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**Children’s Surgery**

**Options Appraisal**

**Version 3 - 19.05.2014**



Contents

[1 Introduction 4](#_Toc388275354)

[1. Executive summary 5](#_Toc388275355)

[1.1 Options being considered 5](#_Toc388275356)

[1.2 Programme Board recommendation 5](#_Toc388275357)

[1.3 Next steps 6](#_Toc388275358)

[3. Evaluating the options 7](#_Toc388275359)

[4. Equality Impact Assessment (EQIA) 8](#_Toc388275360)

[4.1 Equality data 8](#_Toc388275361)

[4.2 Public feedback on equality issues 10](#_Toc388275362)

[5.3 Benefits 11](#_Toc388275363)

[5.4 Equality Impact Assessment 12](#_Toc388275364)

[5.5 Evaluation criteria assessment 12](#_Toc388275365)

[6. Option 2 – Rotate Consultants between both sites 13](#_Toc388275366)

[6.1 Assumptions 13](#_Toc388275367)

[6.2 Risks / issues 13](#_Toc388275368)

[6.3 Benefits 13](#_Toc388275369)

[6.4 Equality Impact Assessment 14](#_Toc388275370)

[6.5 Evaluation criteria assessment 14](#_Toc388275371)

[7. Option 3 – Rotational training programme with tertiary providers 15](#_Toc388275372)

[7.1 Assumptions 15](#_Toc388275373)

[7.2 Risks / issues 15](#_Toc388275374)

[7.3 Benefits 15](#_Toc388275375)

[7.4 Equality Impact Assessment 16](#_Toc388275376)

[7.5 Evaluation criteria assessment 16](#_Toc388275377)

[8. Option 4 – Decommission the local service and send all children’s surgery to tertiary centres 17](#_Toc388275378)

[8.1 Assumptions 17](#_Toc388275379)

[8.2 Risks / issues 17](#_Toc388275380)

[8.3 Benefits 17](#_Toc388275381)

[8.4 Equality Impact Assessment 18](#_Toc388275382)

[8.5 Evaluation criteria assessment 18](#_Toc388275383)

[7. Appendix Log 21](#_Toc388275384)

[Appendix 1 – NLaG Business Case for Children’s surgery – May 2014 21](#_Toc388275385)

[Appendix 2 – Evaluation Criteria Process 21](#_Toc388275386)

[Appendix 3 – Equality Impact Assessment for Children’s surgery – May 2014 21](#_Toc388275387)

[Appendix 4 – Evaluation Criteria Assessment for Children’s surgery – May 2014 21](#_Toc388275388)

# 1 Introduction

This commissioner options appraisal should be read in conjunction with the NLaG business case for children’s surgery, which sets out the background information to the children’s surgery (Appendix 1).

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 how to address quality and safety concerns raised by the provider clinical teams.

# Executive summary

The delivery of surgical services for children in the United Kingdom has changed in the last 20 years and there has been a significant decline in the number of children who have surgery performed in district general hospitals over this time (NCEPOD 2011). Several reports have identified the need for improved and consistent care for paediatric surgical patients and significant changes have resulted in the way paediatric surgery is led and delivered (Every Child Matters 2003, the Children’s Plan 2007, the NHS Next Stage Review 2008, RCPCH 2013). Improvements include specialisation and centralisation of children’s surgical services and modifications to staff training. Recommendations were made that surgeons and anaesthetists should not undertake occasional paediatric practice and that consultants who have responsibility for children need to maintain their competence in the management of paediatrics. Provider clinical teams have raised concerns that the volumes of children having surgery in Northern Lincolnshire do not give critical mass to maintain the specific expertise required for operating on children.

Within Northern Lincolnshire there already exists robust mechanisms which ensure complex paediatric care needs are met by a tertiary provider. This option appraisal document in conjunction with the NLaG children’s surgery paper considers a range of options for addressing the quality concerns raised by provider clinicians.

## 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 surgery on Children services where they are available.

Considerations on the location of the service take into account the impact of provision in different locations according to access, deliverability and cost.

