Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review

for

Healthy Lives Healthy

Futures ENT Proposals

Version 1

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

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Yorkshire and the Humber Clinical Senate
Joanne.poole1@nhs.net

13th June 2014

Version Control

Document Version	Date	Comments	Drafted by
Version 0.1	10th June	Based on email comments prior to teleconference	Joanne Poole
Version 0.2	13th June	Updated following teleconference	Joanne Poole
Final Version 1.0	1st July	Updated following commissioner comments	Joanne Poole

1. Chair's Foreword

1.1 This review has been made more complex as the Senate required information in addition to the written evidence provided. The Senate was unable to endorse the proposed option on the basis of the written evidence but following the clinical discussion the Senate is now able to provide the endorsement of the commissioners preferred option.

2. Summary Recommendations

2.1 The Senate reviewed the body of written evidence provided and recommended that further information was required to support the preferred option as the case for consolidating ENT services on one site was not robustly made within the documentation. The subsequent clinical discussion was able to provide the additional information to enable the Senate to endorse the preferred option. The Senate recommends that:

i. there such be a protocol/Standard Operating Procedure describing which patients can be done as day surgery in Scunthorpe with the purpose being to keep the risk of unexpected admission due to complications to an absolute minimum

ii. there should be a full explanation/plan for accommodating the additional inpatients that would result from centralising the service. The Senate was not assured that this element of the preferred option had been completely planned out but it appears to be achievable.

3. Background

Clinical Area

3.1 North East Lincolnshire and North Lincolnshire CCGs approached the Clinical Senate to review the options that are being considered for service change, including the preferred option, and contribute with any issues or concerns that may need to be considered before going to consultation. The three areas referred to the Senate were identified as:

- Hyper acute stroke services
- ENT surgery
- Children's surgery

3.2 This report focuses on the ENT surgery proposals

3.3 The proposals consider centralising the service onto one hospital site, rather than being delivered at both DGH sites. This recommendation is based on national best practice around volumes, and also local clinical team recommendations around quality and safety improvements that could be facilitated through centralisation.

3.4 The CCGs wish to refer to the clinical senate review in their communications around service change to show that there has been a wider clinical view on these areas, and that the proposals have been discussed outside of the Northern Lincolnshire area.

3.5 The Senate has been approached in their role in providing independent clinical advice into the assurance process, The assurer is NHS England North Yorkshire and the Humber Area Team who requested that the Senate advice was received prior to the proposals going out for public consultation.

Current Position

3.6 The Senate received the draft documentation for the ENT proposals on 16th May with a request to provide our review on the 13th June. To assist with the Senate's understanding of the documents we arranged a teleconference with the Northern Lincolnshire clinician, Dr Bellini, on the 12th June.

3.7 The Senate understands that the commissioners will go out to public consultation on their proposal in July. The short timescales have proved challenging for the Senate and we need to ensure that further reviews provide more time for the Senate to reflect on the evidence.

4. Recommendations Based on Written Evidence

4.1 The Senate clearly understand the argument for the centralisation of services, it is a recurring theme across the NHS. What is not clear to the Senate is why the on call arrangement is unsustainable going forward. The clinical case for change has not been made in the options appraisal document. A reference is made to the alternating site on call cover, which is a principle the senate generally does not support, but there is no detail in the paper that allows the senate to comment with confidence upon the unsuitability of this arrangement nor is the senate able to comment on how the on call arrangement would be improved if service were centralised. The evidence does not mention any significant events because of these arrangements and it appears to affect very few patients. The Senate does not feel a sound argument has been made for the need to change the on call rota and suggests that more information needs to be provided to make the argument more robust

4.2 The Senate is aware of the 2008 document from ENTUK which does support ENT working on a hub and spoke model where day case procedures are done in the spoke hospitals. However the evidence submitted to the Senate does not consider the option of centralising the day case service and the Senate recommends that this is explored alongside the centralisation of inpatient ENT. The Senate recommends that the evidence includes a narrative about the benefits and risks of keeping day case patients on two sites if in-patient services were moved to one site and how the risks would be mitigated. At the very least the facility or arrangements for admitting day case patients if their operation was on a different site to the one hosting inpatient ENT services needs to be explained. For example last year SGH had 147 emergency patients, how will their experience be managed if the service is on one site?

