NHS
The Shrewsbury and Telford Hospital NHS Trust

Paper 15

Recommendation ☐ DECISION ☑ NOTE	**Trust Board is asked to NOTE the content of this report**
Reporting to:	**Trust Board**
Date	31st May 2018
Paper Title	Services under the Spotlight
Brief Description	The purpose of this paper is to provide Trust Board with an updated position regarding key services that have particular workforce challenges.
Sponsoring Director	Nigel Lee, Chief Operating Officer
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Recommended / escalated by	n/a
Previously considered by	Trust Executive Committee
Link to strategic objectives	SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm VALUES INTO PRACTICE - Value our workforce to achieve cultural change by putting our values into practice to make our organisation a great place to work with an appropriately skilled fully staffed workforce
Link to Board Assurance Framework	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**

Paper 15

SERVICES UNDER THE SPOTLIGHT
May 2018

Introduction

This paper provides an ongoing monthly update on fragile clinical services.

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 is reviewed on an ongoing basis to see if there has been any change since the last formal report to Trust Board, on a monthly basis.

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

1. Emergency Departments - Increased risk in Middle Grades since last month. Nurse staffing vacancies slightly improved.

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.

Consultant Workforce – No Change

The Royal College of Emergency Medicine (RCEM) considers the proper staffing of the Emergency Department as the single most important factor in providing a high quality, timely and clinically effective service to patients.

There are 3.0wte substantive Consultants in post, only 2 of whom will work cross site. Recent interviews have resulted in 1 wte consultant being appointed however as the Consultant is currently working as a locum at SaTH it is unlikely they will commence substantively for a further 3 months.

The Royal College of Emergency Medicine (RCEM) 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. There are 5 Locum Consultants in post following a decision by the Board in December 2016 to over-recruit Locum Doctors to provide additional resilience to the On Call rota as there had been no applicants for the substantive posts.

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.

Table 1: Consultant Workforce Summary

	Required	In post Substantive Consultants	Locums	Total	Gap
SaTH In-Hours	20	3	5	8	-12
	Required	**On Call Substantive Consultants**	**On Call Locums**	**Total**	**Gap**
SaTH On Call	20	3	5	8	-12

Currently there is a budget for 9.0wte consultants. Whilst there is an On Call frequency of 1:8 rota, 50% of this cover is from Locums who contractually have very little obligation to the Trust which will result in 2 of the substantive consultants picking up extra on call shifts. Following a previous resignation of a substantive Consultant this moved the frequency to a 1:7, which moved the percentage of cover by Locums to 63%.

The national shortage of ED Consultants persists and feedback from potential candidates is that a two site model and onerous On Call is not an attractive offer.

Specialty Doctors (Middle Grade cover) – Increased Risk

Table 2: Middle Grade Position Summary

Site	Required Number of posts	Substantive in post	Gap
RSH	16	4	-12
PRH	16	6.5	-9.5
Total Trust	32	10.5	-21.5

Currently there is a budget for 15wte specialty level doctors. A recent resignation at RSH will reduce the number of substantive Middle Grades in post to 3 as of the 4th June 2018.

There are several Locum Middle Grade Doctors employed via agencies, covering multiple ad hoc shifts however there is no long term commitment. Due to the old SAS Contract, there are 3 wte that do not work nights at PRH and 2 wte at RSH, meaning there are more night shifts needing Locum cover.

The Royal 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 16 doctors per site.

Whilst the Royal College recommends 16 a pragmatic view by the Clinical Director for Emergency Medicine is that 12 Middle Grades per site would be manageable but would require substantive staff to pick up additional shifts and potentially Locum cover if there were gaps in the Consultant rota.

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 and the requirement for 2 of the consultants to act down. This dependency on locum cover increases the level of risk to quality assurance and the Trust's ability to deliver the 4 hour patient safety standard. The number of changes to the rota to spread the risk is significant and are a potential retention risk to the department. It also compromises the training and supervision of Junior Doctors within the department overnight.

