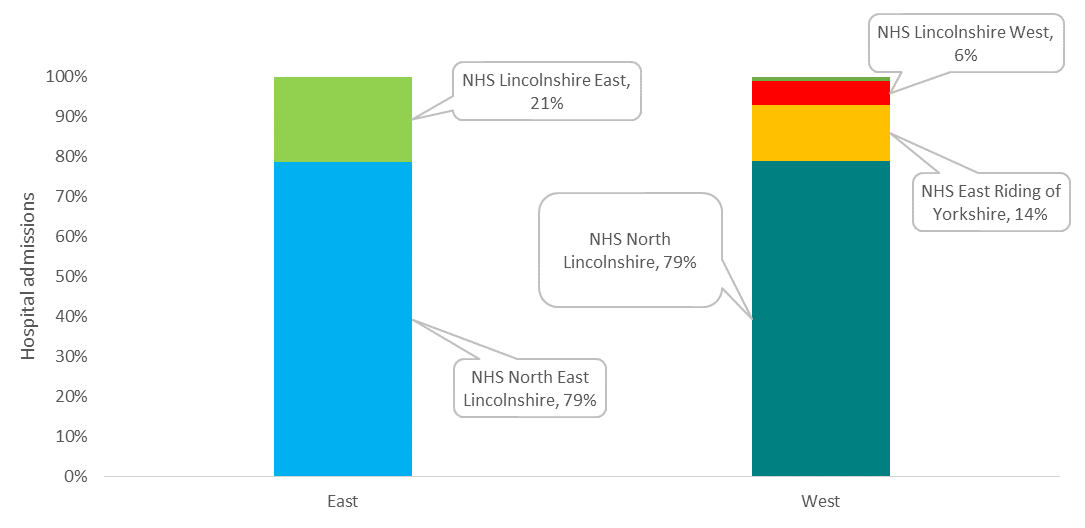
# 3. Health needs assessment

A full health needs assessment has been undertaken and can be found in Appendix 2. Key findings which are relevant for ENT services are outlined in this section.

## 3.1 Population

Hospital services provided by NLaG are accessed by people registered to several local Clinical Commissioning Groups (CCGs). Chart 1 shows how these are distributed across the region.

#### Chart 1 – Distribution of hospital admissions to NLaG by CCG.



Source: BCG Analysis. Percentage of total elective and day case admissions by CCG.

Almost 80% of elective (elective inpatient and day case) attendances to NLaG are by people registered with GP practices within North and North East Lincolnshire. Due to proximity a higher proportion of the populations of North and North East Lincolnshire CCGs attend NLaG compared to proportions from other CCGs.

Estimates of the size of CCGs populations are provided by the Office for National Statistics (ONS) and are based on data from the 2011 Census. The estimated catchment population from each CCG are shown below:

#### Table 2 – Total CCG population size 2011

|  |  |  |  |
| --- | --- | --- | --- |
| CCG | Total CCG population (all ages) | NLaG catchment population | % of CCG population within NLaG catchment |
| NHS North Lincolnshire | 167516 | 162114 | 97% |
| NHS North East Lincolnshire | 159735 | 161933 | 101% |
| NHS Lincolnshire East | 227771 | 81154 | 36% |
| NHS East Riding of Yorkshire | 313386 | 57226 | 18% |
| NHS Lincolnshire West | 225253 | 34190 | 15% |

Sources: Office for National Statistics (ONS) mid-2011 Census based population estimates for Clinical Commissioning Groups. ONS 2011-population counts by postcode sector. BCG activity analysis

The NLaG catchment population is defined as the combined population of postcode sectors from which 97% of elective care activity originates. The remaining 3% excluded from the analysis refers to postcode sectors with very small volumes of activity (less than 0.05% activity) and patients from out of area. Postcode sectors do not map neatly to CCG or conventional area boundaries and therefore the sum of sector populations may not equate to CCGs populations. This is why some may seem larger than expected, e.g. 101%.

## 3.2 Age and sex

The population age profiles of North and North East Lincolnshire CCGs are relatively similar, whereas the populations of Lincolnshire East and East Riding of Yorkshire are shown to be older with a higher percentage of people aged 50 years and over. Lincolnshire West’s profile is similar to Lincolnshire East and East Riding of Yorkshire at younger ages, the highest percentage of people aged 19 to 49 years and older age profile more similar to North and North East Lincolnshire. All local populations demonstrate a higher percentage of males in the population at younger ages which declines with age.

#### Table 3 – Age and sex distribution of CCG populations 2011

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CCG | Age band (years) | | | | | | | All ages |
| 0 - 4 | 5 – 16 | 17 - 18 | 19 - 49 | 50 - 64 | 65 – 74 | 75+ |
| NHS North Lincolnshire | 10221 | 23140 | 4199 | 65584 | 34056 | 16440 | 13876 | 167516 |
| % Male | 51% | 51% | 52% | 50% | 50% | 49% | 40% | 49% |
| NHS North East Lincolnshire | 10001 | 22215 | 4225 | 64212 | 30569 | 14870 | 13643 | 159735 |
| % Male | 51% | 51% | 50% | 50% | 50% | 48% | 41% | 49% |
| NHS Lincolnshire East | 11282 | 28047 | 5326 | 78463 | 49874 | 30292 | 24487 | 227771 |
| % Male | 51% | 51% | 52% | 49% | 49% | 50% | 43% | 49% |
| NHS East Riding of Yorkshire | 15402 | 40393 | 7909 | 113019 | 68652 | 36818 | 31193 | 313386 |
| % Male | 51% | 51% | 52% | 50% | 49% | 48% | 41% | 49% |
| NHS Lincolnshire West | 12358 | 28864 | 5800 | 94218 | 42854 | 22228 | 18931 | 225253 |
| % Male | 52% | 51% | 49% | 49% | 49% | 49% | 42% | 49% |

Source: Office for National Statistics (ONS) mid-2011 Census based population estimates for Clinical Commissioning Groups.

## 3.3 Population projections

As population projections are not currently available for CCG populations, population projections for Local Authorities (LA) and Unitary Authorities (UA) have been used as a proxy. 2011 Census estimates of LA and UA populations are included to enable comparison to 2011 CCG populations as shown below. The rates of population growth vary by local area. North East Lincolnshire is expected to have the lowest net population increase at 1%, while the populations of East and West Lindsey are expected to see the highest, each projecting 7%. However, in terms of numbers of people, East Riding of Yorkshire is expected to have the largest increase in the number of people, with North East Lincolnshire expected to have the smallest.

#### Table 4 – Projected population change 2011 to 2020, all ages by area

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Year | North Lincolnshire UA | North East Lincolnshire UA | East Riding of Yorkshire UA | East Lindsey UA | West Lindsey LA |
| 2011 | 167516 | 159735 | 334673 | 136683 | 89352 |
| 2014 | 170991 | 160110 | 341997 | 141387 | 92750 |
| 2015 | 172185 | 160337 | 344422 | 142967 | 93863 |
| 2016 | 173381 | 160557 | 346839 | 144546 | 94971 |
| 2017 | 174561 | 160783 | 349209 | 146084 | 96064 |
| 2018 | 175740 | 161016 | 351558 | 147615 | 97138 |
| 2019 | 176882 | 161257 | 353919 | 149152 | 98218 |
| 2020 | 178006 | 161504 | 356273 | 150692 | 99288 |
| Change 2014-2020 | 7015 | 1394 | 14277 | 9305 | 6538 |
| Change 2014-2020 (%) | 4% | 1% | 4% | 7% | 7% |

*Source: Office for National Statistics Interim 2011-based subnational population projections. \*Unitary and Local Authority populations used as proxy for CCG populations*

Details of the age-related population projections can be found in the full health needs assessment, enclosed as Appendix 2.

# 4. Current service provision

Elective, non-elective and day case surgery is performed at both DPoW and SGH sites. Outpatient clinics are offered at both sites and also provided at Goole District Hospital (GDH) with an outreach service at Louth and Mablethorpe.

The current on-call out of hour’s service is based on a weekly/fortnightly rotation between the two main sites with the following pattern - two weeks at SGH and three weeks at DPoW, Monday to Friday out of hours and weekends. This rota is determined by the balance of consultants and middle grade doctors currently employed on each site and potentially results in any inpatients on the site that is not covered by the on-call being transferred for continued out of hours care.

Clinicians recognise that transferring patients between sites is not in the best interest of good patient care and patient experience, so temporary arrangements are in place where clinicians cover their own inpatients out of hours. This arrangement is deemed unsustainable going forward and represents a risk to service delivery and optimal patient care.