4.3 The Senate were also concerned that Diana Princess of Wales Hospital has not explained exactly how they will accommodate the additional ward patients and theatre lists, except to say that this can be done. It is however almost a doubling of theatre capacity for inpatients and the Senate feels that the evidence base needs to explain how they will accommodate the extra lists particularly in light of the fact that 18 week performance for inpatients is currently almost 10% less than SGH. Consequently the Senate feels unable to comment on the suitability of this hospital (on any other hospital) to take on the additional activity that moving to a single site would create.

4.4 The Senate advises that more detail is required about the impact centralising services would have on the staff who currently work in the two hospitals. For instance how would the day surgery staff keep up their skills if there were no in-patient ENT facility? How many more staff would be required to work in the centralised hospital and would they come from the other site or not. Would there be any staff who could lose their job as a result of any of the options? Are there any concerns from the medical staff about moving base hospital and are there any implications for training?

5. Revised Recommendations based on Clinical Discussion

5.1 Within clinical discussion the Senate agrees that Dr Bellini made a good case for the unsustainability of the on call rota. The discussion described how long term admissions have to swap sites to ensure patients are in the hospital which is on call which clearly provides a poor experience for the patients. It was also acknowledged that annual leave can sometimes leave a consultant on call for 3 weeks depending on when this falls. There was also a discussion on how the reducing hours of middle grades means consultants are more involved in this arrangement and whilst the current consultant base tolerates the current system it would not be attractive to future appointments.

5.2 With regard to the day cases it is clear that there is not the capacity to centralise the day case on one site due to theatre capacity. It was acknowledged that clinicians are keen to maintain as much service as close to home as possible offering day case in DPOW or SGH which the Senate agreed was a reasonable principle. Following discussion of the types of day cases the Senate suggested that clinicians needed a clear process for discussing potential complication (and overnight stay) with patients when they choose where they have their day case. Patients may wish to choose the hospital where the 24hr cover exists to have their tonsils removed for example.

5.3 Regarding the capacity within DPOW, Dr Bellini discussed potentially moving some simple day cases from DPOW to SGH to free up bed space in DPOW for the greater inpatient workload. It was not clear to the Senate that the plan for accommodating the additional inpatients in DPOW following centralisation had been completely worked through.

5.4 It was acknowledged that although DPOW is the preferred option there will be many patients west of SGH which will have a long journey to DPOW and this issue may receive further focus in the public consultation. Certainly SGH is a more central location although the Senate supports the reasons why DPOW is the preferred location for the service.

5.5 With regard to the impact of centralising services on the staff the Senate was reassured that the proposals can accommodate current consultants within the new rota if they centralise at either SGH or DPOW.

5.6 On the basis of the clinical discussion the Senate agrees that a good case has been made for the preferred option of centralising the ENT service at DPoW. The Senate advises however that commissioners need to ensure that:

i. There is a protocol describing which patients can be done as day surgery in Scunthorpe with the purpose being to keep the risk of unexpected admission due to complications to an absolute minimum. This requires endorsement from all clinicians.

ii. There should be a full plan for accommodating the additional inpatients that would result from centralising the service. The Senate was not assured that this element of the preferred option had been completely planned out although we received verbal assurance that this is achievable.

6. Summary and Conclusions

6.1 The Senate has found this to be a difficult piece of work due to the challenging timescales.

6.2 From the written evidence submitted to the Senate we did not feel that the case for consolidating ENT services on one site had been robustly made. Subsequent clinical discussion has resulted in the Senate agreeing that there is a good case for the preferred option of centralising the ENT service at DPoW. The Senate advises however that further work is required on the protocol for choosing the site of day surgery and a plan is developed which clearly sets out how the additional inpatients would be accommodated at DPoW.

APPENDICES

Appendix 1

LIST OF COUNCIL MEMBERS LEADING ON THIS REVIEW

Caroline Hibbert

Steve Ollerton

The HLHF proposals for ENT surgery were discussed at the June Council meeting.

