RESPONSE BY HEREFORDSHIRE COUNCIL'S HEALTH SCRUTINY COMMITTEE TO CONSULTATION ON THE PROVISION OF EAR, NOSE AND THROAT SERVICES ISSUED BY HEREFORDSHIRE PRIMARY CARE TRUST

SUMMARY

Introduction

Herefordshire Primary Care Trust (HPCT) issued its consultation paper on the provision of Ear, Nose and Throat Services on 30th March 2004, requesting responses by 7th May, 2004

The consultation document set out three options: a "do nothing" option; a Local Development option, investing additional resources into Hereford Hospitals NHS Trust to develop the local service; and the "network" option involving Hereford Hospitals NHS Trust (HHT) working closely with another NHS Trust to develop a joint service. The Committee has noted that there are a range of other options open to the HPCT, for example closing the service in total and commissioning it elsewhere, but that the document has sought to highlight what the HPCT considers to be the key possibilities.

This is the first consultation exercise to which the Health Scrutiny has been asked to respond. It has taken great care to seek to gather as much information as it can in the time available to it. It has considered the impact of the potential change on patients and the present and future delivery of Services in Herefordshire.

The Committee would have liked to have gathered additional evidence but the time constraints have prevented it from doing so. If further relevant information is brought to the Committee's attention it may wish to submit additional comments before the deadline.

The response is submitted by the Committee in its role as one of many consultees. When the consultation period is completed and the Herefordshire Primary Care Trust has announced its preferred course of action the Committee may wish to scrutinise the overall process and examine the evidence considered by the Primary Care Trust in reaching its conclusions.

Recommendations

The Committee's observations and recommendations based on the evidence provided to it are set out below. The evidence is included in the full response.

(a) The evidence, based on the professional guidance received, is that the current service is unsustainable and the "do- nothing" option is in fact not a viable option.

(b) The findings of the British Association of Otorhinolaryngologists Head and Neck surgeons' report also militate against the local development option as described in the consultation document, although the Committee considers that the Primary Care Trust should provide firmer evidence to support its concerns about the feasibility of this option.

(c) **The Committee acknowledges the reasoning provided by the Primary Care Trust in support of the Network Option but would request the Primary Care Trust to confirm that arrangements can be put in place which will address concerns about patient safety, to confirm that the continued provision of the ENT service as far as possible within Hereford, and indeed other services, remains its objective and that it will consider the scope for developing specialisms within Hereford.**

(d) **It is accepted that the need for change and the assessment of options is being driven by issues of clinical governance and not cost. It nevertheless recognises that there will be cost implications arising from any proposed solution and requests further details regarding the proposed solution.**

(e) **The Primary Care Trust and the Hospitals Trust need to address communications with Consultants, GPs and support staff. The network option will only work in practice if protocols are in place and Teams understand the aims and objectives, own them and can work effectively together.**

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Introduction

The Committee was made aware of consideration being given to the provision of ear, nose and throat services (ENT) in October 2003. The Committee indicated that it considered the issue potentially represented a substantial variation in Service and the HPCT agreed that it should be treated as such, requiring consultation to be undertaken.

The Committee conducted some evidence gathering in February 2004 in advance of the formal consultation and subsequent to receipt of the formal consultation document.

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Evidence Considered

The Committee has based its response on the following evidence:

Information provided in discussions with

- The Chief Executive of the Herefordshire Primary Care Trust
- The Chief Executive, the Director of Operations and the Medical Director at the Hereford Hospitals NHS Trust

- Consultants involved with the delivery of Ear, Nose and Throat Services at the Hereford Hospitals NHS Trust and the Worcestershire Acute Hospitals NHS Trust.

- Representatives of the General Practitioners on the Herefordshire Primary Care Trust Practitioners Executive Committee and the Local Medical Committee.

Written views from

- Mr G Hanna, Consultant ENT surgeon, Hereford Hospital

- Mr M Smith Consultant Otolaryngologist, Hereford Hospital

- The Director of Development – Herefordshire Primary Care Trust

The British Association of Otorhinolaryngologists Head and Neck surgeons report on the provision of Otorhinolaryngological (Ear, Nose and Throat) and head and neck services in the UK (November 2003), which is referred to in the consultation document.

The Committee wishes to record the open and helpful manner in which information has been provided to the Committee and would like to thank those concerned for their co-operation.