Northern Lincolnshire & Goole Trust provides ENT services across all three of its sites and routine outreach clinics in both Mablethorpe and Louth. The service works in collaboration with a number of other services, predominantly:

* NLaG Audiology service
* NLaG Speech & Language service
* Hull & East Yorkshire & United Lincolnshire Trust (dependent upon CCG of residency) through the Head and Neck MDTs

## 4.1 Key Performance Indicators

The ENT service has scope to improve how, where and when it offers this service to ensure the maximisation of service delivery and to further improve on its service delivery to the population within the catchment area.

#### Table 5: ENT performance measures (February 2013 – January 2014)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Measure | DPOW | SGH | GDH | Total | Peer |
| Outpatient services |  |  |  |  |  |
| New DNA rate | 6.3% | 7% | 7.8% | 6.7% |  |
| Follow-up DNA rate | 16.4% | 16.9% | 17.3% | 16.6% |  |
| New : Review ratio | 1.9 | 1.3 | 1.1 | 1.6 |  |
| Outpatient cancellations (Hospital) | 2,509 | 1,350 | 545 | 5,182 |  |
| Outpatient cancellations (Patient) | 2,224 | 1,350 | 265 | 3,839 |  |
| 18 weeks performance at 28th Feb 14 | 98.3% | 99.3% | 100% | 98.8% |  |
| Inpatient services |  |  |  |  |  |
| Daycase rate | 61.3% | 85.8% | - | 70.6% | 57.4% |
| Average length of stay | 1.9 | 1.4 | - | 1.8 | 0.9 |
| Emergency readmissions within 30 days | 1.6% (21)\* | 4.6% (36)\* | - | 2.7% | 4.3% |
| Operations cancelled (non-clinical) | 1.4% | 4.2% | - | 2.5% |  |
| 18 weeks performance at 28th Feb 14 | 89.1% | 97.7% | - | 92.5% |  |

Source: NLaG ENT

\* Small volumes driving higher percentage

The ENT service receives a number of outpatient referrals for patients from the following CCG areas:

Table 6 - Number of ENT referrals for outpatient clinic by CCG February 2013-January 2014

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Referring CCG | DPOW | SGH | GDH | Total |
| NHS North Lincolnshire | 165 | 3,207 | 15 | 3,387 |
| NHS North East Lincolnshire | 2,794 | 39 | 1 | 2,834 |
| NHS Lincolnshire East CCG | 1,867 | 16 |  | 1,883 |
| NHS East Riding of Yorkshire CCG | 11 | 151 | 654 | 816 |
| NHS Lincolnshire West CCG | 21 | 187 |  | 208 |
| Non-contract CCGs | 40 | 59 | 35 | 134 |
| Total | 4,989 | 3,659 | 705 | 9,262 |

Activity levels for locations across the sites are as follows:

#### Table 7 - Activity levels across the locations are indicated below February 2013-January 2014

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | DPOW | Louth | Mablethorpe | SGH | GDH | Total |
| Outpatient services |  |  |  |  |  |  |
| OP Referrals | 4,898 | - | - | 3,659 | 705 | 9,262 |
| New OP attendances | 3,178 | 690 | 309 | 3,190 | 618 | 7,985 |
| Review OP attendances | 6,392 | 861 | 672 | 4,108 | 710 | 12,743 |
| Total OP attendances | 9,570 | 1,551 | 981 | 7,298 | 1,328 | 20,728 |
|  |  |  |  |  |  |  |
| Outpatient attendances | 4,507 | 789 | 416 | 2,872 | 550 | 9,134 |
| Outpatient procedures | 5,063 | 762 | 565 | 4,426 | 778 | 11,594 |
| Total | 9,570 | 1,551 | 981 | 7,298 | 1,328 | 20,728 |
|  |  |  |  |  |  |  |
| Inpatient services |  |  |  |  |  |  |
| Adult day case | 391 | - | - | 391 | - | 782 |
| Child day case | 195 | - | - | 115 | - | 310 |
| Total day case activity | 586 | - | - | 506 | - | 1,092 |
|  |  |  |  |  |  |  |
| Adult elective | 244 | - | - | 53 | - | 297 |
| Child elective | 126 | - | - | 31 | - | 157 |
| Total elective activity | 370 | - | - | 84 | - | 454 |
| Elective thyroid activity | 1 (Mr Samy) | - | - | 21 (Mr Moore)  14 (Mr Dhanasekar) | - | 36 |
|  |  |  |  |  |  |  |
| Adult non-elective | 225 | - | - | 115 | - | 340 |
| Child non-elective | 29 | - | - | 32 | - | 61 |
| Total emergency activity | 254 |  |  | 147 |  | 401 |
| Emergency thyroid activity | 1 (Mr McAdam) | - | - | 1 (Mr Moore) | - | 2 |

## 4.2 Current bed and theatre configuration

The current bed and theatre configuration has designated occupancy and theatre slots at each site according to the adult and paediatric allocation. This currently means that ENT inpatient services are fully operational on each site. There is capacity to centralise the surgical service on a single site and an opportunity to address the on-call issues and improve efficiency and productivity.

## 4.3 Current staffing profile

Consultant medical, junior medical and nursing staffing levels at SGH, DPOW and GDH are operating with minimal vacancies and small usage of locum support. Support therapist staff are also aligned with the ENT service.

The priority to address is the on call arrangements. The current on call arrangement is not robust due to:

* Reliance upon temporary arrangements not sustainable in the longer term
* The disruption to elective work
* Post-operative inpatients may need to transfer to on call site

# 5. Communication and engagement on ENT Services

A pre-engagement phase and two formal public engagement phases have been held as part of the HLHF programme. The Healthy Lives, Healthy Futures programme has received a significant amount of media coverage, however there have been no specific comments received about the possible centralisation of ENT services. A brief overview of the relevant communications and engagement activities/feedback is included below.

## 5.1 Pre-engagement phase

A Stakeholder Summit was held on 22 July 2013 to give stakeholders the opportunity to understand the work being carried out as part of the HLHF programme and to discuss how it may impact upon their organisation. As preparation for the Summit, individual meetings were arranged with organisations and stakeholders to share the emerging vision, direction of travel and criteria that will form the foundations for the programme.

During the pre-engagement phase there was a high level of support for the vision and general recognition that some services may need to be centralised in order to achieve the improvements in quality that are required. The Pre-Summit Stakeholder Engagement Report can be found as Appendix 3 and this provides an overview of the feedback received from those meetings.

## 5.2 Engagement phase 1 – the vision and case for change

In July –September of 2013 the first public engagement phase was carried out, which focussed on the case for change and strategic vision. There are two key drivers for change, which underpin the Healthy Lives, Healthy Futures programme: Quality improvement and financial sustainability. The full case for change document is included as Appendix 4.

The programme vision is shown below:

#### Diagram 1 – Vision for the Healthy Lives, Healthy Futures programme

#### 

ENT services span the whole breadth of this funnel; patients receive some treatment in the community either through the GP or outreach services such as outpatients, audiology and hearing aids support, however ENT surgery is usually offered in a hospital environment. Specialist ENT surgery such as head and neck cancer surgery is delivered in the tertiary centre at Hull, and routine inpatient and day case procedures are undertaken in the main sites at SGH and DPOW.

Commissioners believe that shifting the focus from care in hospitals to more self-care and independent living will result in higher-quality care, with more lives saved and more people returned to full health. Commissioners recognise that it may not be feasible to deliver every service on every hospital site so the centralisation of certain specialist services was raised with the public in principle.

Generally people understood the case for change with over 70% of respondents in agreement that there are good reasons for reviewing local healthcare services. A majority of people (over 80%) said that quality and safety should be prioritised as the most important factors when making decisions about how services are delivered in the future, and most people said that they would be prepared to travel further than they currently do to access services if they were of a better quality. 50% of people said that they would travel any distance.

Transport was raised as a key concern and people said that this should be considered before making any decisions about where services will be located to ensure that patients and visitors are able to access services. As a result of this feedback the evaluation criteria was refined and a specific integrated transport group was established, to consider transport issues that relate directly to the proposals being brought forward by the programme.

The full engagement report can be found as Appendix 5

## 5.3 Phase 2 – Moving the conversation on

The second phase of public engagement ran from early February until the end of March 2014 and consisted of a wide range of engagement activities and events across North and North East Lincolnshire. This involved contact with over 1500 people at the range of public events and stakeholder meetings, and over 300 formal responses to the questionnaire. The purpose of the engagement was to engage in a much more detailed dialogue with the public about the direction of travel for services within the local area. Commissioners stated that several hospital services were being considered for centralisation and consultation, including a permanent solution for centralisation of the elective and non-elective inpatient ENT services. Commissioners asked how the public felt about centralisation of hospital services for safety and quality purposes, and whether people would be prepared to travel further than they currently do to access safer and higher quality care.

