NHS
The Shrewsbury and Telford Hospital
NHS Trust

Recommendation ☐ **DECISION** ☑ **NOTE**	**The Trust Board** is asked to **NOTE** the update provided on fragile services.
Reporting to:	**Trust Board**
Date	Thursday 29th June 2017
Paper Title	Services Under the Spotlight
Brief Description	This paper provides an update on the Trust's fragile clinical services and indicates whether the risk to service delivery has changed since the last formal update to Trust Board in March 2017.
Sponsoring Director	Chief Operating Officer
Author(s)	Assistant Chief Operating Officer – Unscheduled Care Assistant Chief Operating Officer – Scheduled Care
Recommended / escalated by	Sustainability Committee
Previously considered by	Sustainability Committee
Link to strategic objectives	Patient and Family Safest and Kindest Innovative and Inspirational Leadership Values into Practice
Link to Board Assurance Framework	RR668 RR859
Equality Impact Assessment	● **Stage 1 only (no negative impacts identified)** ● **Stage 2 recommended (negative impacts identified)** ● negative impacts have been mitigated ● negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	● **This document is for full publication** ● **This document includes FOIA exempt information** ● **This whole document is exempt under the FOIA**

The Shrewsbury and Telford Hospital NHS Trust

Paper 14

Trust Board

Thursday 29th June 2017

SERVICES UNDER THE SPOTLIGHT

Introduction

This paper provides an update on fragile clinical services following the paper that went to Trust Board on 30th March 2017 and subsequent verbal updates.

There are a number of services currently provided by the Trust that are considered fragile due to workforce constraints which impact on service delivery. Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCG's) have been aware of these longstanding capacity and workforce issues and have been working closely with the Trust to find suitable and safe alternative capacity, where appropriate. All these specialties are challenged nationally and SaTH's current service configuration increases the challenge of finding sustainable solutions to these fragile services. Each service risk has been reviewed to see if there has been any change since the last formal report to Trust Board in March 2017.

A summary of the services affected, the actions taken to date and the current workforce position is outlined below.

1.0 Emergency Departments – Increased risk in Middle Grades

The workforce constraints within both Emergency Departments have been well documented within the county and are linked to the regional and national emergency medical workforce challenge and form the basis of the reconfiguration of hospitals services under the Future Fit programme of work. Until a preferred option is agreed, consulted upon and final reconfiguration implemented, this situation will continue and the hospital will remain dependent on locum consultants and agency staff to maintain services across both sites.

1.1. Consultant Workforce – No Change

There are 5.0WTE substantive Consultants in post only 4 of whom cover the on call rota. The College of Emergency Medicine (CEM) recommends that all A&E departments should have an establishment of at least 10 Emergency Medicine Consultants to provide up to 16 hours a day of consultant cover. On a two site model to meet this recommendation there would need to be a further 15 consultants to allow 16 hour consultant presence over 7 days.

Due to the challenges of the current workforce configuration across two sites the on call rota is particularly demanding for our substantive workforce some of whom will consistently provide cover twice a week.

1.2. Specialty Doctors (Middle Grade cover) – Increased Risk

At PRH there are 5.0 wte substantive in post. At RSH there are 5.0 wte substantive in post. There are currently 4.0wte vacancies plus another 1.0 wte post will become vacant in July. There are not currently any substantive middle grade doctors employed, instead multiple shifts are covered by various locum doctors provided by agencies.

The College of Emergency Medicine recommends that there should be a middle grade doctor on site 24 hours a day. To have substantive middle grade cover 24 hours a day there needs to be 12 doctors per site.

This inability to recruit to substantive middle grade posts has led to an almost total reliance on locum middle grade cover after 23.00hrs at PRH and on some nights at RSH.

This dependency on locum cover increases the level of risk to quality assurance and the Trusts ability to deliver the 4 hour patient safety standard. It also compromises the training and supervision of junior doctors within the department overnight.

