

Reporting to:	TRUST BOARD, Thursday 30th June 2016
Title	Stroke Services
Sponsoring Director	Debbie Kadum, Chief Operating Officer
Author(s)	Debbie Kadum, Chief Operating Officer
Previously considered by	Executive Directors
Executive Summary	<p>The risk of sustainability of clinical services due to potential shortages of key staff is a risk on the Board Assurance Framework.</p> <p>Due to gaps in the Stroke Consultant workforce, one known, and another unexpected, on 16th June 2016, in the interest of clinical safety, the Trust made the decision to temporarily change the Stroke Service model by moving all Stroke rehabilitation from the Royal Shrewsbury Hospital to the Princess Royal Hospital.</p> <p>This paper describes the rationale and process by which this was done.</p> <p>A brief guide for effective involvement is attached as Appendix A as a baseline for future changes and will be issued to Care Groups for future reference</p>
Strategic Priorities	
1. Quality and Safety	<input checked="" type="checkbox"/> Reduce harm, deliver best clinical outcomes and improve patient experience. <input checked="" type="checkbox"/> Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards <input checked="" type="checkbox"/> Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme <input type="checkbox"/> To undertake a review of all current services at specialty level to inform future service and business decisions <input checked="" type="checkbox"/> Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme
2. People	<input type="checkbox"/> Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation	<input type="checkbox"/> Support service transformation and increased productivity through technology and continuous improvement strategies
4. Community and Partnership	<input type="checkbox"/> Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population <input type="checkbox"/> Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies
5. Financial Strength: Sustainable Future	<input type="checkbox"/> Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	<input checked="" type="checkbox"/> If we do not deliver safe care then patients may suffer avoidable harm and poor clinical outcomes and experience <input type="checkbox"/> If the local health and social care economy does not reduce the Fit To Transfer (FTT) waiting list from its current unacceptable levels then patients may suffer serious harm <input checked="" type="checkbox"/> Risk to sustainability of clinical services due to potential shortages of key clinical staff <input type="checkbox"/> If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards <input type="checkbox"/> If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale and patient outcomes may not improve <input checked="" type="checkbox"/> If we do not have a clear clinical service vision then we may not deliver the best services to patients

	<input type="checkbox"/> If we are unable to resolve our structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	<input checked="" type="checkbox"/> Safe <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Caring <input checked="" type="checkbox"/> Responsive <input checked="" type="checkbox"/> Well led
<input checked="" type="checkbox"/> Receive <input type="checkbox"/> Review <input type="checkbox"/> Note <input checked="" type="checkbox"/> Approve	Recommendation The Trust Board is asked to RECEIVE and APPROVE the temporary relocation of Stroke Rehabilitation from RSH to PRH.

STROKE SERVICES

Temporary Transition towards Sustainable Services

June 2016

Version 1.0

1 BACKGROUND

1.1 Current Service Model

In 2013 the Trust Board approved the development of a single site Hyperacute (HASU) and Acute Stroke Service on the Princess Royal Hospital (PRH) site with stroke rehabilitation continuing on both hospital sites. This was supported by commissioners.

The patient pathways are:

- all suspected strokes go to the Emergency Department (ED) PRH and then direct admission to the HASU;
- in the rehabilitation phase patients from Telford & Wrekin go to the rehabilitation ward (Ward 16, PRH). Shropshire and Welsh patients are transferred to the Royal Shrewsbury Hospital site to undergo their rehabilitation (Ward 22S);
- Therapy-led early supported discharge from both sites facilitates ongoing rehabilitation in the patients' own home and reduces length of stay.

Following the development of the HASU the majority of Shropshire patients were transferred back from PRH to RSH within 72 hours. The number of patients transferring back has gradually reduced to the point that on average Ward 22S at RSH has 3-4 stroke rehabilitation patients on this 20 bedded ward.