Recommendations

The Committee's observations and recommendations are set out below in bold font, accompanied by the supporting evidence.

(a) The evidence, based on the professional guidance received, is that the current service is unsustainable and the "do- nothing" option is in fact not a viable option.

The Committee's attention was repeatedly drawn to the British Association of Otorhinolaryngologists Head and Neck surgeons report on the provision of Otorhinolaryngological (Ear, Nose and Throat) and Head and Neck services in the UK (November 2003) (the BAOHNS) report. It was noted that, "the objective of these guidelines was to create the best possible environment in which excellence in care will flourish, and ensure that patients have rapid access to a safe, high quality service provided by trained specialists".

Reasons for change to the provision of ENT services are set out in the BAOHNS report. It is understood these underpin the HPCT's consultation exercise. They include the effects of the European Working Time Directive (EWTD) and staffing levels, the tendency to increasing clinical super-specialisation, the requirements of multi-disciplinary team working; training requirements, emergency out of hours cover in the light of the EWTD, clinical governance and patient expectation.

None of the evidence presented to the Committee sought to suggest that the service could continue to operate effectively as a stand alone service at Hereford with two consultants.

(b) The findings of the British Association of Otorhinolaryngologists Head and Neck surgeons' (BAOHNS) report also militate against the local development option as described in the consultation document, although the Committee considers that the Primary Care Trust should provide firmer evidence to support its concerns about the feasibility of this option.

The Committee wishes to ensure that services are as accessible as possible to the people of Herefordshire. In considering whether a change to provision represents a substantial variation and substantial development the Government guidance suggests that changes in accessibility of services should be taken into account. It notes that communities attach considerable importance to the local provision of services and local accessibility can be a key factor in improving population health.

In seeking further details on this option the Committee was again referred to the BAOHNS report and in particular the reference that, "provision of services based on a catchment area of approximately one-third of a million people does not allow such newly appointed consultants to practice and hone their skills to maintain a level of competence that they would expect of themselves as professionals."

Attention was also drawn to the BAOHNS view that there is a requirement for one consultant per 76,000 population (in England there is currently one consultant otorhinolaryngologist for 113,000 population). This suggests that even with 3 consultants Hereford would have too few. However, the Committee was also advised that 4-5 consultants, the number thought necessary "to allow corporate working, sub-specialisation and cross-referrals", would be too great a number to be sustained within Herefordshire based on current caseload.

The Committee therefore acknowledges the concerns expressed by the HPCT. However it considers the assertion in the consultation document that "even if the significant resources could be found it is **unlikely** that Hereford Hospitals NHS Trust would be able to appoint another consultant" coupled with the phrase "it is **unlikely** that a job description for another post would receive national approval" requires firmer evidence to support and justify concerns about the feasibility of this option.

In seeking clarification on the appointment of a third consultant the Committee understands that this, to some extent is a matter of clinical judgement. However, the HPCT considers that wide experience of similar issues leads the HPCT to form a view that if this option was pursued, a vacancy created, funding found and a job description produced then it is likely that this would not receive national approval, simply because it would not comply with the professional recommendations set out by the British Association of Otorhinolaryngologists.

(C) The Committee acknowledges the reasoning provided by the Primary Care Trust in support of the Network Option but would request the Primary Care Trust to confirm that arrangements can be put in place which will address concerns about patient safety, to confirm that the continued provision of the ENT service as far as possible within Hereford, and indeed other

services, remains its objective and that it will consider the scope for developing specialisms within Hereford.

The BAOHNS report acknowledges suburban or rural services do not easily conform to the collaborative approach being adopted for urban metropolitan services. "Local medical and political opinion coupled with a Trust's desire not to appear to be downgrading a service may hamper any effort to provide collaborative service provision. Further, the local population feels an inherent right of access to nearby services that they have traditionally supported and held dear to their hearts. Such taxpayers may not see any benefit to more comprehensive, safer or modern services. Often transport infrastructure does not assist in helping patients to travel distances or routes that are not modern hub and spoke transport systems."

In assessing this option the Committee has focused on patient safety, together with the future provision of services in Herefordshire. The Committee also recognises the difficulties such arrangements may present for relatives/carers/friends of patients.