The options being considered by commissioners are:

1. Do nothing
2. Rotate consultants between both sites for specialties where there are insufficient volumes
3. Rotational training programme with tertiary centre/providers
4. Decommission the local service and send all Children’s surgery to tertiary centres

## Programme Board recommendation

The programme board met to discuss the options listed above, and to review them against the evaluation criteria that was agreed for use with large scale change. The outcome of this meeting was that options 1 and 2 were not acceptable for quality reasons, however the programme board did not feel that options 3 or 4 offered an acceptable solution to the quality issues raised. Two additional options were suggested by the programme board for additional work prior to any decisions being taken:

1. Centralise the children’s surgery on SGH site
2. Centralise children’s surgery on DPOW site

## Next steps

It has not been possible to undertake the full business case review for this service at this time, so this paper provides the outline options appraisal for discussion. The programme board recommendation is that options 5 and 6 are worked up in more detail to allow a formal review of benefits and risks.

The provider clinicians have requested advice from the Clinical Senate on the safety and validity of these options.

These will then be taken through a public engagement phase to gain input from the public, patients and our stakeholders, and the full business case content will be prepared at that time.

# 3. 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 1 - 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 hyper-acute stroke.

The evaluation process has been documented in Appendix 2.

# 4. 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).

## 4.1 Equality data

The demographic data for the protected groups is shown below.

#### Table 2 – 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 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+ |
| 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 4 – 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 5 – 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 6 – 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:

#### Table 7 – 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.

## 4.2 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”*

The full Equality Impact Assessment analysis can be found as Appendix 3.

5. Option 1 – Do nothing: Children’s surgery remains unchanged

5.1 Assumptions

This option makes the following assumptions:

* The service will remain on both sites in its current capacity

5.2 Risks and Issues

#### Table 8 – Risks and issues of option 1 (do nothing)

| Category | Risk / Issue | RAG | Mitigation |
| --- | --- | --- | --- |
| Quality & Safety | With the current volumes going through the service there will be insufficient activity in some specialties to maintain all round clinical competency. This particularly relates to General Surgery, Urology and Ophthalmology. However it is suggested by provider clinicians that the complexity of Ophthalmology procedures now undertaken in an outpatient setting provide the volumes and complexities to ensure skills are maintained. | Red | Consider reducing the number of General Surgeons and Urologists and associated clinical teams that operate on children to increase the volumes per person. However this will impact on the ability to cover holiday and sickness absences or to cover out of hours rotas. |
| Quality & Safety | Clinical outcomes and patient safety may be compromised in low volume specialties. | Red | Consider joint working with another trust to repatriate surgery from other sites to increase the volumes going through the service. |
| Deliverability | More activity is moving to tertiary centres, which means fewer General Paediatric Surgery (GPS) training opportunities. (GPS is defined as the surgical management of relatively common non-specialised conditions in general surgery and urology in children who do not require complex perioperative care arrangements). This could impact on the number of surgeons coming through the system that are exposed to GPS in medical training, and able to cover routine or emergency GPS rotas. | Red | None identified. |

## 5.3 Benefits

Benefits associated with this option are shown below:

#### Table 9 – Benefits of option 1 (do nothing)

| Category | Benefit |
| --- | --- |
| Access | Public have raised concerns over transportation and access if services are moved, so the “do nothing” option may be more acceptable publically. |
| Finance | No impact on finance unless activity increases |

## 5.4 Equality Impact Assessment

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

#### Table 10 – Assessment of the impact on people with protected characteristics

|  |  |  |
| --- | --- | --- |
| Protected characteristic | Impact | Nature of impact |
| Age | Negative | With the current volumes of children patients going through the service there will be insufficient activity in some specialties to maintain all round clinical competencies. This particularly relates to General Surgery, urology and ophthalmology. However it is suggested by provider clinicians that the complexity of ophthalmology procedures now undertaken in an outpatient setting provide the volumes and complexities to ensure skills are maintained. |
| Disability | 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. |
| 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 | National Stroke Association noted that statistics showed that males have a higher risk of having a stroke. Therefore returning the service back to its delivery prior to summer 2013 would have a potentially negative impact across 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 | Neutral | 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 28.3% of children are in poverty and in North Lincolnshire the figure is 21.0%. In view of the large demographic areas both SGH and DPoW service serves, and the associated deprivation within North East Lincolnshire in particular, the need to ensure children and families can access appropriate healthcare is paramount. |
| Human rights | Negative | If the service were to be remain clinical outcomes and patient safety may be compromised in low volume specialties. |