1.2 Workforce

The SaTH Stroke Service currently employs four Stroke Consultants who support the Acute Stroke Unit based at PRH (Ward 15 - which includes the Hyperacute Stroke Unit) and the two Stroke Rehabilitation wards (Ward 16 at PRH and Ward 22S at RSH). With the main Stroke Unit based at PRH, two Stroke Consultants (Dr Meena Srinivasan and Dr Usman Ghani) work solely there. The other two Consultants (Dr Uttam Sinha and Dr Indranil Mukhopadhyay) are based at RSH but work across both sites.

The two RSH Consultants job plans are split 50:50 between stroke and care of the elderly and the 4 Consultants, between them, deliver a 5 day Hyperacute and Acute Stroke Service.

2 CURRENT SITUATION

2.1 Consultant Resignation

Dr Usman Ghani who joined SaTH in early 2015 and was based at PRH, unexpectedly resigned due to personal circumstances and left the Trust on 20th June 2016.

Actions to address the resultant gap in workforce were:

- Dr Ghani's resignation was made known mid-March;
- Recruitment attempts were immediately actioned to obtain an agency locum or an internal locum and a job description was approved by the Royal College for substantive recruitment. The post was advertised in the BMJ and on NHS Jobs and closed on 16th June with 2 late applications. One applicant is shortlisted and will be interviewed on 15th July 2016;
- Stroke is a specialty where it is recognised nationally that there are recruitment challenges. Current job plans for Stroke Consultants are unattractive as they

- contain a requirement to support the general medicine on call rota rather than a stroke specific on call rota;
- x 3 adverts for external and internal Locum Consultants with no applicants.

2.2 Recruitment and Cover Options

In the absence of any applicants for a locum post and with the closing date for the substantive post only 4 days prior to Dr Ghani's leaving date, the Unscheduled Care management team convened a clinical group to discuss options and agree actions. Dr Ghani had indicated in April that he had colleagues some of whom may potentially be interested in a locum position but unfortunately none of these came to fruition but remain an option. The team has met several times over the past few weeks to discuss the situation.

In view of the need for immediate service continuity the temporary options considered were:

- Option 1** : Do nothing. Risk is the inability to continue to deliver Hyperacute and Acute Stroke services in the county. SaTH is the only service provider;
- Option 2** : Temporarily relocate the 2 x RSH Consultants to the PRH site and make them full time stroke consultants thereby ensuring the continuation of the HASU and Acute Stroke Service. Risk to Care of the Elderly Service due to loss of Consultant sessions to the Acute Stroke Service.

2.3 Risks and Options

A paper outlining the risks and benefits was presented to the Executive Team on 8th June 2016 and it was agreed that the options should be presented to Trust Board for discussion at the end of June, and in the meantime alert the Joint Health Oversight and Scrutiny Committee to the risk and to begin a period of public involvement and engagement.

2.4 Benefits of Option 2

Ward 22 at RSH will still receive consultant cover now provided by Dr Kevin Eardley and alternative arrangements are in place to ensure that the Care of the Elderly Service is not affected.

This offers several opportunities:

- Potential to engage more strongly with Powys. There are 4 dedicated and staffed stroke rehabilitation beds at Newtown which are not often utilised, to transfer stroke patients out of SaTH but the move to rehabilitate all patients at PRH may reinforce this need and could accommodate the small number of Powys patients who have longer post-stroke rehabilitation needs;
- In the immediate term utilise the beds on Ward 22S for stepdown patients e.g. those who are medically fit for discharge. This is a replication of Ward 21 which served this purpose as part of the 2015/16 Winter Plan and worked well;
- Opportunity to refocus Ward 22S – reduced registered nurse requirement and reignite the Frailty Elderly Care Short Stay model to complement the frailty pathway in the Emergency Department (ED);
- The therapy-led Early Supported Discharge (ESD) team are working with the inpatient specialist staff to enable the ESD team to support 10 extra patients in their own home to mitigate the increased need for rehabilitation at PRH.

2.5 Patient Impact

- No negative clinical impact on patient outcomes. A pathway is in place to support patients who may have a stroke when at RSH. Numbers are small and mostly require only therapy and general medical input at that stage. Patients can be transferred to PRH Acute Stroke Unit if required;
- All stroke rehabilitation patients will be accommodated at PRH, and other rehabilitation patients will continue to be accommodated at RSH;
- Patient numbers affected are small overall (3-4 per week); both for those who would no longer be repatriated and RSH based patients All other rehabilitation work will continue as it does now on both sites.