Patient Safety

The Committee notes that the proposal envisages the vast majority of the local service remaining at the County Hospital; however some of the more complex inpatient and all medical emergencies requiring emergency ambulance transport would be transferred to a larger hospital outside of Herefordshire. The proposal then goes on to outline discussions held with the Worcestershire Acute Hospitals NHS Trust about developing services along these lines.

The consultation document states that analysis of patient activity data indicates that approximately 180 patients per year would travel to Worcester for treatment under this option.

Patient safety is clearly an important consideration for the Committee. The argument that better care would be provided to a patient in Worcester has to be balanced against the concerns expressed about emergency patients travelling to Worcester, in particular from the West of Herefordshire and Mid-Wales.

The Committee notes the statement in the consultation document that patients requiring immediate life saving treatment would be initially stabilised at the Accident and Emergency Department of the County hospital, Hereford before subsequent transfer to Worcester and that clear clinical protocols would be agreed for this stabilisation and transfer process.

It is also noted that if the network option were to proceed clear clinical protocols would be put in place. It has been advised that if the network option is pursued then further clinical work will occur to ensure that people requiring emergency, eg life saving treatment could receive this in Hereford before onward transfer to Worcester.

The Committee had not, at the time of publication of this response had the time to confirm the views of the Hereford and Worcester Ambulance Service NHS Trust.

It was suggested to the Committee that the distances involved in travelling to Worcester are relatively small and that for patients in parts of the north of the County and the east of the County there was little difference in the journeys.

The Committee has sought clarification on bed availability at Worcester given the recent confirmation that they are struggling to meet current demand across the board and do not have sufficient dedicated ward space for ENT patients to meet current demand. The HPCT has advised that the HPCT would commission additional emergency activity from Worcestershire Acute Hospitals NHS Trust. It is for that Trust to determine the capacity needed to provide this service. However, whilst the additional flows to Worcester only relate to a relatively small number of patients, the HPCT will want to receive assurances that the appropriate capacity is available. It is worth noting that these will be emergency patients, therefore initial provision of capacity is not particularly an issue, although subsequent ward bed space may be.

The Committee also had concerns about the ability of relatives, carers and friends to visit patients in Worcester. It has been advised that based on a clinical decision, if after receiving emergency treatment in Worcester a local patient requires ongoing inpatient hospital treatment then it is possible that the patient would be transferred to Hereford. This happens currently across a whole range of services where patients will often receive specialist treatment outside Hereford and then are transferred back for ongoing local care.

The Committee has visited the ENT facilities at Worcester and was informed that the service was regarded nationally as well equipped. It was considered by staff that this had been instrumental in the service being permitted to recruit 2 high quality trainees. The service also hoped to receive approval to appoint a further consultant.

Future Service Provision in Hereford Hospital

Clearly one of the Committee's concerns is that this proposal represents the thin end of the wedge, mindful of the earlier introduction of a linked service for vascular surgery with Worcester.

The Committee has been told that this is not the case and that a strategy is being developed for Hereford hospital's future. The strategic vision for acute services in Herefordshire has been previously set out within the "Beds in Herefordshire" programme. This focuses on the provision of a range of acute services at the County Hospital, Hereford with network arrangements with surrounding NHS Trusts and tertiary flows to specialist centres when required. In general there are a range of "core services" which the HPCT would want to protect locally and there are other services where there are options on how they are provided. Emergency ENT activity falls into this latter category. The move towards sub-specialisation, the impact of the European Working Time Directive and other factors influencing ENT are very much affecting a whole range of other services. The Hereford Times recently reported concerns about the local paediatric service and HPCT has already had to review and make decisions regarding a number of other services previously. It is the view of the HPCT that if it does nothing on this matter the HPCT risks losing the whole ENT service whereas if it can find an appropriate way forward the vast majority of the service can be retained locally.

The HPCT has stated to the Committee that the desired outcome of the service review and possible change will be that there will be a robust high quality ENT service provided to local people from the County Hospital, Hereford. This will cover the full range of outpatient, day case and some inpatient treatment. Also, emergency activity will be dealt with appropriately and the service fully staffed by appropriately trained and qualified medical and other staff.

The Hereford Hospitals NHS Trust has observed that the introduction of a linked service for vascular surgery has been extremely successful. This was a 2 Consultant service in Hereford and is now a 5 Consultant linked, multidisciplinary service with Worcester with tremendous benefits for the patients and staff.