78% of respondents agreed that centralising some hospital services would improve safety and quality of care. 82.5% stated that they were prepared to travel further for safer improved services. In addition to the multiple choice questions people were asked to provide any free text feedback on the themes raised in the engagement.

Some specific comments were received in support of the centralisation of specialist services for quality and safety purposes:

*“Agree with this it makes sense to have an excellent service rather than mediocre at two sights”*

*“Avoid multiple sites with very few patients seen at each location”*

*“Ensure utilisation of local facilities wherever possible. Any centralisation should be area central to reduce travel time and waiting”*

*“Sensible transport options are a better option than trying to keep all services on all sites”*

*“Providing investment is made into the community”*

In addition some concerns were raised:

*“Have to be careful not to destabilise the acute setting”*

*“Do not de-skill some of the excellent clinical expertise we have in North East Lincolnshire”*

*“All hospitals should cater for all eventualities”*

*“Unintended consequences – hospitals are a mix for other co-dependent services – need to make sure that one change does not lead to the demise of others”*

*“Big is not always better”*

*“Centralising services may not offer quality to people living a long way away from services. Small and local can mean quality as well”*

*“All our hospitals should provide safe, secure, caring services in the local area”*

*“No proof of safety or quality being improved”*

*“Farming care out to other locations and displacing patients far away from home, families and familiar surroundings at the time of most significant need is not conducive to their overall health and wellbeing or recovery. Safer care is no excuse - all care should be safe and effective”*

*“They tried this with children's heart service, causing more problems than were solved”*

*“Centralisation, leads to the rarefication of specialism, making any affected service much less resilient”*

*“I am concerned that the concentration will be only in cities with big populations and means people in towns will be on the end of the waiting lists”*

*“Quality and safety can be carried out at any setting, centralising is only a cost cutting exercise”*

*“Care needs to be easily accessible and available to all. Not everyone has transport to enable them to travel”*

The full engagement feedback report can be found as Appendix 6.

## 5.4 Implications for the ENT service review

There are several key themes that the public would like commissioners to be mindful of:

* Transport and access for patients if the service is to remain centralised onto one site
* Clarity around the rationale and evidence for the decision if the service is moved
* The impact that a change in location could have on workforce and expertise in the local hospitals

Commissioners and providers will need to ensure that all reasonable steps are taken to minimise the impact that centralisation of the ENT service may have upon patients from the area that does not host the service. Patients, relatives and carers are worried about whether they will still be able to access the care they need if services are moved, for affordability and practical reasons such as access to personal transport and availability of public transport. Commissioners are mindful of this concern and a separate transport analysis has been undertaken.

The rationale and evidence for decisions must be clearly outlined for the public to assure people that commissioners have reviewed and considered all the evidence around the case for centralisation and that it is shared with the public as part of the consultation exercise.

Concerns that centralisation could impact on the competence and knowledge of the workforce should be considered to ensure that it does not undermine local services.

# 6. Travel and transport analysis

Commissioners are reviewing three key options for the long term provision of the ENT service.

1. Do nothing, continue to deliver ENT services as currently in operation across all sites
2. Centralise the elective and non-elective inpatient ENT service to DPOW, Grimsby
3. Centralise the elective and non-elective inpatient services to SGH, Scunthorpe
4. Decommission the local service and send all surgical ENT patients to tertiary centres

## 6.1 Travel analysis summary

Options 2, 3 and 4 involve a solution that will require changed travel requirements for patients, families and visitors. A transport analysis has been undertaken to review how access to ENT inpatient services may be affected by a change to the location of these services, using the following measures of access:

* Average travel time (car, blue light, public transport)
* Car and/or van ownership
* Public transport options

The travel time analyses were performed using data provided by Boston Consulting Group (BCG). Using postcode sector (5-digit postcode) as a proxy for patient location, BCG calculated the average travel time to the nearest relevant acute provider by mode of transport - car, ambulance (blue light) and public transport - using data used data from GoogleTrack. The specific definitions of the travel times used in the analysis are as follows:

* Car and blue light travel times – average travel time by postcode sector – all days all hours
* Public transport travel times – average weekday travel time by postcode sector – non-off peak

Analysis of public transport travel times was restricted to off peak hours to overcome the distortionary effect of the absence of weekend services on journey times. Blue light travel times are assumed to be one-third faster than average car journeys based on the findings of *Travel times and ambulance coverage for proposed hyper-acute stroke units* *and major trauma centres in London* (Healthcare for London, briefing 2009)*.*

It must be assumed that if inpatient services are moved, then patients will access the site that offers the service they require. For ENT inpatient services the relevant hospital sites being considered as potential options for the Northern Lincolnshire population are as follows:

* DPoW (Diana Princess of Wales, Grimsby, NLaG)
* SGH (Scunthorpe General Hospital, NLaG)
* Doncaster Royal Infirmary
* Hull Royal Infirmary (part of HEY – Hull and East Yorkshire Hospitals NHS Trust)
* Lincoln County Hospital
* Rotherham Hospital
* York Hospital

The metric used to assess the impact on travel times of any change to the location of services is the population weighted average travel time. Population weighting is used to adjust the average travel time of an area for the number of people affected. A breakdown of average time to nearest relevant hospital site by CCG and for the NLaG catchment population is shown below.

#### Table 8 – Baseline population average weighted travel times (minutes) to nearest relevant acute trust by CCG

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Travel time in minutes | | | Total population | Catchment population | % |
| CCG | Car | Blue light | Public transport |
| North Lincolnshire | 18 | 12 | 42 | 167516 | 162114 | 97% |
| North East Lincolnshire | 11 | 8 | 31 | 159735 | 161933 | 101% |
| Lincolnshire East | 32 | 21 | 84 | 227771 | 81154 | 36% |
| East Riding of Yorkshire | 29 | 20 | 72 | 313386 | 57226 | 18% |
| Lincolnshire West | 28 | 19 | 66 | 225253 | 34190 | 15% |
| Doncaster | 23 | 15 | 55 | 1093661 | 496616 | 45% |
| Catchment | 19 | 13 | 50 | 167516 | 162114 | 97% |

Source: BCG Travel analysis.

Postcode sectors do not map neatly to CCG or conventional area boundaries and therefore the sum of sector populations may not equate to CCGs populations. This is why some may seem larger than expected, e.g. 101%.

## 6.2 Travel impact on options

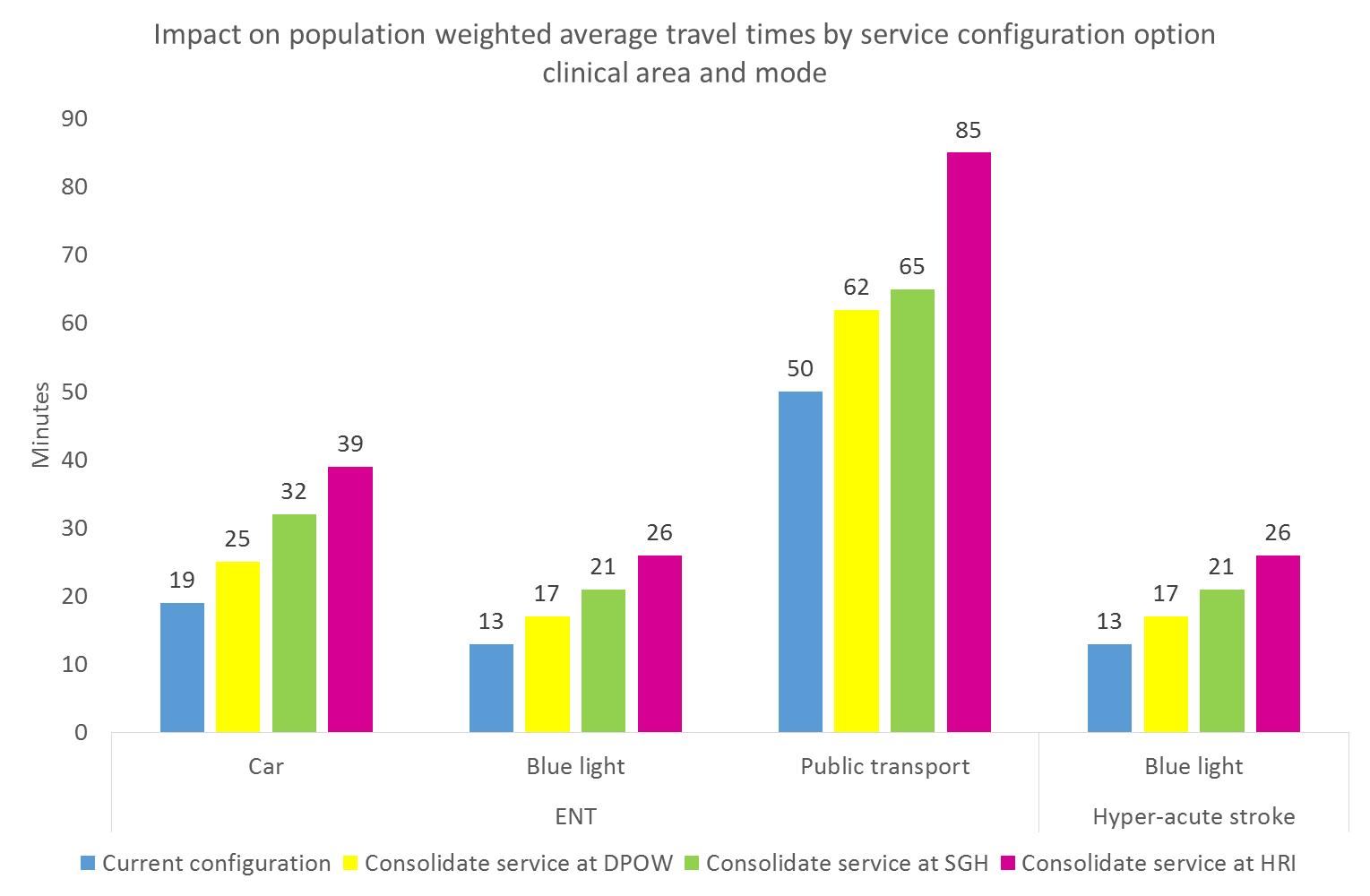
The impact on travel times for each option has been calculated using the average population weighted travel time.