2.6 Risks of Doing Nothing

- Inability to run a Hyperacute and Acute Stroke Service;
- Risk to patient outcomes e.g. not receiving thrombolysis within 4.5 hours;
- Inability to meet best practice national standards and the associated tariff which averages £100k per month;
- Risk of loss of specialist stroke staff across the multidisciplinary team.

2.7 Current & Proposed Service Configuration following Implementation of Option 2

Ward	Beds	Consultants	Patient Group	Comments
22S RSH	20	Dr Sinha/Dr Mukhopaddhyay on rotation	Stroke to become Supported Discharge	Interim model supported by Kevin Eardley
22AR RSH	20	Dr Suzy Thompson/Dr Shu Ho on rotation	General Rehab inc Orthogeriatrics (approx. 50/50)	Remains the same
15 PRH	18	Stroke consultants/Dr Nigel Mike on rotation	Stroke & General Rehab	Remains the same
16 PRH	18	Stroke consultants on rotation	Acute Stroke	Remains the same
HASU PRH	6 + thrombo room	Stroke consultants on rotation	Hyper acute stroke (12-24 hours)	Remains the same
17 PRH	14	Dr Nigel Mike/Dr Erica Capps (COE)	Step down rehab & gen med elderly care	Remains the same

2.7 Communication and Engagement

At the time of receiving the paper at Executive Directors on 8th June 2016 it was understood that the Hyperacute and Acute Stroke Service could continue with its existing service model until the end of the month to enable the Trust Board to receive a paper outlining the risks to delivery on the Stroke Service and for stakeholders to be informed (both HOSC's and Commissioners) and for a period of involvement and engagement with patients, users and advocates, involving HealthWatch and CHC.

However, due to further instability introduced into the service on 15th June 2016 with one of the 3 remaining Stroke Consultants needing to take emergency leave due to a family member's critical illness in India, this then meant that the Consultant workforce was reduced by half and therefore unable to maintain a service across two sites. An immediate decision with regards to service delivery was needed to be taken in the interest of clinical safety and Option 2 was approved for implementation on 20th June 2016.

This event serves to underline the fragility of clinical services at SaTH and the urgent need for reconfiguration as part of the sustainable services programme.

It is regrettable that the public were made aware of the temporary change in service provision before the Chair of the HOSC's and our other stakeholders including commissioners and HealthWatch. The Trust deeply regrets that it was unable to work with all stakeholders and discharge its responsibilities under s242 Health Act 2006, to arrive at a more timely decision with proper engagement due to the unexpected events which precipitated the need for change. A review of the process to highlight risks to service delivery has been undertaken and will be embedded into the standard working of the Care Groups.

A brief guide for effective involvement is attached as **Appendix A** as a baseline for future changes and will be issued to Care Groups for future reference

3 SUMMARY

- In order to maintain service delivery a decision was taken to temporarily change the service model for stroke care with all of the service being based at PRH;
- During July it is hoped that a substantive Stroke Consultant will be appointed;
- The successful candidate could be in post at the beginning of November 2016 at which point the Stroke service will return to its former delivery model;
- If this is not the case and a locum is still unavailable the temporary model will need to continue until a final solution is identified in the Sustainable Services Outline Business Case being produced in Autumn this year;
- The Trust Board, both HOSC's and other stakeholders will be updated on the position of this in July 2016.

4 ACTION REQUIRED

- 1) The Trust Board is requested to discuss and APPROVE the temporary change to the Stroke Service model.

*Debbie Kadum
Chief Operating Officer
June 2016*

Shrewsbury and Telford Hospital NHS Trust

Reconfiguring services: when must NHS bodies involve the public? How do they go about doing it? And how can they protect themselves from legal challenge?