The HPCT has also indicated that it is probable that a vacancy occurring in the local service as currently structured would be extremely difficult to fill whereas a vacancy occurring in the network service which would be a vacancy within a larger team working across both sites, would be more attractive. Herefordshire already "networks" for a wide range of services, for example all cancer services. Other similarly situated Trusts are working on similar issues nationally. Whether it is called "hub and spoke", "network" or "partnership working" this in now very much a favoured model for providing local services from small geographically isolated hospitals. High quality, robust services are more likely to retain staff.

The Committee has noted that under the network option the existing consultants based in Hereford and Worcester would work together as a single team serving both hospital sites. It has been advised that there are, at the moment, no plans to appoint further consultants to the service. The Committee would if at all possible like to see a third consultant based at Hereford as part of any proposal. If this is not feasible the Committee would hope that additional specialist time would be available in Hereford.

The Committee also explored whether consideration had been given to whether there were any other partners, or combination of partners, other than Worcester with whom it would be practical to develop the network option.

The Committee was advised that at this stage no decision had been made and therefore discussions with other NHS providers had been very much at a preliminary stage to provide the HPCT with some assurance that the options presented are viable. The consultation paper suggests how the arrangements could potentially work with Worcester. Worcester is considered the most obvious partner for a host of reasons, including the shared ENT Consultant. A range of other issues need to be taken into account including established patient flows for tertiary services. It is unlikely that any other NHS Trust would be in a position to develop a network solution with Hereford. One of the key issues is to find a partner that is willing and able to enter into a network solution and has needs of its own which need to be met. Worcestershire Acute Hospitals NHS Trust has a clear interest in developing a network solution unlike other surrounding hospitals which have more fully developed services and would not have any particular reason to want to work with Hereford in this way.

In determining the possible options the HPCT advised that it has looked at other similar geographical areas nationally. It has also sought advice on this matter from senior clinicians. The British Association of Otorhinolaryngologists took a detailed look at this

matter in its report and came to the conclusion that network options provide the most secure way forward.

In the course of its investigations it was suggested to the Committee that there were opportunities to develop specialisms within the ENT service in Hereford and indeed that one opportunity to do so had already been lost. The Committee would welcome consideration being given to this point.

(d) It is accepted that the need for change and the assessment of options is being driven by issues of clinical governance and not cost. It nevertheless recognises that there will be cost implications arising from any proposed solution and requests further details regarding the proposed solution.

The assessment of the "Local Development" option uses the phrase "even if the significant resources could be found" and the estimated costings show it to be the most expensive option. However, in response to its questions the Committee received specific assurances that the proposals had been generated from within the Hereford Hospitals NHS Trust, prompted by clinical governance issues and future needs.

The Committee has been advised that the consultation document sets out some likely costs for the various broad options available. The actual cost would probably not be known until there is a preferred option and this has been worked up over the coming months.

(e) The Primary Care Trust and the Hospitals Trust need to address communications with Consultants, GPs and support staff. The network option will only work in practice if protocols are in place and Teams understand the aims and objectives, own them and can work effectively together.

The evidence provided to the Committee suggested that the Consultants in Hereford were not aware of the intention of the Hereford Hospitals NHS Trust Board and the HPCT Board to undertake a formal consultation exercise on the provision of ENT services and therefore the proposed timescale.

Whilst the representatives of GPs indicated that communication links had improved the Committee thought that further improvement could be achieved.

Consultation Process

The Committee does have the power where it is not satisfied with the content of the consultation or that sufficient time has been allowed to report the issue to the Secretary of State in writing and the Secretary of State may require the local NHS body concerned to carry out such consultation or further consultation with the Committee as he considers appropriate. It is important to note, however, that the referral power of the Committee in this context only relates to the consultation with the Committee by the NHS and not consultation with other stakeholders.

In this particular instance the Committee is mindful that with the co-operation of the Primary Care Trust, the Hospitals Trust and others it has already had the opportunity to consider many of the issues involved. It is therefore minded not to seek an extension to the consultation period.

The Committee does, however, wish it to be noted that it considers that there will be merit as a rule in formal consultation exercises following the Cabinet Office guidelines.

With regard to the consultation document itself, the Committee notes that this was tailored to meet the needs of a range of audiences. It suggests, however, that in future consideration be given to producing a summary consultation document supported by more detailed supporting information on the options considered.

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