Summary of keys risks

- Inability to staff both sites consistently with substantive workforce;
- Inability to recruit into posts;
- Retention of staff due to regular gaps on the rota;
- Reliance on Consultants acting down;
- Impact on ED performance due to high level of locum usage;
- Financial impact of very expensive locums.

Action taken to date

- Continued rolling national and international recruitment;
- Specialty doctor posts to be advertised in the BMJ (previously this has been reserved for Consultant level posts);
- Consider enhanced rates to attract doctors into emergency medicine;
- Rolling request for agency cover at all levels in place;
- Mutual aid agreement with UHNM was in place however they are unable to support this due to their workforce pressures;
- Progressed joint recruitment plan with UHNM – advertised but no applicants;
- Bi-weekly medical staffing meetings to address rota issues and mitigate risks;
- All long term locums have been met with to discuss substantive options and discussions are continuing;
- NHS locum posts being offered accordingly.

Service Continuity Plan

The service continuity plan was further developed involving all stakeholders at a workshop held on 16th June 2017 to progress the development of the plan should it be required. A further meeting has now been scheduled to follow up on the agreed actions at the end of July.

2.0 Ophthalmology – Increased Risk

The Trust has had historical capacity and workforce issues for Ophthalmology, again similar to regional and national consultant workforce issues in this specialty, and a Local Health Economy Eye Care Steering Group was established to review this in 2012. As a result of this work both CCGs have commissioned a range of services to support access to eye care services across the county, these include a Community Ophthalmology Provider and a range of Schemes delivered from Community Optometry practices. Within Shropshire CCG all ophthalmology referrals suitable for the Community Service are sent to the Provider for clinical triage and acceptance or onward referral, approximately 70 referrals are sent to this service per week. Telford & Wrekin CCG undertake clinical triage at TRAQS and forward all appropriate referrals to the Community Provider. The Optometry Schemes are delivered across the county from a large number of Optometry Practices, these schemes include:

i. Primary Eye Care Assessment and Referral Service (PEARS), a service that treats minor emergency eye conditions;
ii. Pre-Referral Cataract Scheme – this scheme ensures patients are only referred for cataract surgery once they understand the full implications, benefits and risks to their sight and quality of life impact;
iii. Post-Operative Cataract Scheme – this scheme enables patients to be followed up closer to home following their surgery, rather than attending the Acute Trust for their follow up appointment;
iv. Children's Screening Pathway – children who fail the school screening programme were referred into Acute Services, this pathway now enables the children to be seen close to their own homes;
v. Repeat Pressures – this scheme follows NICE Guidance in that patients can have repeat pressure checks at their optometry practice, which often negates the need for referral to Secondary Care;
vi. Ocular Hypertension Monitoring (OHT) – this scheme enables SaTH to discharge patients who have stable OHT to community optometrists for regular follow up close to home.

In addition, the CCG has recently undertaken a procurement exercise to secure a three year contract for the on-going provision of Community Ophthalmology Services.

Following discussions between the Trust, Commissioners and NHS England a decision was made to close some sub-specialism areas within the Ophthalmology Service to new referrals, these included glaucoma, general ophthalmology and Adult Squint Surgery on 1st January 2017 for a period of six months. Bi-weekly meetings take place to review activity against the plan for sustainable service delivery. Commissioners, along with the Trust are currently discussing whether the service can re-open to new referrals and a decision will be made on the re-opening of the service at a Task & Finish Group scheduled for 12th July 2017.

At a risk review meeting that took place in October 2016, the Trust presented its review of the service and the areas which needed addressing to ensure the provision of a safe and sustainable service for the long term in the County and Mid Wales.

The areas outlined were as follows:

- Substandard and fragmented accommodation;
- On-going serious untoward incidents;
- Workforce gaps and Team dynamics
- The inability to see patients within the past maximum wait standard, and demand exceeding capacity.

Substandard and fragmented accommodation

Ophthalmology currently delivers services from 3 sites, RSH, PRH and Euston House in Telford, as well as from peripheral units throughout the locality. The increasing demands on the service means that the Ophthalmology department accommodation is not fit for purpose. This view is supported following visits from the Royal College of Ophthalmologists, the Macular Society and other bodies, who have deemed that the facilities at RSH clinic 10 are no longer suitable for Ophthalmology patients.