1. Introduction

The law requires NHS bodies to involve the public in certain circumstances, such as when NHS Trusts develop and consider changes to the way its health services are provided which impact the manner in which the services are delivered to patients or to the range of services available. NHS bodies can discharge this duty in different ways such as by carrying out consultations or by providing information. This is an important area which can lead to the potential for legal challenge if not considered properly. For example, there have been numerous reported cases in the last three years, where commissioners and other public bodies have faced a judicial review brought by individuals or groups angered by service changes.

This note does not describe the process for **significant** service changes, which are expected to require a formal 12-week consultation and will normally be carried out with Commissioners, nor does it cover service changes such as switching the take for a few hours from one site to another. It focuses on those service changes which may not affect many people and may be temporary but nonetheless is a service change. It is not attempting to cover all guidance, statute and caselaw that exists around this matter but seeks to provide some legal context, an overview of the core requirements and a practical guide to discharging appropriate public and patient involvement. Should more detailed information be required, advice can be sought by contacting [XXXX] via [XXX]. More information can also be found in the 2008 Department of Health document, "Real involvement: working with people to improve services, the NHSE "Planning and Delivering Service Changes for Patients" 2014 and Cabinet Office Consultation Principles, published on 14 January 2016. There is also the contextual framework enshrined in the four Government (previously Lansley) tests published in 2010;

- Support from GP Commissioners.
- Strengthened public and patient engagement (including with local authorities).
- Clarity on the clinical evidence base underpinning proposals.
- Consistency with current and prospective patient choice

2. The legal duty to involve

Proper public and patient engagement and involvement is a two-way conversation that allows the public, patients, voluntary and community sectors a realistic and timely opportunity to influence decisions being taken by any NHS body when making decisions such as redesigning or reconfiguring healthcare services. Engagement and involvement should help to inform decisions made. The obligation on NHS Trusts to make arrangements for public and patient involvement is set out in section 242 of the NHS Act 2006. The statute does not insist on "consultation", but seeks to make sure that service users are "**involved**". In practice, for any significant proposed change to services, some form of consultation exercise will be required to comply with this duty. The consequences of failing to comply with the requirement to involve the public can be severe. NHS organisations can face legal challenges from several different directions. Individual service users, groups of service users and current providers who risk "losing out" when a service is changed, can all bring a judicial review. Even if the ultimate decision made was plainly the best one, failing to comply with this duty and enabling proper involvement renders the decision flawed and it could be quashed by the Courts. This is because judicial review is a process of scrutiny of decision making processes by public authorities.

Proposals will come under scrutiny by patients and carers, communities, clinicians, staff, local authority councillors, MPs and the media. Effective engagement and involvement means being open and transparent about proposals, and that local stakeholders have the opportunity to genuinely influence change.

3. Are there some types of decisions where we do not have to involve the public and patients?

Yes – it depends on the nature of the decision and the potential impact that it will have. A public consultation or another form of public and patient involvement is not needed for every minor or temporary change in the way a hospital functions or community health services are provided. So for example changes to administrative functions or operational changes (such as to rotas) which do not affect service delivery would not require any public or patient engagement under section 242. However, any proposals as to the planning of provision of health services and any proposals that will lead to a change in the way that local health services will be provided which affects the manner in which services are delivered to service users or the type of services available should be subject to public and patient involvement. **The law is clear that this applies even to changes that are temporary, are driven by clinical concerns or affecting small numbers.**

However, not every such change requires a full 12-week public consultation exercise, other forms of proper public and patient involvement may be suitable and appropriate. As a general rule, the Trust expects that any change affecting a service, even if it does not affect many people and may be temporary, should nonetheless involve a consultation normally lasting four weeks as the very minimum, unless there were unforeseeable and immediate risks to public and/or staff safety. Legal advice should be sought where necessary.

4. Local authority scrutiny

Regulations governing local authority scrutiny of health services are now in force, namely the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Local authorities are no longer required to have a Health Overview and Scrutiny Committee (“HOSC”) as the means by which they discharge their scrutiny function, although in practice most have retained them. The key points to note are these:

Under Regulation 23, NHS England, CCGs, public and independent sector providers of NHS services *must* consult with the local authority about any proposals for a substantial development or variation of the health service in the authority’s area. “Substantial” is not defined! If the local authority ultimately disagrees with the decision of the NHS body, it is entitled to refer the matter up to the Secretary of State for a final decision.