#### Table 9 – Impact on population weighted average travel times (additional minutes) by service configuration option and mode

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Option | | | |
| Mode | Decentralise service | Centralise on SGH site | Centralise on DPOW site | Centralise on HRI site |
| Car | 19 minutes | + 13 minutes | + 6 minutes | +20 minutes |
| Public transport | 50 minutes | + 15 minutes | + 12 minutes | +35 minutes |
| Blue light | 13 minutes | + 8 minutes | + 4 minutes | +13 minutes |

Source: BCG Travel analysis

#### Chart 2 - Impact on population weighted average travel times by service configuration option clinical area and mode



The travel impact is presented as the change (addition or reduction in minutes) compared to the baseline for each of the options being considered within the defined scope. The baseline for ENT inpatient surgery is the current configuration or “do nothing” option.

From the results shown in Chart 2 the do-nothing option would have the least impact on journey times. Centralisation at DPOW is less impactful than SGH. Decommissioning the service and sending patients to their nearest tertiary site has the most significant impact.

## 6.3 Patient outflows impact

The BCG team worked with commissioners to review the potential change to patient flows associated with different options. As part of this work they agreed a set of assumptions about likely patient behaviour for a range of services, including elective care and urgent / acute care, which is relevant for the majority of the elective and non-elective inpatient ENT patients. It is assumed that if services are not available on the SGH site then patients east of the River Trent will stay on patch, but patients on the Isle of Axholme will go to another site off patch. If services are not available on the DPoW site then it is assumed that patients will travel to the nearest hospital with the shortest travel time and easiest travel connections.

These assumptions have been used to calculate estimated patient flows based on real public and private travel times from postcodes in North and North East Lincolnshire to nearby hospitals. It should be noted that this analysis was undertaken at a high level to incorporate all of the elective care service lines, however they can be used as an indicator for changes to the patient flows if inpatient ENT services were centralised on either the SGH or DPoW site.

#### Diagram 2 – Patient outflow map for elective attendances

#### 

Source: BCG analysis: ONS, SHMI, NLaG, NL and NEL CCG data

#### Diagram 3 – Patient outflow map for urgent & acute attendances



Source: BCG analysis: ONS, SHMI, NLaG, NL and NEL CCG data

The heat maps above show the estimated change in elective attendances if elective and urgent/acute services were centralised on either the SGH or DPOW site. Table 11 shows the projected percentage outflow from different local options.

#### Table 10 – Projected patient outflow dataset

|  |  |  |  |
| --- | --- | --- | --- |
| Configuration | Option 1 –  Do nothing  (baseline) | Option 2 – SGH main centre | Option 3 – DPOW main centre |
| Elective care projected off-patch as % of total NLaG admissions | - | 10% | 17% |
| Elective care projected off-patch as % of total NL/NEL admissions | 19% | 20% | 32% |
| Urgent & acute projected off-patch as % of total NLaG admissions | - | 0% | 44% |
| Urgent & acute projected off-patch as % of total NL/NEL admissions | 15% | 15% | 53% |

Source: BCG analysis: ONS, SHMI, NLaG, NL and NEL CCG data

## 6.4 Public feedback on transport issues

As described in the various public engagement reports, patients and public have expressed concern over travelling to centralised locations for their care. This has been raised by the public with particular reference to the huge support that visitors can offer for patients. Much of the focus was on the cost of transport, bridge tolls (if services are located in Hull), and parking fees. Transport was cited as enhancing tiredness and anxiety for patients, and issues were raised around the current provision of the patient transport services. Examples were given where friends and family members were not able to travel with patients on the patient transport vehicles and this was queried as a potential area for review.

## 6.5 Implications for the ENT Inpatient service review

The travel times are likely to have some impact on the patient, visitors, friends and family members. However most ENT inpatient operations undertaken within Northern Lincolnshire are of short duration, and the length of stay is low. The major ENT surgery, such as head and neck cancer surgery is already undertaken at a tertiary centre, and outpatients and day cases will still be delivered at each site.

Commissioners may need to review transportation for visitors and friends and family members along with the patient transport service for the short time that patients are outside of their local hospital if a centralisation option is considered.

The outflows data should be considered for the DPOW location as this could impact on viability of the service.

The full transport analysis can be found in Appendix 7.

# 7. Evaluating the options

Commissioners will use a range of information to consider the options including evidence around risks and benefits (as documented in this options appraisal), evaluation criteria and equality impact assessments.

At the start of the programme commissioners developed an evaluation criteria to use as part of the decision making process to highlight benefits and dis-benefits with any significant service change areas. These criteria are shown below:

#### Table 11 - Healthy Lives, Healthy Futures Evaluation Criteria

|  |  |
| --- | --- |
| Criteria | Indicator |
| Quality of care | * Impact on premature / avoidable deaths * Impact on staffing levels * Patient experience e.g. complaints and feedback * Deaths in place of choice / place of residence (if applicable) * Patient safety – conforming with best practice / guidelines |
| Access to care | * Impact on population weighted average travel time * Feedback from patients and public – i.e. acceptability, willingness to travel * Proportion of visits/interventions delivered locally in the community or in patients’ homes * Number of options available for service delivery to local patients (i.e. patient choice) |
| Affordability | * Up front capital and other non-recurring costs required to implement reconfiguration * Assessment of ongoing financial viability of hospital sites * Assessment of affordability within commissioners allocations * Total value of each option incorporating future capital and revenue implications * Assessment of payback period (if applicable) |
| Deliverability | * Workforce experience/quality (attractiveness for employment) * Assessment of ease of delivering option in terms of public and stakeholder acceptability * Assessment of ease of creating required capacity shifts within timescales (workforce and physical facilities) * Degree of integration across acute, primary, community and mental health services |

Commissioners agree that quality of care should be the highest priority when it comes to decisions about service provision. However it is important to balance the other elements of the criteria to ensure that our services are maintained with the right level of skilled workforce, at locations that are accessible for patients, and in a way that uses the scarce resources as efficiently as possible.

As part of the engagement processes patients and the public were asked about the evaluation criteria headings and how they would prioritise them. Over 80% of people felt that quality of care should be rated the highest priority when considering service change ideas. It has been agreed that the quality and safety criteria will be weighted accordingly when it comes to making decisions about changes to the service including inpatient ENT.

The evaluation process has been documented in Appendix 10.

# 8. Equality Impact Assessment (EQIA)

Commissioners are committed to achieving equality, celebrating diversity, promoting inclusion and embracing human rights as set out in the NHS Constitution, and in line with the public sector equality duty outlined in the Equality Act 2010. This includes paying due regard to eliminating unlawful discrimination, advancing equality of opportunity and fostering good relationships between equality groups.

There are 9 “protected” characteristics that the Equality Act defines:

* Age
* Disability
* Gender re-assignment
* Marriage and Civil partnership
* Pregnancy and maternity
* Race
* Religion or belief
* Sex
* Sexual orientation

In line with work undertaken as part of the health needs analysis, Commissioners will also give consideration to people from differing socio economic groups / backgrounds (health inequalities).

## 8.1 Equality data

The demographic data for the protected groups is shown below.