As a result the Trust has supported a capital investment which is supporting the redevelopment of space within the Copthorne building on the RSH site to build an ophthalmology patient friendly facility to relocated Clinic. The new facility will be open to patients on 26th June 2017 and will provide an increased number of clinical rooms.

There are on-going discussions about whether supporting a further reconfiguration of accommodation would benefit the service for patients in terms of volume and quantity. Numerous discussions and papers have been presented to Trust groups and a Stakeholder Event took place in March 2017. Trust Board on the 27th April 2017 agreed that:

- New Paediatric Outpatient rooms will be provided within the Copthorne Building which will mean paediatric outpatients can be provided at both RSH and PRH sites as current in upgraded accommodation.
- That Euston House would close and outpatients will be provided at both RSH and PRH, and that Cataracts would move to RSH.

Finalised timetables of the works required to complete these are currently being scoped and contractors being awarded. Tenders expected back by end of July to enable a decision.

On-going Serious Untoward Incidents

The department had a number of serious incidents over a number of years which related to two themes:

- Individual clinicial issues and poor practice;
- Incidents relating to patients waiting longer than clinically recommended.

The department recognised this and realigned its governance structures and as part of this a Consultant Ophthalmologist was appointed as the departments Consultant Governance Lead. Harm pro-formas completed by the clinicians for every patient that has waited longer than clinically determined and concerns are investigated at the patient safety meeting. Bi-weekly department patient safety meetings take place to review incidents. Relevant trends and outcomes of investigations carried out by the patient safety representatives are reported at the monthly Governence meeting to aid learning and to support the delivery of the action plans. Any serious incidents and those causing harm are investigated in line with Trust policies and procedures.

Workforce Gaps and Team dynamics

The department has had some significant challenges in recruitment and retention of medical staff for a number of years. This has resulted in the department employing agency clinicians who put an additional strain on finances and whilst bolstering the quantity of staff the commitment to improving the department may not be their priority. The department has also been subject to high levels of sickness absence.

The department has made some improvements by redefining its management structure and has appointed the following:

- A Consultant Ophthalmologist;
- A Consultant Ophthalmologist as Governance Lead;
- A dedicated Centre Manager for a 12 month period.

As well as this, with the improved accommodation proposals the department is hopeful of attracting a permanent workforce to replace the vacancies that have remained vacant or being filled by locum positions. This remains however, the greatest risk element of the service currently.

Recruitment plans have commenced to reduce the reliance on premium rate locum workforce and in summary the current vacancies (including sickness) and recruitment plans are listed below. These have been separated into subspecialty areas:

Paediatrics and Adult Squint

- Paediatric Consultant vacant since March 2016. Interviews took place in September 2016 and March 2017 and none of the participants interviewed were appointable. It is planned that the Paediatric Consultant post will be readvertised if there are suitable candidates. A locum consultant has been in post from May 2016-January 2017 with a gap until April 2017 when a new Locum Consultant commenced. At the time of writing this paper the current Locum Consultant is due to leave the Trust on the 27th June 2017 and a replacement advertisement has been issued for an agency replacement. Patients on the admitted waiting list have been referred to Alder Hay Childrens Hospital. The Trust is supporting commissioners with identifying alternative providers for those patients that may need to be referred for a surgical opinion. The Paediatric Consultant who left the Trust also carried out adult squint surgery, the Locum Consultants that were recruited are unable to carry out this activity and thus the commissioners have being diverting new referrals to other providers.
- Due to a period of sickness absence from February 2017 until May 2017, there was a reduction in capacity for delivery of paediatrics and adult squint, however this is now addressed and this staff group are back to full capacity.