It is important to have good channels of communication with our local authorities, and that their members are kept informed of any possible changes.

The threshold for reporting proposals to the local authorities under the overview and scrutiny process is higher than that for arranging to involve the public under section 242. However, it makes good sense to involve and inform the HOSC of proposals at the earliest stage. Under Regulation 23(2) there is an exemption to following the overview and scrutiny process where a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff. But this would have to be an immediate and unforeseeable risk – and the local authority must still be informed immediately of the decision and the reason why no consultation took place.

5. What needs to be done for less significant changes in the way a service is delivered?

This sort of change could include developing a service operational policy; Redesigning patient pathway to improve service quality; Retendering for a service with minimal changes to the contract other than a ‘refresh’ to bring it in line with national and regional guidelines; arguably changing the site of a service only involving a handful of patients (although this is more contentious).

Depending on the impact of these changes, it may not be proportionate for these decisions to be subject to a 12 week formal public consultation period but they will still be likely to require the involvement of key stakeholders e.g. CCGs, NHSI, HOSC updates, possible user focus groups, user/advocacy groups, Healthwatch/CHC, staff engagement, media and MPs/politicians.

Engagement and involvement exercises do not necessarily need to be publicised formally but will still need to be carefully targeted at the relevant stakeholders to ensure that the public and patients have sufficient information and reasons to understand what is proposed, to consider proposals and to respond. Engagement projects should therefore have a clear Communications and Engagement plan which includes involving stakeholders routinely and regularly throughout the lifecycle of a particular programme.

The lead clinician and project lead are expected to act as spokespeople when required during the consultation process. Where clinical leaders genuinely develop and support proposals, they play a vital role in building public and patient confidence. Strong links with the media will be encouraged from the outset. The Communications team can advise on this.

There is no set form for a consultation. 10 simple rules are attached at Appendix A. It is for the NHS body undertaking the consultation to decide which form it will adopt. What matters is that clear information and reasons are given to the public; that they are able to consider and respond; and that their responses are taken into account before making a final decision.

Typical methods of consultation would include:

- Writing to affected service users and their families / carers
- Involvement of CCGs, users, HOSC, HealthWatch
- Poster campaigns in NHS buildings
- Items in Board papers and on website, before and after the decision
- Information in the local media

In short, the greater the impact of proposed changes, and the more people they are likely to affect, the more detailed and comprehensive the public involvement will have to be. A sample minimum timeline is attached at Appendix B.

7. Public sector equality duty

The Trust will also need to consider how its proposals may impact upon individuals with protected characteristics. To discharge these duties, it is strongly recommended that an equality impact assessment ("EIA") is carried out in respect of any proposals. The Workforce Team can advise on this

Ten rules for an effective, lawful consultation process
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1. Consult when your proposals are at a formative stage

Making a decision on a change to services, and then consulting on that decision, is unlawful. If you are strongly of the view that only one of a number of alternatives is realistic, then you should say so and explain why that option is preferred, but you must give people the opportunity to disagree and keep an open mind.

2. Mind your language!

Decisions by public bodies have been struck down by the courts, simply for the use of language that gives an appearance to the public that a decision had already been taken and the consultation was a sham. It is important that the Trust and its staff fully understands the duty to involve the public and are clear that they will take the outcome of any public involvement exercise conscientiously into account in making a final decision.

3. Set out what you are proposing; what the options are; and why these changes are needed

The public body must give out information that contains sufficient reasons for particular proposals, to allow those consulted to give those reasons intelligent consideration and an intelligent response. If the public do not know what they are being consulted about or why a change needs to be made, they cannot properly take part in the consultation process.

4. Be up front about the reasons for a proposed change

In the current climate, the driver for change will often be largely financial. If that is the case, say so. Set out the financial position that you are faced with and if this is the reason for the proposed changes. Consider and explain the other alternatives and options.