A full list of Council members can be found on our website: http://yhsenate.wordpress.com

Appendix 2

COUNCIL MEMBERS' DECLARATION OF INTERESTS

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict
Paul Twomey	Medical Director	NHS England North Yorkshire Area Team	15.4.14	NLaG falls within the North Yorkshire's Area Team boundaries	16.4.14	Many thanks for your email declaring a conflict of interest in relation to the work referred to us from North Lincolnshire and NE Lincolnshire CCGs for their proposals within Healthy Lives Healthy Futures. Your conflict arises because you are Medical Director of the Area Team responsible for assuring this work. To manage this conflict of interest we need to ensure that you do not take part in any Council or sub group discussions as they relate to this matter.

Appendix 3

Template to request advice from the Yorkshire and the Humber Clinical Senate

Name of the lead (sponsoring) body requesting advice: NEL CCG and NL CCG

Type of organisation: Clinical Commissioning Groups

Name of main contact: Jenny Briggs

Designation: Strategic Lead, Healthy Lives, Healthy Futures

Email: jenny.briggs1@nhs.net **Tel:** 07795 908890 **Date of request: Feb 2014**

Please note other organisations requesting this advice (if more than the lead body noted above):

The CSU is programme managing the work on behalf of 2 CCGs.

Is the Senate being consulted for advice or as part of the formal assurance process?

This is for advice and feedback to form a clinical assurance element of the programme, which will feed into the work taken to public consultation.

Please state as clearly as possible what advice you are requesting from the Clinical Senate.

We would like the clinical senate to review the options that we are considering for service change, including our preferred option, and contribute with any issues or concerns that we may need to consider before going to consultation. The three areas are expected to be:

- Hyper acute stroke services
- ENT surgery
- Children's surgery

Please state your rationale for requesting the advice? (What is the issue, what is its scope, what will it address, how important is it, what is the breadth of interest in it?).

Each of the three areas is being considered for centralisation onto one hospital site, rather than being delivered at both DGH sites. This recommendation is based on national best practice around volumes, and also local clinical team recommendations around quality and safety improvements that could be facilitated through centralisation.

This is not expected to save money or contribute to the overall financial "gap"

What is the purpose of the advice? (How will the advice be used and by whom, how may it impact on individuals, NHS/other bodies etc.?).

We would like to be able to refer to the clinical senate review in our communications around service change to show that there has been a wider clinical view on these areas, and that we have discussed it outside of the Northern Lincolnshire area.

We are conscious that only involving local clinicians could be criticised by the public if they don't like the preferred options we are suggesting.

Please provide a brief explanation of the current position in respect of this issue(s) (include background, key people already involved).

A range of provider and commissioner clinicians, (not just medical staff), have been involved in the work so far and we are working through the location discussions with our clinical working groups. This will be taken through our Clinical Advisory Group which is a formal sub group of the programme board and chaired by Hugo Mascie-Taylor.

When is the advice required by? Please note any critical dates.

We would like the senate workshop to take place on 10th April if possible.

Our decision making programme board meeting will take place on 17th April.

The COM and Governing Body decisions will take place early May.

Has any advice already been given about this issue? If so please state the advice received, from whom, what happened as a consequence and why further advice is being sought?

We have had advice from local clinicians and also Hugo Mascie-Taylor, and also drawn on national best practice and evidence. We had always planned to drawn on the Senate's expertise to support a clinical assurance process.

Is the issue on which you are seeking advice subject to any other advisory or scrutiny processes? If yes please outline what this involves and where this request for advice from the Clinical Senate fits into that process (*state N/A if not applicable*)

We are also working with the Gateway team to provide programme assurance on the non-clinical elements.

Please note any other information that you feel would be helpful to the Clinical Senate in considering this request.

Appendix 4

BACKGROUND INFORMATION

There follows a list of documentation provided to the Senate:

- Options Appraisal ENT v8
- Appendix 1 NLaG ENT Business Case May 2014
- Appendix 2 Health Needs Assessment for Hyper Acute Stroke and ENT May 2014 v3
- Appendix 3 Pre Summit Stakeholder Engagement August 2013
- Appendix 4 HLHF Case for Change July 2013
- Appendix 5 Promoting the Case for Change Engagement Report Oct 2013
- Appendix 6 Moving the Conversation on Engagement Report July 2014
- Appendix 7 Transport Analysys Hyper Acute Stroke and ENT May 2014 v3
- Appendix 8 Equality Impact Assessment May 2014
- Appendix 9 Evaluation Criteria Assessment ENT May 2014 v3
- Appendix 10 Evaluation Criteria Process May 2014