Glaucoma

- The department has been reliant on a Locum Glaucoma Consultant since August 2015; alongside this two third party providers also provide additional capacity at weekends. This has been in place since 2013. The Locum Consultant who was recruited to cover the position left the Trust December 2016 and despite advertising to date we have not been able to replace. Patients requiring specialist glaucoma opinions are referred to other Trusts around the region.
- This surgery element of glaucoma requires a long term decision regarding the Trust's ability to deliver this service. We are currently out to advert for a Glaucoma Consultant, however if the latest round of recruitment is not successful in attracting either substantive or locum consultants, then further discussions will necessary with the CCG's and Powys around the long term sustainability of glaucoma services.

Medial Retina (including diabetes and injections)

- One Consultant who has been unable to work since September 2015 returned to work on the 3rd January 2017. During this time this post has been covered by Locum Consultants.
- Specialty Doctor Vacancies x3 from November 2016
    - 5 specialty doctors were interviewed on the 13th Dec 2016 and all 3 vacant posts were offered: 2 withdrew, and 1 commenced in post 18th April 2017. A second round of interviews took place on the 2nd May 2017 and the 2 vacant positions were offered, however, once again the individuals withdrew their applications. Another round of interviews is therefore due to take place at the end of June 2017.
- The 2nd and 3rd Nurse Injectors with Medical Retina are competent and delivering independent activity.

Corneal

- The department has one Corneal Specialist Consultant, with no other consultant able to provide this service. In February 2017 the sole Consultant had a period of unplanned sickness absence for 3 months which meant waiting times significantly increased. The Consultant is now back at work and waiting times have reduced, however this emphasised the fragility of this sub-specialty.

Workforce remains the department's single biggest challenge and risk to performance delivery. Feedback on failed recruitment attempts is that candidates do not want to cover numerous sites and that the clinical accommodation available is poor. With the new accommodation being available from the end of June and plans for further site reconfiguration, it is hoped that recruitment outcomes will improve. The department is planning to complete a further round of recruitment leading up to the opening of the new facility, and it is anticipated that the new facility may attract more candidates through our promotion of this within our advertising campaign literature. The current establishment and WTE in post position is as follows:

	Establishment (Whole Time Equivalent)	In post (excluding Locums)	Variance
Consultants	10	7.4	- 2.6
Specialty Doctors	6	4	-2

Lack of capacity to see and treat patients in a timely manner

The long waiting times in Ophthalmology can be categorised into two main areas; patients on a referral to treatment (RTT) pathway awaiting first outpatient appointment, and those waiting for follow up appointments (PMW).

PMW- Past Maximum Waiting Time for follow up appointment

There is a significant issue within Ophthalmology with a large number of patients waiting longer than clinically recommended for follow up appointments. This issue has been on-going for a number of years and since January 2016 these numbers have significantly reduced. This is monitored weekly and workforce is flexed to address this. The tolerance level is 500 patients and the current position is that there are 925 patients are waiting PMW. This has reduced consistently from 3400 patients in January 2016. The plan is to achieve the 500 threshold by end of September 2017; however this is proving challenging due to the workforce issues.

RTT - Ophthalmology is failing the 92% standard, with current position at 82.8%. The trajectory going forward shows the position will not recover by end of March 2018, due to the workforce gaps.

Plans going forward

- Currently exploring alternative insourcing providers for a potential single source support;
- Continue with locums in high risk areas;
- Working with HR Business Partner and a recruitment marketing consultancy to develop a recruitment campaign;
- Develop further nurse injectors for Medical Retina;
- Working in partnership with CCG colleagues to address the quality and safety issues;
- Develop a plan for sustainability of the sub- specialties – particularly glaucoma;
- Working with other provider Trusts to source additional capacity.

3.0 Neurology Outpatient Service – No Change/Slight Improvement

SaTH has experienced long-standing capacity and workforce issues for several years, again similar to regional and national consultant workforce issues also in this specialty, and following discussions with commissioners the service was closed to all new referrals from 27th March 2017 for a period of six months. Commissioners have sourced and secured additional capacity from Royal Wolverhampton Hospital Trust during this period. In addition, both local CCGs are working with Powys colleagues and Walton Hospital to secure additional out-reach capacity to support patients accessing care closer to home during this time.