5. Think about how long the consultation will last

The public must have adequate time to respond. It is important to be proportionate taking into account the nature and impact of any proposal and any legal advice. The Cabinet Office Principles state “ Consulting for too long will unnecessarily delay policy development. Consulting too quickly will not give enough time for consideration and will reduce the quality of responses.”

6. Take the responses into account before making a final decision

NHS bodies are not bound by the views of the public. Consultation is not a vote. It is, however, essential that you put the public's views in front of the decision makers and that they take those views into account when reaching their decision. You must ensure that you have a paper-trail demonstrating that this was done. If a public body takes a decision that goes against the general views of the public, it needs to have good reasons for it and to make sure those reasons are recorded.

7. There is no set form for a consultation

How to conduct one is a decision for the public body. The courts have approved consultations that involve responses on paper or electronically, public meetings and even citizens juries. What matters is whether the consultation is fairly conducted.

8. You can consult on a single option

If a public body identifies only one serious option to put to the public, it is entirely lawful to consult on implementing that single option. However, you need to justify why only one option was realistic and you should explain other options that have been considered as not viable and why. Also, you must allow members of the public to suggest alternative views and options and, if they do so, you must give those comments genuine consideration.

9. You can reach a final decision that was not one of the options put forward for consultation

But remember two points. First, there must be good reason for such a change of approach – usually it will be based on information discovered as part of the consultation. Secondly, if the final decision departs very substantially from the initial options, it may be necessary to undertake a second consultation. You do not have to give consultees the opportunity to see and to comment on the responses of other consultees. However, if a response has opened up a new issue that you are taking into account, you should consider giving other consultees the opportunity to comment on that issue.

10. Be careful of making promises!

If clear, unequivocal promises have been made to individual service users or groups as part of the consultation process, the public body will have created a “legitimate expectation” that those promises will be kept. Before making any such promises, can you be sure that you can fulfil it?

SAMPLE MINIMUM TIMELINE FOR LESS SIGNIFICANT CHANGES

**Pre-Consultation/involvement, Consultation and Post-consultation Proposed Timelines
(this may not necessarily follow sequentially, depending on timings some actions may run concurrently)**

	Action	Action owner	Indicative Timescale
Stage 1: Problem identified - Preparation Weeks 1-4			
1	Draft background and options paper for Care Group Board for approval– explain background, current options (which may change after consultation) and define the project group membership and communications engagement plan	Centre Manager	Week 1
2	Submit approved paper to Exec Directors	Care Group Director	Weeks 1-3
3	Submit approved paper to Sustainability Committee	Chief Operating Officer	Weeks 2-4
4	Advise Board of issue and current options and next steps in public session	Chief Operating Officer	Week 2-4
5	Brief CCGs, HOSC and Health and Wellbeing Board	Chief Executive and Chief Operating Officer	Weeks 2-4
Stage 2: Involvement/engagement/consultation- Weeks 5-8			
6	Set up steering group consultation group to discuss/approve consultation documents and plan	Project Manager/Lead clinician	Weeks 3-5
7	Send invitations to publicise consultation events for clinicians and staff to discuss context and options	Project Manager/Lead clinician	Weeks 3-5
8.	Send invitations to stakeholders for consultation events (CCGs, HealthWatch, patient/carers groups etc) to discuss context and options	Project Manager/Lead clinician	Weeks 3-5
9.	Set up page on internet for comments and views, consider inclusion of article in regular newsletters (Comms to advise)	Project Manager/Lead clinician	Weeks 3-5
9.	Email wider stakeholders to submit views	Project Manager/Lead clinician	Weeks 4-6
10.	Regularly update CCGs, TDA, NHSI, HOSC, MPs	Chief Operating Officer/Chief Executive	Throughout
11.	(Ideally) hold one public meeting	Project Manager/Lead clinician	Week 7-8
Stage 3: Decision – Weeks 9-12			
12.	Analyse all responses to consultation and prepare feedback report	Project Manager/Lead clinician	Week 9-12

13.	Present feedback report, recommendations and implementation plan to Board for decision	Chief Operating Officer	Week 9-12
14.	Advise stakeholders of decision and ?review process	Chief Executive	Week 9-12