#### Table 12 – Age distribution of CCG populations 2011

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CCG | Age band (years) | | | | | | | All ages |
| 0 - 4 | 5 – 16 | 17 – 18 | 19 - 49 | 50 - 64 | 65 - 74 | 75+ |
| North Lincolnshire | 10221 | 23140 | 4199 | 65584 | 34056 | 16440 | 13876 | 167516 |
| 6% | 14% | 3% | 39% | 20% | 10% | 8% | 100% |
| North East Lincolnshire | 10001 | 22215 | 4225 | 64212 | 30569 | 14870 | 13643 | 159735 |
| 6% | 14% | 3% | 40% | 19% | 9% | 9% | 100% |
| Lincolnshire East | 11282 | 28047 | 5326 | 78463 | 49874 | 30292 | 24487 | 227771 |
| 5% | 12% | 2% | 34% | 22% | 13% | 11% | 100% |
| East Riding of Yorkshire | 15402 | 40393 | 7909 | 113019 | 68652 | 36818 | 31193 | 313386 |
| 5% | 13% | 3% | 36% | 22% | 12% | 10% | 100% |
| Lincolnshire West | 12358 | 28864 | 5800 | 94218 | 42854 | 22228 | 18931 | 225253 |
| 5% | 13% | 3% | 42% | 19% | 10% | 8% | 100% |

Source: Office for National Statistics (ONS) mid-2011 Census based population estimates for Clinical Commissioning Groups.

#### Table 13 – Age and sex distribution of CCG populations 2011

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CCG | Age band (years) | | | | | | | All ages |
| 0 - 4 | 5 – 16 | 17 - 18 | 19 - 49 | 50 - 64 | 65 - 74 | 75+ |
| North Lincolnshire | 10221 | 23140 | 4199 | 65584 | 34056 | 16440 | 13876 | 167516 |
| % male | 51% | 51% | 52% | 50% | 50% | 49% | 40% | 49% |
| North East Lincolnshire | 10001 | 22215 | 4225 | 64212 | 30569 | 14870 | 13643 | 159735 |
| % male | 51% | 51% | 50% | 50% | 50% | 48% | 41% | 49% |
| Lincolnshire East | 11282 | 28047 | 5326 | 78463 | 49874 | 30292 | 24487 | 227771 |
| % male | 51% | 51% | 52% | 49% | 49% | 50% | 43% | 49% |
| East Riding of Yorkshire | 15402 | 40393 | 7909 | 113019 | 68652 | 36818 | 31193 | 313386 |
| % male | 51% | 51% | 52% | 50% | 49% | 48% | 41% | 49% |
| Lincolnshire West | 12358 | 28864 | 5800 | 94218 | 42854 | 22228 | 18931 | 225253 |
| % male | 52% | 51% | 49% | 49% | 49% | 49% | 42% | 49% |

Source: Office for National Statistics (ONS) mid-2011 Census based population estimates for Clinical Commissioning Groups.

#### Table 14 – Ethnicity by CCG population

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| CCG | Ethnicity | | | | | All ages |
| White | Mixed / multiple | Asian/Asian British | Black / African / Caribbean / Black British | Other |
| North Lincolnshire | 160748 | 1244 | 4549 | 494 | 411 | 167446 |
| 96% | 1% | 3% | 0.3% | 0.2% | 100% |
| North East Lincolnshire | 155421 | 1186 | 2129 | 411 | 469 | 159616 |
| 97% | 1% | 1% | 0.3% | 0.3% | 100% |
| Lincolnshire East | 327789 | 2301 | 2961 | 598 | 530 | 334179 |
| 98% | 1% | 1% | 0.2% | 0.2% | 100% |
| East Riding of Yorkshire | 134314 | 937 | 789 | 264 | 97 | 136401 |
| 98% | 1% | 1% | 0.2% | 0.1% | 100% |
| Lincolnshire West | 87600 | 630 | 728 | 224 | 68 | 89250 |
| 98% | 1% | 1% | 0.3% | 0.1% | 100% |

Source: Office for National Statistics (ONS) mid-2011 Census based population estimates for Clinical Commissioning Groups.

#### Table 15 – Religion / belief distribution of CCG populations 2011

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CCG | Religion | | | | | | | | |  |
| None | Christian | Buddhist | Hindu | Jewish | Muslim | Sikh | Other | Not stated | Total |
| North Lincolnshire | 40176 | 110554 | 381 | 445 | 48 | 3024 | 538 | 417 | 11863 | 167446 |
| 24% | 66% | 0.2% | 0.3% | 0% | 2% | 0.3% | 0.2% | 7% | 100% |
| North East Lincolnshire | 48476 | 96836 | 347 | 386 | 64 | 1332 | 158 | 533 | 11484 | 159616 |
| 30% | 61% | 0.2% | 0.2% | 0.0% | 1% | 0.1% | 0.3% | 7% | 100% |
| Lincolnshire East | 78296 | 227343 | 702 | 607 | 337 | 1309 | 174 | 863 | 24548 | 334179 |
| 23% | 68% | 0.2% | 0.2% | 0.1% | 0.4% | 0.1% | 0.3% | 7% | 100% |
| East Riding of Yorkshire | 31196 | 93691 | 226 | 126 | 84 | 366 | 49 | 565 | 10098 | 136401 |
| 23% | 69% | 0.2% | 0.1% | 0.1% | 0.3% | 0.0% | 0.4% | 7% | 100% |
| Lincolnshire West | 19439 | 62739 | 141 | 172 | 31 | 212 | 88 | 303 | 6125 | 89250 |
| 22% | 70% | 0.2% | 0.2% | 0.0% | 0.2% | 0.1% | 0.3% | 7% | 100% |

Source: Office for National Statistics (ONS) mid-2011 Census based population estimates for Clinical Commissioning Groups.

#### Table 16 – Sexual orientation (proxy) and marital state distribution of CCG populations 2011

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| CCG | Single | Married | In a registered same sex civil-partnership | Separated | Divorced | Widowed | Population aged 16+ |
| North Lincolnshire | 39393 | 68435 | 212 | 3369 | 14278 | 10418 | 136105 |
| 29% | 50% | 0.2% | 2% | 10% | 8% | 100% |
| North East Lincolnshire | 42808 | 58434 | 185 | 3369 | 14492 | 10089 | 129377 |
| 33% | 45% | 0.1% | 3% | 11% | 8% | 100% |
| Lincolnshire East | 72618 | 150812 | 600 | 6239 | 25674 | 22390 | 278333 |
| 26% | 54% | 0.2% | 2% | 9% | 8% | 100% |
| East Riding of Yorkshire | 28024 | 61840 | 194 | 2582 | 11875 | 10903 | 115418 |
| 24% | 54% | 0.2% | 2% | 10% | 9% | 100% |
| Lincolnshire West | 18435 | 40509 | 110 | 1657 | 7202 | 5840 | 73753 |
| 25% | 55% | 0.1% | 2% | 10% | 8% | 100% |

Source: Office for National Statistics (ONS) mid-2011 Census based population estimates for Clinical Commissioning Groups.

#### Table 17 – Disability distribution of CCG populations 2011

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| CCG | No disability | Day to day activities limited a lot | Day to day activities limited a little | Population |
| North Lincolnshire | 270214 | 29029 | 34936 | 334179 |
| 81% | 9% | 10% | 100% |
| North East Lincolnshire | 128496 | 14786 | 16334 | 159616 |
| 81% | 9% | 10% | 100% |
| Lincolnshire East | 135167 | 15333 | 16946 | 167446 |
| 81% | 9% | 10% | 100% |
| East Lindsey | 100999 | 17475 | 17927 | 136401 |
| 74% | 13% | 13% | 100% |
| West Lindsey | 71466 | 7944 | 9840 | 89250 |
| 80% | 9% | 11% | 100% |

Source: Office for National Statistics (ONS) mid-2011 Census based population estimates for Clinical Commissioning Groups.

A high level assessment has been made of each option, and the impact on the protected groups and is included as part of the options review.

## 8.2 Public feedback on equality issues

As part of the second engagement phase a range of questions were asked about equality issues. Most of the feedback in this section related to accessibility, particularly for vulnerable people and those living in rural locations. Comments were also received about reaching vulnerable people and supporting those with disabilities, families and those on a low income. Older people and those with mental health problems were highlighted, particularly dementia. Commissioners need to proactively meet the needs of vulnerable people especially if services are moved further away and no additional support is in place.