Background

While referrals for neurology services have remained largely static over the years, the service has been consistently challenged in terms of delivery due primarily to workforce limitations.

This was further exacerbated due to the departure of two specialist nurses in November 2016 who had provided additional clinical support in outpatient follow up capacity. As a consequence, the service which was already performing poorly has seen a steady rise in patients awaiting their first appointment and follow ups.

Current Workforce

There are currently 2 substantive general neurology consultants in post. This is supported by 1 wte locum consultant post. This is against a budgeted position of 3.80 wte, leaving a shortfall in capacity of 0.8 wte. It should be noted however that the national average position is 1 neurologist per 80,000 people that would equate to 6 wte for SaTH's population. The Care Group has successfully recruited 2 new, but inexperienced specialist nurses, who took up their positions in January 2017.

The locum consultant has advised that he will be unavailable for work from 13th to 31st July 2017, and will then leave the Trust from 3rd August 2017. The Trust is out to advert for a replacement locum.

Summary of key risks

The following points are the key risk areas:

- Failure to deliver access waiting time target
- Securing substantive consultants given the national shortage;
- Securing a locum consultant within capped rates;
- Managing the levels of demand once the service reopens the front door to new referrals.

Current Position
The service delivered RTT performance of 39.47% in May 2017. This deterioration in performance is expected as the backlog of patients is treated

Actions taken
To mitigate the clinical risk associated with the delays in time to be seen, it was agreed to close the service to all new Neurology referrals. Referrals stopped being received by SATH on 27th March 2017 and will continue for 6 months.

As mentioned previously, 2 specialist nurses have been recruited and have been fully up and running from the 1st May releasing 12 consultant slots per week which are being used to concentrate on General Neurology.

In addition to these short term actions, a scoping exercise for the options to deliver a sustainable service in the future has been undertaken. Options include working with Commissioners to 'triage' referrals prior to referral to neurology services for some pathways (i.e. headache) and potentially establishing a 'hub and spoke' model with neighbouring Trusts.

Next steps
A meeting took place with commissioners on the 18th of May to further discuss the options for sustainable delivery with a particular focus upon implementing the potential for triage at the point of referral. It was agreed that Commissioners would establish a Task and Finish Group to oversee the development of the identified options. This group has convened and reviewed the long list of potential options and a short list of options has now been identified and actions have been assigned to appropriate leads to progress these accordingly. The Task and Finish Group is meeting on a fortnightly basis to maintain oversight of this work. This group will report into the Planned Care Working Group which is a sub-committee of the commissioner and provider contract meeting.

4.0 Dermatology Outpatient Service – Reduced Risk

The Trust has been operating with a single handed consultant for many years despite numerous attempts, to recruit to a substantive Consultant Dermatologist post. Nationally there is a shortage of Consultant Dermatologists. The previous Trust Locum Consultant resigned on 22nd February 2017 with immediate effect. Shropshire PCT in 2005 developed a GP with Special Interest Advanced Primary Care Service in Dermatology to provide additional capacity for the residents of Shropshire County. In addition, Shropshire Clinical Commissioning Group (SCCG) successfully commissioned a Consultant-led Community Dermatology Service from The Skin Clinic based in Shrewsbury in 2012 to significantly supplement the capacity available within the county. The Trust also uses The Skin Clinic on a sub-contract basis for the provision of some of their skin cancer services. Telford and Wrekin Clinical Commissioning Group (T&W CCG) also uses The Skin Clinic but via a subcontract relationship with one of their main practices at Donnington.

The Trust has appointed a locum consultant to mitigate the immediate issue within the service, identified within their original paper. All inpatient work is undertaken by SaTH Consultant workforce.

Summary of key risks

A single Consultant led service is not viable due to the need for all Cancer 2 week referrals (2WW) and New Patient activity to be supervised by a Consultant Dermatologist. During periods of annual leave / sickness without alternative Consultant presence all New Patient and 2WW activity clinics would have to be cancelled. This would mean that SaTH would not be able to deliver against its agreed contract.