## 

## 5.5 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 11 – Evaluation scoring for option 1 (do nothing)

|  |  |  |
| --- | --- | --- |
| Criteria | Score | Rationale |
| Quality | 72 | Concerns were raised by the provider clinicians, and so the programme board did not feel it would be appropriate to maintain the service in its current form. |
| Access | 36 | This was not expected to have negative impact on access, however it was recognised that the public had been told about quality concerns so they would likely expect changes to be implemented to address those issues. |
| Affordability | 40 | This scored highest from an affordability perspective as there would be no additional costs incurred. |
| Deliverability | 48 | This would not offer improvements to staffing or attractiveness for employment, however it was not anticipated that there would be a significant negative impact either. |
| Total | 196 |  |

# 6. Option 2 – Rotate Consultants between both sites

## 6.1 Assumptions

This option makes the following assumptions:

* The numbers of surgeons, anaesthetists and support teams operating on children is reduced to form a joint team, and medical staff achieve all round clinical competence through combining volumes from both sites
* Where practicable procedures will be delivered from one speciality to increase volumes per surgeon (e.g. circumcision)
* On call and out of hours service is provided by the joint team, and they will travel to the appropriate site when required
* Outpatient services continue to be delivered from both sites

## 6.2 Risks / issues

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

#### Table 12 – Risks and issues of option 2 (rotation of consultants between both sites)

| Category | Risk / Issue | RAG | Mitigation |
| --- | --- | --- | --- |
| Quality & Safety | Patients (children) may still attend local A&E departments with problems that require emergency surgery. If there is no surgical service on that site for that time, patients may be required to be transferred between local and tertiary sites. | Amber | Establish protocol to ensure that ambulances take presenting children to the relevant tertiary centre if it is likely they may require surgery.  For those patients who do not have obvious symptoms a protocol will be require to transfer them to the appropriate site if required. |
| Quality & Safety | Rotation of surgeons may still present risks if the Anaesthetic and theatre teams do not work regularly with children. | Red | Rotate the whole surgical team as a joint team (including Anaesthetists, ODPs, scrub team and recovery staff). |
| Quality & Safety | Ward staff may not see sufficient children to maintain their skills if the service rotates between both sites. | Red | Consider rotating a specialist paediatric matron with post-operative experience to support the ward staff with regular training and oversight. |
| Deliverability | Rotating across sites is not attractive to staff, and this may impact negatively on morale. | Amber | Staff could be incentivised to move within the service with travel contributions. |
| Deliverability | Rotating across sites may compromise on call rotas and reduce the ability to offer a comprehensive service. This has already been raised by the ENT service as being unsustainable. | Red | Anaesthetists and Paediatricians could take responsibility for post-operative patients. If there are complications the joint rotational team could be available on the telephone or travel to the relevant site if required. |

## 6.3 Benefits

Benefits of this option are shown below:

#### Table 13 – Benefits of option 2 (rotation of consultants between both sites)

| Category | Benefit |
| --- | --- |
| Quality & safety | Provider clinicians suggest that this would address the quality issues with volumes of surgery for the specialties that are currently below the recommended volume to achieve a safe service. |
| Access | This will still provide the surgical service at both sites which will be more acceptable for patients. |