The public want services that are person-centred rather than designed around the needs of the organisations:

*“If services are right for disadvantaged groups they are probably right for everyone else”*

*“Give due regard to the quiet-voiced majority”*

*“Make sure that important information is clear in other languages”*

*“Vulnerable and elderly people are often reluctant to ask for help. They need to keep their independence but need varying degrees of help”*

# 9. Option 1 – Do nothing: ENT inpatient surgery remains unchanged

## 9.1 Assumptions

This option makes the following assumptions:

* Both ENT inpatient surgical services (DPOW and SGH) will continue in their current forms
* The rotational on-call and out of hours service will continue
* There would be transfer of patients to other sites for continued access to medical staff in emergencies post operatively

## 9.2 Risks / issues

The risks and issues associated with this option are outlined below:

#### Table 18 – Risks and issues of option 3 (do nothing)

| Category | Risk / Issue | RAG | Mitigation |
| --- | --- | --- | --- |
| Quality & Safety | The rationale for centralising the service is to ensure a more robust on call and out of hours service, less disruption of elective work, and less need for transfer of patients between sites. These are all risk factors with the current service provision and are unlikely to be addressed fully with a “do nothing” solution. | Red | Recruit additional medical staff to cover the on-call rotas and offer a comprehensive out of hours service at both sites. Organise on call arrangements with other medical/anaesthetic staff to cover ENT inpatients that have complications. |
| Quality & Safety | Provider clinicians are concerned that the current service is not sustainable and relies heavily on goodwill of medical staff. | Red | Patients will need to be transferred across sites to ensure emergency treatment is available quickly instead. |

## 9.3 Benefits

Benefits of this option are shown below:

#### Table 19 – Benefits of option 3 (do nothing)

| Category | Benefit |
| --- | --- |
| Finance | No impact on finance |
| Access | Public may find the decentralised service more acceptable. They have raised concerns over transportation and access if services are moved. |

## 9.4 Equality Impact Assessment

The impact on people with protected characteristics can be seen below:

#### Table 20 – Assessment of the impact on people with protected characteristics

|  |  |  |
| --- | --- | --- |
| Protected characteristic | Impact | Nature of impact |
| Age | Negative | ENT services apply to people of all ages. The overall population for North Lincolnshire is expected to increase by 4%, North East Lincolnshire by 1%. The current on-call arrangements rotate between the DPOW and SGH sites which currently means there is no formal specialist coverage on both sites 24/7. This has resulted in the informal agreement between consultants and senior doctors to cover their own patients if on-call team are on rotation to another site. This avoids transfer of patients but has been deemed unsustainable for the long term this could have a potential negative impact on adults who are the higher patient level for this service if the service was no longer able to sustain its current arrangements |
| Disability | Negative | Although there is no current data to show the number of disabled residents accessing ENT services both North and North East Lincolnshire have 9% of its residents who experience a lot of limited day to day activities and both have 10% who experience a little limited day to day activities The current on-call arrangements rotate between the DPOW and SGH sites which currently means there is no formal specialist coverage on both sites 24/7. This has resulted in the informal agreement between consultants and senior doctors to cover their own patients if on-call team are on rotation to another site. This avoids transfer of patients but has been deemed unsustainable for the long term this could have a potential negative impact on this protected group if the service was no longer able to sustain its current arrangements |
| Gender reassignment | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Marriage and civil partnership | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Pregnancy and maternity | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Race | Neutral | Potential negative impact for service users for whom English is not their first language and may have issues understanding and retaining information about their condition and its future management. |
| Religion and belief | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients |
| Sex | Negative | Although there is no data to show either gender having a greater use of ENT services Northern Lincolnshire does have a higher local population of males at a younger age (0-18). The current on-call arrangements rotate between the DPOW and SGH sites which currently means there is no formal specialist coverage on both sites 24/7. This has resulted in the informal agreement between consultants and senior doctors to cover their own patients if on-call team are on rotation to another site. This avoids transfer of patients but has been deemed unsustainable for the long term this could have a potential negative impact on this protected group if the service was no longer able to sustain its current arrangements |
| Sexual orientation | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients |
| Deprivation | Negative | It should be noted that deprivation cuts across Northern Lincolnshire. The low number of people with access to private transport is well documented, especially in the context of accessing services. This is exacerbated by the rural nature of the area and poor public transport. In North East Lincolnshire 38.2% of the population of residents is in the most deprived quintile and in North Lincolnshire the figure is 19.6%. With high deprivation in Northern Lincolnshire and East Lindsey all 4 proposals would have a negative impact on this cohort of population with gaining access to any of the sites and also their relatives for visiting. |
| Human rights | Negative | If the service continued to be offered from both sites with no formal specialist coverage on both sites 24/7 this may present challenges in relation to access to life-saving treatment. |

## 9.5 Evaluation criteria assessment

The programme board undertook an evaluation criteria scoring exercise, taking into consideration the above benefits and risks and the views of the local clinical community. A summary of the scoring is included below:

#### Table 21 – Evaluation scoring for option 1 (do nothing)

|  |  |  |
| --- | --- | --- |
| Criteria | Score | Rationale |
| Quality | 62 | Quality concerns have been raised by clinical teams, so the “do nothing” option scored lowest on these indicators. |
| Access | 76 | This option scored highly from an access perspective as it would be easiest for patients to access the service if it was on both sites. However it was acknowledged that the service rotation can be confusing for patients. |
| Affordability | 40 | This was deemed an expensive option because investment would be required in medical staff to be able to offer a safe out of hours service on both sites. It was assumed that the safety issues would need to be addressed. |
| Deliverability | 56 | The rotational element is not popular with staff, which scored low, however it was suggested that the “do nothing” option would be easiest to implement. |
| Total | 234 | This scored third in the evaluation scoring exercise. |

# 10. Option 2 - Centralise the ENT surgery at DPOW, Grimsby Site

## 10.1 Assumptions

This option makes the following assumptions:

* The SGH ENT inpatient service will be decommissioned
* The inpatient service will be accommodated entirely on the DPoW site
* Day cases will still be undertaken at both sites
* There would be some outflows of patients to other sites
* Out of hours on call issue will become sustainable and safe for patients
* All Medical Staff will re-locate to DPoW

## 10.2 Risks / issues

The risks and issues associated with this option are outlined below:

#### Table 21 – Risks and issues of option 2 (centralising the ENT Inpatient service at DPoW)

| Category | Risk / Issue | RAG | Mitigation |
| --- | --- | --- | --- |
| Quality & safety | Not all patients listed for day case end up going home that day. There are a small number of patients who do need to stay overnight due to unexpected complications, however this is usually solved by longer time in the recovery unit. If patients on the SGH site cannot be discharged there will be no ENT consultant on call overnight. | Amber | ENT day case patients could be scheduled to have surgery before 11am to give maximum time in recovery before discharge. Patients could be transferred to DPOW for overnight stay for the small number of complications that become serious. |
| Access | Public may find a centralised service less acceptable. They have raised concerns over transportation and access if services are moved. This would incur additional travel for some patients. | Amber | The case for change should be clearly communicated, and the feedback from the large number of patients and public who said they would be happy to travel further for higher quality care. Emphasise that all other elements of the service (e.g. OP and daycase) will remain on both sites. |
| Affordability | 4% of East Riding referrals convert into elective activity. If the service were moved to DPOW these patients may be lost to either Hull or Doncaster, along with the associated tariff payment. Similarly Lincolnshire West patients could be lost to Doncaster due to travel distance to DPOW as Doncaster is the closer hospital for this population. | Green | The inpatient surgery is linked to the whole pathway, including OP. If GPs refer to SGH for the outpatient appointment it is likely that patients will want to have their surgery by the same consultant. |
| Deliverability | Service delivery for ENT inpatients is expected to be accommodated within the capacity at DPoW due to concurrent services reorganising its provision. This may not allow much flexibility if activity levels increase over time. | Green | NLaG is undertaking a review of all theatre and bed usage, and have indicated confidence that the capacity could be identified at DPOW. |
| Deliverability | The centralisation may require some nursing/support staff to move to the DPOW site from SGH. Staff may not wish to move. | Green | Key staff could be incentivised to move with the service with travel contributions etc. Training programmes should be established to ensure skill mix is reviewed appropriately. |

## 10.3 Benefits

Benefits of this option are shown below:

#### Table 22 – Benefits of option 2 (centralising the ENT Inpatient service at DPoW)

| Category | Benefit |
| --- | --- |
| Quality & Safety | This provides a safe and sustainable on call rota. Reduces the risk to patient recovering from inpatient surgery experiencing an emergency without full medical cover from the on call rotas |
| Access | Less patients affected by change of site as there are significantly more within the DPOW site. |
| Deliverability | ENT inpatients are more ably accommodated at DPoW and cause minimal disruption to service delivery. Capacity at DPOW has been identified. |
| Deliverability | Centralisation will facilitate easier filling of rotas and shifts as the staff will be pooled to cross-cover. |
| Deliverability | A larger service with less reliance on goodwill and flexibility may facilitate improved morale, and greater ability to recruit and retain staff. |

## 10.4 Equality Impact Assessment

The impact on people with protected characteristics can be seen below:

#### Table 23 – Assessment of the impact on people with protected characteristics

|  |  |  |
| --- | --- | --- |
| Protected characteristic | Impact | Nature of impact |
| Age | Negative | ENT services apply to people of all ages. ENT activity information for period of February 2013-January 2014 below shows less patient flows for children & adults at the SGH therefore there would be less of an impact to population if centralisation of the elective and non-elective inpatient ENT services was at DPOW, Grimsby. |
| Disability | Negative | Although there is no current data to show the number of disabled residents accessing ENT services North Lincolnshire have 9% of its residents who experience a lot of limited day to day activities and have 10% who experience a little limited day to day activities. The centralisation of the elective and non-elective inpatient ENT service to Diana Princess of Wales (DPOW), Grimsby could have a potentially negative impact on North Lincolnshire residents |
| Gender reassignment | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Marriage and civil partnership | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Pregnancy and maternity | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Race | Neutral | Potential negative impact for service users for whom English is not their first language and may have issues understanding and retaining information about their condition and its future management. |
| Religion and belief | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients |
| Sex | Negative | Although there is no data to show either gender having a greater use of ENT services North Lincolnshire does have a higher local population of males at a younger age (0-18) slightly higher than North East Lincolnshire population. Therefore if the centralisation of the elective and non-elective inpatient ENT services was at DPOW, Grimsby this would have a potentially negative impact to North Lincolnshire residents |
| Sexual orientation | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients |
| Deprivation | Negative | It should be noted that deprivation cuts across Northern Lincolnshire. The low number of people with access to private transport is well documented, especially in the context of accessing services. This is exacerbated by the rural nature of the area and poor public transport. In North East Lincolnshire 38.2% of the population of residents is in the most deprived quintile and in North Lincolnshire the figure is 19.6%. With high deprivation in Northern Lincolnshire and East Lindsey all 4 proposals would have a negative impact on this cohort of population with gaining access to any of the sites and also their relatives for visiting. |
| Human rights | Negative | Not all patients listed for day case end up going home that day, there are a small number of patients who do need to stay overnight due to unexpected complications, however this is usually solved by longer time in the recovery unit. It patients on the SGH site cannot be discharged there will be no ENT consultant on call overnight. However patients could be transferred to DPOW for overnight stay for the small number of complications that become serious |

## 10.5 Evaluation criteria assessment

The programme board undertook an evaluation criteria scoring exercise, taking into consideration the above benefits and risks and the views of the local clinical community. A summary of the scoring is included below:

#### Table 24 – Evaluation scoring for option 2 (centralising the ENT Inpatient service at DPoW)

|  |  |  |
| --- | --- | --- |
| Criteria | Score | Rationale |
| Quality | 133 | Options 2 and 3 (DPOW and SGH) were deemed equal from a quality perspective as the service would be able to offer a sustainable out of hours service. |
| Access | 68 | Activity levels show that this option would require less people to travel than options 1, 3 and 4. |
| Affordability | 32 | Given that the activity numbers are larger at the DPOW site it would not have a significant financial impact to locate the service there. |
| Deliverability | 64 | Given that the activity numbers are larger at the DPOW site it would be easier to locate the service there, rather than having to find capacity at SGH. It is assumed that this option would be more attractive to staff than the “do nothing” option as they will be based on one site rather than rotating. |
| Total | 297 | This option scored highest in the evaluation scoring process. |

# 11. Option 3 – Centralise Inpatient ENT services on the SGH site

## 11.1 Assumptions

This option makes the following assumptions:

* The DPoW ENT inpatient service will be decommissioned
* The inpatient service would be accommodated entirely on the SGH site
* Both sites will continue to offer day case surgery
* There would be minimal outflows of patients to other sites
* Out of hours on call issue will become sustainable and safe for patients

## 11.2 Risks / issues

The risks and issues associated with this option are outlined below:

#### Table 25 – Risks and issues of option 3 (centralising the ENT Inpatient service at SGH)

| Category | Risk / Issue | RAG | Mitigation |
| --- | --- | --- | --- |
| Quality & safety | Not all patients listed for day case end up going home that day. There are a small number of patients who do need to stay overnight due to unexpected complications, however this is usually solved by longer time in the recovery unit. If patients on the DPOW site cannot be discharged there will be no ENT consultant on call overnight. | Amber | ENT day case patients could be scheduled to have surgery before 11am to give maximum time in recovery before discharge. Patients could be transferred to SGH for overnight stay for the small number of complications that become serious. |
| Access | Public may find a centralised service less acceptable. They have raised concerns over transportation and access if services are moved. This would incur additional travel for some patients. | Amber | The case for change should be clearly communicated, and the feedback from the large number of patients and public who said they would be happy to travel further for higher quality care. Emphasise that all other elements of the service (e.g. OP and daycase) will remain on both sites. |
| Access | The NEL area has higher numbers of deprived people and people on low incomes, therefore this option could be considered to disadvantage more vulnerable people than siting it at DPOW. | Amber | Support with travel costs is available for certain people that meet the criteria for subsidy or refund. This could be reviewed to be more inclusive. |
| Affordability | Increases in inpatient numbers would not be easily accommodated within the SGH bed base and could undermine other service reviews. | Red | Investment in infrastructure/capital at SGH, or move another service to accommodate the ENT inpatient work. |
| Deliverability | Majority of the elective inpatient activity is delivered at DPOW. It is unlikely that adequate capacity can be generated to accommodate the centralisation without extensive reconfiguration of all services. This causes the greatest disruption to service delivery. | Amber | Much greater and wider service review required to ensure capacity is available to accommodate the activity from DPOW. |

## 11.3 Benefits

Benefits of this option are shown below:

#### Table 26 – Benefits of option 3 (centralising the hyper-acute stroke service at SGH)

| Category | Benefit |
| --- | --- |
| Quality & safety | This provides a safe and sustainable on call rota. Reduces the risk to patient recovering from surgery experiencing an emergency without full medical cover from the on call rotas |
| Deliverability | Centralisation will facilitate easier filling of rotas and shifts as the staff will be pooled to cross-cover. |
| Deliverability | A larger service with less reliance on goodwill and flexibility may facilitate improved morale, and greater ability to recruit and retain staff. |

## 11.4 Equality Impact Assessment

The impact on people with protected characteristics can be seen below:

#### Table 27 – Assessment of the impact on people with protected characteristics

|  |  |  |
| --- | --- | --- |
| Protected characteristic | Impact | Nature of impact |
| Age | Negative | The centralisation of the elective and non-elective inpatient ENT service to SGH, Scunthorpe could have a potentially negative impact on North East Lincolnshire residents who currently have a higher level of children and adults attending the service |
| Disability | Negative | Although there is no current data to show the number of disabled residents accessing ENT services North East Lincolnshire have 9% of its residents who experience a lot of limited day to day activities and have 10% who experience a little limited day to day activities. The centralisation of the elective and non-elective inpatient ENT service to SGH, Scunthorpe could have a potentially negative impact on North East Lincolnshire residents |
| Gender reassignment | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Marriage and civil partnership | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Pregnancy and maternity | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Race | Neutral | Potential negative impact for service users for whom English is not their first language and may have issues understanding and retaining information about their condition and its future management. |
| Religion and belief | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients |
| Sex | Negative | Although there is no data to show either gender having a greater use of ENT services North East Lincolnshire does have a slightly higher local population of males at a younger age (0-18) however slightly lower than North Lincolnshire population. Therefore if the centralisation of the elective and non-elective inpatient ENT services was at SGH this would have a potentially negative impact to North East Lincolnshire residents |
| Sexual orientation | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients |
| Deprivation | Negative | It should be noted that deprivation cuts across Northern Lincolnshire. The low number of people with access to private transport is well documented, especially in the context of accessing services. This is exacerbated by the rural nature of the area and poor public transport. In North East Lincolnshire 38.2% of the population of residents is in the most deprived quintile and in North Lincolnshire the figure is 19.6%. With high deprivation in Northern Lincolnshire and East Lindsey all 4 proposals would have a negative impact on this cohort of population with gaining access to any of the sites and also their relatives for visiting. |
| Human rights | Negative | Not all patients listed for day case end up going home that day, there are a small number of patients who do need to stay overnight due to unexpected complications, however this is usually solved by longer time in the recovery unit. It patients on the DPOW site cannot be discharged there will be no ENT consultant on call overnight however patients could be transferred to SGH for overnight stay for the small number of complications that become serious. It also needs to be noted that NEL area has a higher number of deprived people and people on low incomes there this option could be considered to disadvantage more vulnerable people than siting it at DPOW |

## 11.5 Evaluation criteria assessment

The programme board undertook an evaluation criteria scoring exercise, taking into consideration the above benefits and risks and the views of the local clinical community. A summary of the scoring is included below:

#### Table 28 – Evaluation scoring for option 3 (centralising the ENT Inpatient service at SGH)

|  |  |  |
| --- | --- | --- |
| Criteria | Score | Rationale |
| Quality | 133 | Options 2 and 3 (DPOW and SGH) were deemed equal from a quality perspective as the service would be able to offer a sustainable out of hours service. |
| Access | 61 | Activity levels show that this option would require more people to travel than options 1, 2 and 4. |
| Affordability | 24 | Given that the activity numbers are larger at the DPOW site there may be investment requirements in order to site the service at SGH. |
| Deliverability | 56 | Given that the activity numbers are larger at the DPOW site it may be harder to identify the require capacity to locate the service at SGH. It is still assumed that this option would be more attractive to staff than the “do nothing” option as they will be based on one site rather than rotating. |
| Total | 274 | This option scored second in the evaluation scoring process. |

# 12. Option 4 – Decommission the local service and send all surgical ENT patients to tertiary centres

## 12.1 Assumptions

This option makes the following assumptions:

* Both DPOW and SGH ENT inpatient service will be decommissioned
* All inpatient ENT surgery would be commissioned from tertiary centres (whichever is nearest for patients)
* Both sites will continue to offer day case surgery and outpatient appointments

## 12.2 Risks / issues

The risks and issues associated with this option are outlined below:

#### Table 27 – Risks and issues of option 2 (Decommission local service)

| Category | Risk / Issue | RAG | Mitigation |
| --- | --- | --- | --- |
| Quality & safety | Not all patients listed for day case end up going home that day. There are a small number of patients who do need to stay overnight due to unexpected complications, however this is usually solved by longer time in the recovery unit. If there is no inpatient service locally then these patients would need to be transferred to the tertiary centre for ongoing treatment. This is “red” due to the fact that this would be transfer to a different organisation, rather than within the same trust. | Red | ENT day case patients could be scheduled to have surgery before 11am to give maximum time in recovery before discharge. Patients could be transferred to tertiary centres overnight stay for the small number of complications that become serious, or will have to be managed by the on-take surgical teams at either DPOW or SGH. |
| Access | Public may find a centralised service less acceptable. They have raised concerns over transportation and access if services are moved. This would incur additional travel for some patients. Particular concerns have been raised about access to services in Hull and the cost of the Humber Bridge. | Amber | The case for change should be clearly communicated, and the feedback from the large number of patients and public who said they would be happy to travel further for higher quality care. Emphasise that all other elements of the service (e.g. OP and daycase) will remain on both sites. |
| Access | Both areas within Northern Lincolnshire have deprived populations and pockets of communities with low incomes. This could be seen to disadvantage a heavily deprived population. | Amber | Support with travel costs is available for certain people that meet the criteria for subsidy or refund. This could be reviewed to be more inclusive. |
| Deliverability | Qualified nursing staff may be demotivated if they are no longer providing inpatient care, and we may lose them from the local service | Amber | Rotate staff around other specialities so they still have experience working with post-operative patients and inpatient surgery. |

## 12.3 Benefits

Benefits of this option are shown below:

#### Table 28 – Benefits of option 2 (centralising the hyper-acute stroke service at SGH)

| Category | Benefit |
| --- | --- |
| Quality & safety | This provides a safe and sustainable on call rota. Reduces the risk to patient recovering from surgery experiencing an emergency without full medical cover from the on call rotas |
| Deliverability | Centralisation will facilitate easier filling of rotas and shifts as the staff will be pooled to cross-cover |
| Deliverability | This will free up beds and theatre space for NLaG to focus efforts on other patients. |

## 11.4 Equality Impact Assessment

The impact on people with protected characteristics can be seen below:

#### Table 29 – Assessment of the impact on people with protected characteristics

|  |  |  |
| --- | --- | --- |
| Protected characteristic | Impact | Nature of impact |
| Age | Negative | ENT activity information for period of February 2013-January 2014 shows the activity across all locations. Therefore North & North East Lincolnshire would have a potentially negative impact if the service was decommissioned and all surgical ENT patients were sent to tertiary centres |
| Disability | Negative | Although there is no current data to show the number of disabled residents accessing ENT services both North and North East Lincolnshire have 9% of its residents who experience a lot of limited day to day activities and both have 10% who experience a little limited day to day activities. Decommissioning the local service and sending all ENT patients to tertiary centres would have a potentially negative impact on the residents of Northern Lincolnshire |
| Gender reassignment | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Marriage and civil partnership | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Pregnancy and maternity | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients. |
| Race | Neutral | Potential negative impact for service users for whom English is not their first language and may have issues understanding and retaining information about their condition and its future management. |
| Religion and belief | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients |
| Sex | Negative | Although there is no data to show either gender having a greater use of ENT services Northern Lincolnshire does have a higher local population of males at a younger age (0-18). Decommissioning the local service and sending all ENT patients to tertiary centres would have a potentially negative impact on the residents of Northern Lincolnshire |
| Sexual orientation | Neutral | Potential negative impact for the population in general, however there is currently no data gathered to monitor the impact on this cohort of patients |
| Deprivation | Negative | It should be noted that deprivation cuts across Northern Lincolnshire. The low number of people with access to private transport is well documented, especially in the context of accessing services. This is exacerbated by the rural nature of the area and poor public transport. In North East Lincolnshire 38.2% of the population of residents is in the most deprived quintile and in North Lincolnshire the figure is 19.6%. With high deprivation in Northern Lincolnshire and East Lindsey all 4 proposals would have a negative impact on this cohort of population with gaining access to any of the sites and also their relatives for visiting. |
| Human rights | Negative | If there is no inpatient service locally then patients requiring admitting after day cases due to complications would need to be transferred to the tertiary centre for on-going treatment or they will have to be managed by the on-take surgical teams at either DPOW or SGH. Both areas within Northern Lincolnshire have a deprived population and pockets of communities with low incomes. This could be seen to disadvantage a heavily deprived population. |

## 11.5 Evaluation criteria assessment

The programme board undertook an evaluation criteria scoring exercise, taking into consideration the above benefits and risks and the views of the local clinical community. A summary of the scoring is included below:

#### Table 30 – Evaluation scoring for option 3 (centralising the ENT Inpatient service at SGH)

|  |  |  |
| --- | --- | --- |
| Criteria | Score | Rationale |
| Quality | 115 | This option scored highly from a quality perspective due to the clinical expertise offered by a tertiary centre, however risks were identified with not having an inpatient and out of hours service locally. |
| Access | 44 | This option would have the biggest impact on access as it would require all patients to travel for their treatment. This option would not be popular with patients and public who have expressed concerns with travelling off patch for their care. |
| Affordability | 16 | There would be implications for the receiving trust who may require capital investment in order to identify capacity for these patients, however the commissioner costs would not change. |
| Deliverability | 56 | This was deemed an attractive option for staff, however the practicalities of siting the service off patch scored lower. |
| Total | 231 | This option scored lowest in the evaluation scoring process. |

12. Recommendation

This options appraisal sets out the options, risks and benefits for ENT surgery within Northern Lincolnshire. The programme board have reviewed this work, and undertaken an evaluation criteria scoring exercise to form a preferred option for the future of the service.

The summary scores can be seen below:

#### Table 41 – Summary evaluation scoring

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Option 1 | Option 2 | Option 3 | Option 4 |
| Quality | 62 | 133 | 133 | 115 |
| Access | 76 | 68 | 61 | 44 |
| Affordability | 40 | 32 | 24 | 16 |
| Deliverability | 56 | 64 | 56 | 56 |
| Total | 234 | 297 | 274 | 231 |

Through consideration of these scores, and careful review of the benefits and risks associated with service delivery the programme board recommend that Option 2 (centralise the service on the DPOW site) should be considered by the Council of Members and Governing Bodies as the preferred option.

The Council of Members and Governing Bodies are asked to review and endorse the proposal that option 2 be taken for Clinical Senate review and full public consultation.

# 13. Appendix Log

## Appendix 1 – NLaG Business Case for ENT Inpatient Surgery – May 2014

## Appendix 2 - Health Needs Assessment: Hyper-Acute Stroke & ENT – Apr 2014

## Appendix 3 - HLHF Pre-Summit Engagement Report Jul 2013

## Appendix 4 - Healthy Lives, Healthy Futures Case for Change – Jul 2013

## Appendix 5 – Promoting the case for change: engagement feedback report Oct 2013

## Appendix 6 – Moving the conversation on: engagement feedback report Apr 2014

## Appendix 7 – Transport analysis: Hyper-Acute Stroke & ENT – Apr 2014

## Appendix 8 – Equality Impact Assessment analysis: ENT - May 2014

## Appendix 9 – Evaluation Criteria Assessment: ENT – May 2014

## Appendix 10 – Evaluation Criteria Process