Current performance

Cancer Performance Targets are continually maintained in all target areas and RTT currently stands at 97.14%.

Actions taken

A service options appraisal paper was written following the resignation of the Trust Locum. Initially, Shropshire Skin Clinic was approached with a request for them to provide Consultant cover as an in-reach service for leave/ sickness absence however they would not agree to this. Consequently, the only viable alternative has been to recruit a Locum Consultant at above cap rates. This replacement Consultant started on the 2nd of May. There is however, clearly still a risk associated with this service due to the reliance on Locum availability who contractually have very little obligation to the Trust. To ensure the long term stability of the service, initial discussions have been held with neighbouring Trusts who are in a similar position to us around the potential for a mutual aid arrangement to be developed and agreed.

Next steps

A meeting with Commissioners has been held to discuss the options for sustainable service delivery. It was agreed that Commissioners would have further discussions with Shropshire Skin Clinic regarding the provision of support if required. Commissioners are also going to raise a concern with NHS England about the regional fragility of this service. Monthly meetings with Commissioners regarding the plans for developing a sustainable service locally will continue.

A discussion with Countess of Chester NHS Trust has been held regarding the potential of their Doctors providing support to our service. Chester NHS Trust report having three substantive wte Consultant Dermatologists in post with a plan for a fourth to join them in October. Despite this, they are struggling to deliver the 92% standard for RTT and don't believe they have any capacity to support SaTH on a regular basis. However, they have agreed that they would 'step in' to support us should an urgent situation arise.

Further discussions with Wolverhampton and Walsall NHS Trusts were held at the end of May 2017 to discuss and progress the potential of the development of a mutual aid model locally. In addition to this, discussions have also been held recently with Dudley NHS Trust. These discussions have progressed recently and while there is not a direct offer of assistance available to us, there is a commitment from all to provide aid on a short term basis should we need it. This is to be formalised in writing.

5.0 Spinal Service – No Change

Due to the unexpected sudden illness of our single- handed spinal surgeon at SaTH, we are not currently able to provide a full spinal service within the organisation. This surgeon went on immediate sick leave in February 2017.

SaTH have worked in partnership with RJAH hospital to manage this on a temporary basis by negotiating an agreement for the spinal service to be transferred to RJAH from 1st April 2017 as we have no staff to deliver it. The impact at SaTH is as follows:

- We have closed the service to new referrals temporarily;

- We have IPT'd the urgent cases over to RJAH as per national 18 week guidance. Patients have been advised;
- We have transferred the PTL for all new patients waiting on the list and identified those that are urgent – these have been discussed on a patient per patient basis with RJAH;
- We have managed the routine follow-up patients at SaTH, with our orthopaedic surgeons managing the care of these patients.

The three main CCG's, NHSI and HOSC have all been advised.

All patients have been contacted and advised. Those patients who did not want to attend RJAH were offered alternative providers.

The Informatics team at RJAH worked with our team at SaTH to ensure the transfer of the PTL was completed and to ensure that reporting arrangements are in place to attribute any 18 week breaches as a result of this transfer to SaTH.

The SaTH spinal surgeon returned to work on 16th June 2017. He has indicated that he does not wish to continue to operate, offering to undertake OPD and teaching.

Agreement between both CEO's of SaTH and RJAH has been reached regarding the long term provision of spinal services in Shropshire, with a proposal to provide a hub and spoke model. A case for change is being prepared jointly by RJAH and us for discussion with the Commissioners, HOSC and the Trust Board.

This paper provides an update on the Trust's fragile clinical services since the paper that last went to Trust Board on 30th March 2017, with the risks associated with each of the challenged services having been reviewed to identify any changes since that last formal update of March 2017.
The paper also identifies the actions that the Trust and CCG's are taking to mitigate the challenges currently identified, along with planned next steps.

Debbie Kadum
Chief Operating Officer
June 2017