## 6.4 Equality Impact Assessment

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

#### Table 14 – Assessment of the impact on people with protected characteristics

|  |  |  |
| --- | --- | --- |
| Protected characteristic | Impact | Nature of impact |
| Age | Negative | Children patients may still attend local A&E with problems that require emergency surgery. If there is no surgical service on that site for that time, patients may be required to be transferred between local and tertiary sites. In addition rotation of surgeons may still present risks if the anaesthetic and theatre teams do not work regularly with children and ward staff may not see sufficient children to maintain their skills if the service rotates between both sites. |
| Disability | 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. |
| 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 | National Stroke Association noted that statistics showed that males have a higher risk of having a stroke. Therefore returning the service back to its delivery prior to summer 2013 would have a potentially negative impact across 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 | Neutral | 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 28.3% of children are in poverty and in North Lincolnshire the figure is 21.0%. In view of the large demographic areas both SGH and DPoW service serves, and the associated deprivation within North East Lincolnshire in particular, the need to ensure children and families can access appropriate healthcare is paramount. Rotating surgical services either entirely or by speciality will undoubtedly cause access to the appropriate healthcare an issue for some families. Consideration needs to be given to the potential increase in families being unable to access services if they are not local to them. |
| Human rights | Negative | Rotation of consultants between both sites may still present risks if the anaesthetic and theatre teams do not work regularly with children, also ward staff may not see sufficient children to maintain their skills due to the rotation. |

## 6.5 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 15 – Evaluation scoring for option 2 (rotation of consultants between both sites)

|  |  |  |
| --- | --- | --- |
| Criteria | Score | Rationale |
| Quality | 45 | This was not deemed a safe option as the clinical teams would not be present on each site for periods of time. It was also anticipated that staffing would not want to rotate, and that patients and the public would find it confusing. |
| Access | 24 | This could cause some patients to travel or be transported depending on urgency, and rotas. |
| Affordability | 16 | This was anticipated to be costly due to travel and additional staffing requirements. |
| Deliverability | 16 | It was assumed that this would be unpopular with staff, and require considerable travelling, and transporting of patients. |
| Total | 101 | This option scored lowest of all options due to the safety and deliverability issues. |

# 7. Option 3 – Rotational training programme with tertiary providers

## 7.1 Assumptions

This option makes the following assumptions:

* Surgery for children is still delivered on both DPOW and SGH sites
* Medical staff rotate with tertiary providers to ensure that they achieve higher volumes of surgery and maintain their skills
* Outpatient services remain unchanged

## 7.2 Risks / issues

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

#### Table 16 – Risks and issues of option 3 (rotational training programme with tertiary providers)

| Category | Risk / Issue | RAG | Mitigation |
| --- | --- | --- | --- |
| Quality & safety | Patients (children) may still attend local A&E departments with problems that require emergency surgery. If there is no surgical service on that site for that time, patients may be required to be transferred between local and tertiary sites. | Amber | Establish protocol to ensure that ambulances take presenting children to the relevant tertiary centre if it is likely they may require surgery.  For those patients who do not have obvious symptoms a protocol will be require to transfer them to the appropriate site if required. |
| Quality & Safety | Tertiary providers may not be able to offer enough procedures to NLaG surgeons to provide the critical mass required. | Red | None identified. |
| Affordability | This may require recruitment of additional Medical staff if they are required off site for periods of time. Currently commissioners and providers are required to deliver significant cost savings, and this investment may prove to be prohibitive. | Red | Discuss with the tertiary provider a reciprocal rotation arrangement where one of their team replace the NLaG clinician during the rotation. |
| Deliverability | Rotating across sites is not attractive to staff, and this may impact negatively on morale. | Amber | Staff could be incentivised to move within the service with travel contributions. |
| Deliverability | Rotating with tertiary centres for may compromise service delivery and on call rotas if the surgeons are required to spend more time off site in the tertiary centre. | Red | Adjust rotas and staffing levels to ensure the service can be maintained.  Use specialist GPs or locums to cover any gaps in rotas or service provision. |
| Deliverability | It may not be possible for all surgeons to take part in the rotational programme due to current commitments and job plans. | Red | Reduce the number involved in the programme, and therefore able to undertake the surgery on children. |

## 7.3 Benefits

Benefits of this option are shown below:

#### Table 17 – Benefits of option 3 (rotational training programme with tertiary providers)

| Category | Benefit |
| --- | --- |
| Access | This will allow the service to be delivered on both sites which will be more acceptable for the public |
| Deliverability | This could offer a more attractive proposition for staff if there is a tertiary rotation. This could impact positively on recruitment. |

## 7.4 Equality Impact Assessment

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

#### Table 18 – Assessment of the impact on people with protected characteristics

|  |  |  |
| --- | --- | --- |
| Protected characteristic | Impact | Nature of impact |
| Age | Negative | Children patients may still attend local A&E with problems that require emergency surgery. If there is no surgical service on that site for that time, patients may be required to be transferred between local and tertiary sites. Tertiary providers may not be able to offer enough procedures to NL&G surgeons to provide the critical mass required. Rotating with tertiary centres may compromise service delivery and on call rotas if the surgeons are required to spend more time off site in the tertiary centre. |
| Disability | 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. |
| 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 | National Stroke Association noted that statistics showed that males have a higher risk of having a stroke. Therefore returning the service back to its delivery prior to summer 2013 would have a potentially negative impact across 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 | Neutral | 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 28.3% of children are in poverty and in North Lincolnshire the figure is 21.0%. In view of the large demographic areas both SGH and DPoW service serves, and the associated deprivation within North East Lincolnshire in particular, the need to ensure children and families can access appropriate healthcare is paramount. Rotating surgical services either entirely or by speciality will undoubtedly cause access to the appropriate healthcare an issue for some families. Consideration needs to be given to the potential increase in families being unable to access services if they are not local to them. |
| Human rights | Negative | Rotational training programme with tertiary providers may result in tertiary providers not being able to offer enough procedures to NL&G surgeons to provide the critical mass required. |

## 7.5 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 19 – Evaluation scoring for option 3 (rotational training programme with tertiary providers)

|  |  |  |
| --- | --- | --- |
| Criteria | Score | Rationale |
| Quality | 118 | This was deemed a safer option as the tertiary provider would be offering clinical leadership for this cohort of patients, but that the service would still be local. |
| Access | 36 | This would be more positive for patients as they would not need to travel for their surgery. |
| Affordability | 16 | This would incur costs as the staff would need to be back-filled while they are on rotation. |
| Deliverability | 40 | This would be deemed more acceptable publically, as the service would still be available on both sites. |
| Total | 210 |  |

# 8. Option 4 – Decommission the local service and send all children’s surgery to tertiary centres

## 8.1 Assumptions

This option makes the following assumptions:

* All children’s surgery services will be decommissioned locally
* Patients will travel to the tertiary provider (e.g. Sheffield Children’s Hospital) for their surgery
* There will be no change to outpatient service provision

## 8.2 Risks / issues

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

#### Table 20 – Risks and issues of option 4 (decommission local service)

| Category | Risk / Issue | RAG | Mitigation |
| --- | --- | --- | --- |
| Quality & safety | Patients (children) may still attend local A&E departments with problems that require emergency surgery. If there is no local surgical service patients may be required to be transferred between local and tertiary sites. | Amber | Establish protocol to ensure that ambulances take presenting children to the relevant tertiary centre if it is likely they may require surgery.  For those patients who do not have obvious symptoms a protocol will be require to transfer them to the appropriate site if required. |
| Access | Public may find an off-site 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. |
| Access | Both areas within Northern Lincolnshire have a deprived populations and pockets of communities with low incomes. This could be seen to disadvantage deprived populations. | 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 | This will reduce income to the acute trust as the tariff will follow the patient to the tertiary provider. | Green | Use the reduction in surgical volumes to support a theatre capacity review, either reduce theatre lists or use that capacity for other specialities. |
| Affordability | There could be a tertiary premium applied to the tariff by the tertiary provider. Commissioners are currently required to reduce their costs within current allocations. | Amber | Negotiate rates with the tertiary provider to avoid additional costs to the commissioners. |

## 8.3 Benefits

Benefits of this option are shown below:

#### Table 21 – Benefits of option 4 (Decommission local service)

| Category | Benefit |
| --- | --- |
| Quality & safety | Children would receive optimal care from staff who meet all the required competency requirements to work within children’s surgery. |
| Quality & safety | Patient safety would be assured by providing care from tertiary centres. |
| Deliverability | This would allow NLaG to focus their resources on other higher volume activities and reduce pressure on the current service. |

## 8.4 Equality Impact Assessment

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

#### Table 22 - Assessment of the impact on people with protected characteristics

|  |  |  |
| --- | --- | --- |
| Protected characteristic | Impact | Nature of impact |
| Age | Negative | Children patients may still attend local A&E departments with problems that require emergency surgery. If there is no local surgical service patients may be required to be transferred between local and tertiary sites. However North East Lincolnshire has 38.2% of the population of residents in the most deprived quintile and in North Lincolnshire the figure is 19.6%, therefore locating the service outside of Northern Lincolnshire would present a risk to this cohort of residents. |
| Disability | 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. |
| 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 | National Stroke Association noted that statistics showed that males have a higher risk of having a stroke. Therefore returning the service back to its delivery prior to summer 2013 would have a potentially negative impact across 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 28.3% of children are in poverty and in North Lincolnshire the figure is 21.0%. In view of the large demographic areas both SGH and DPoW service serves, and the associated deprivation within North East Lincolnshire in particular, the need to ensure children and families can access appropriate healthcare is paramount. Centralising surgical services either entirely or by speciality will undoubtedly cause access to the appropriate healthcare an issue for some families. Consideration needs to be given to the potential increase in families being unable to access services if they are not local to them. |
| Human rights | Positive | Decommissioning the local service and sending all children’s surgery to tertiary centres would still allow the patient (children) to attend local A&E departments with problems that require emergency surgery. If there is no local surgical service patients may be required to be transferred between local and tertiary sites. Support for travel costs is available for certain people that meet the criteria for subsidy or refund.  Option 4 would therefore provide a more positive impact in relation to Human rights and access to treatment as long as transport measures were put in place for the cohort of deprived population to enable them to gain access to the site |

## 8.5 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 23 – Evaluation scoring for option 4 (Decommission local service)

|  |  |  |
| --- | --- | --- |
| Criteria | Score | Rationale |
| Quality | 145 | This scored highly from a safety and quality perspective as specialist surgeons would be undertaking the procedures. |
| Access | 24 | This would require patients to travel off site for their surgery. |
| Affordability | 24 | If capacity could be identified within the tertiary centre it was assumed that this would not require significant financial investment. |
| Deliverability | 72 | It was assumed that this would be very attractive to staff working at the tertiary centre, and would relieve pressure on the local services, creating theatre and ward capacity that could be used on other services. |
| Total | 265 | This scored highest out of the options appraised. |

9. Conclusion and recommendation

This options appraisal sets out the options, risks and benefits for children’s surgery within Northern Lincolnshire as proposed by the provider clinical teams. 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 | 72 | 45 | 118 | 145 |
| Access | 36 | 24 | 36 | 24 |
| Affordability | 40 | 16 | 16 | 24 |
| Deliverability | 48 | 16 | 40 | 72 |
| Total | 196 | 101 | 210 | 265 |

Through consideration of these options the programme board felt these options did not present sufficient solutions to the problems identified by the provider clinical teams, and that there were other options available. The programme board felt that two additional options should be considered before making a recommendation for changing the service:

* Centralise the children’s surgery on SGH site
* Centralise children’s surgery on DPOW site

The Clinical Senate will be approached to discuss options with the paediatric clinical teams to ensure that proposals are robust and will offer a safe alternative to the patients of Northern Lincolnshire.

It is recommended that further work be undertaken to scope out these options and complete the business case content for this options appraisal, and that this work be combined with a further period of public engagement.

The Council of Members and Governing Bodies are asked to review and endorse this course of action.

# 7. Appendix Log

## Appendix 1 – NLaG Business Case for Children’s surgery – May 2014

## Appendix 2 – Evaluation Criteria Process

## Appendix 3 – Equality Impact Assessment for Children’s surgery – May 2014

## Appendix 4 – Evaluation Criteria Assessment for Children’s surgery – May 2014