Registered Nurse Staffing Vacancies

Nurse staffing levels are also a concern due to the level of temporary and permanent vacancies resulting in increased agency cover and unfilled shifts. Currently the permanent and temporary gaps continue to be high, especially at PRH with some shifts running mainly with agency staff. In addition, PRH have had no ward manager for some time due to long term sickness and further long term sickness at band 6 level. There is also long term sickness at Matron level at RSH however the PRH Matron is now responsible for ED and AMU across both sites. An additional 6 Emergency Care Practitioner's (ECP's) have been recruited, 5 of which have commenced in post. Both ED's now have permanent Practice Development Nurse's to support the development of the nursing teams and coordination of the department however one has just returned from long term sick

Summary of Key Risks

- Inability to staff both sites consistently with substantive workforce;
- Business Continuity plan – ability to enact
- 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;
- Impact on ED performance due to shift pattern changes to enable both units to stay open overnight;
- Financial impact of very expensive locums;
- Increasing registered nurse vacancies;
- Staff wellbeing;

Action Taken to Date

Actions taken to address the shortfall in staffing are as follows –

Substantive Recruitment

- Consultant in Emergency Medicine post has been advertised as phase 2 of 'The Legacy Campaign' – interviews to take place 3rd/4th June.
- Specialty Doctors advert through 'The Legacy Campaign' attracted 19 applicants however none were suitable for shortlisting.
- Recently appointed 1 Specialty Doctors visa implications are being progressed and escalated substantive salary agreed – awaiting confirmation of start date.

- 4 SHO's appointed commencing over the next few months however 1 has declined the offer of employment. Approval given to go above budget however briefing paper under development to describe impact.
- Simulation Fellow in A&E has commenced in post (which will provide 40% clinical work equivalent to 4 sessions per week) – additional cost of approximately 3k to pay for PGCert.
- Engaged over 20 agencies to support with substantive recruitment.
- Executive led ED workforce plan meetings established with associated plan

Locum Recruitment

- During the previous month, 1 x new Locum Consultant has commenced in post with a further 1 that has left due to not liking the workload or job plan.
- Ad hoc shifts covered by substantive Specialty Doctors from UHNM although unable to commit long term due to full time roles.
- The Locum Specialty Doctor for Emergency Medicine & Locum Consultant Emergency Medicine posts are all out to our permanent agency recruitment companies.

Business Continuity Plan

Further to the actions taken to date to bridge the workforce gaps there is still a substantial risk that we will be unable to safely manage two ED departments overnight. Therefore further to the full business continuity plan for ED being presented to Trust Board in February 2018 as part of our business continuity planning process we have undertaken table top exercises in March and April 2018. Outputs from this exercise identified that there needs to be further work at specialty level including paediatrics, stroke and cardiology services. It is also clear that further discussion and work is required with other service providers such as New Cross Hospital NHS Trust and the West Midlands Ambulance Service.

On the 20th April an extraordinary meeting took place to discuss the ED workforce position and an urgent plan to support enacting the Business Continuity plan. Following this session further meetings with Executives have taken place to flag the ongoing supported by daily updates.

We are also working with other Trusts who have already implemented this process to identify any lessons learnt in an effort to mitigate risks. Further testing will take place in the first week of April 2018.

2. Neurology Outpatient Service

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. Following discussions with commissioners the service was closed to all new referrals from 27th March 2017. Commissioners sourced and secured additional capacity from The Royal Wolverhampton Hospital Trust during this period.

Current Workforce

There are currently 2 full time substantive general neurology consultants in post. This is against a budgeted position of 3.80 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 2 MS nurses in post. The second MS nurse was appointed in January 2018 and is currently undertaking a six month training programme.

Current Performance

The service's RTT performance was 100% in April 2018. Since the service's closure in March 2017, the backlog of new referrals has been fully addressed. There has been an increase in Past Max Wait (PMW) patients which is being followed up via the Care Group.

Summary of Key Risks

The following points are the key risk areas:

- Securing substantive consultants given the national shortage;
- Securing a locum consultant within capped rates to support any shortfall in substantive capacity;
- Managing the levels of demand once the service reopens the front door to new referrals;
- Securing and retaining sufficient Clinical Nurse Specialist provision to manage demand.

Actions Taken

To mitigate the clinical risk associated with the delays, suspension of receipt of all new Neurology referrals commenced on 27th March 2017 for an initial six month period. A Task and Finish Group was established to identify options for the development of a sustainable neurology service for the local population. Despite numerous discussions with neighbouring Trusts and the identification of preferred options, none of these have proved viable. As a sustainable model could not be secured a further extension to the suspension of referrals was agreed in September 2017 while discussions continued. Further to this, a potential solution has been identified which would include the development of a 'hub and spoke' model from a Trust which has a well-established service. Implementing this solution will require formal procurement and is being worked up currently.

Support has been sought from other Trusts to provide capacity to manage the interim period without success. In the meantime, discussions have taken place with commissioners regarding "repatriation" of those patients diagnosed with neurological Long Term Chronic Conditions (LTCCs) at New Cross Hospital, during the SaTH closure. During the discussions with New Cross no arrangements were made by commissioners and the provider to secure on-going follow up for this group of patients. Following agreement by commissioners, SaTH have seen the 14 patients who were sent back for repatriation. The service is also accepting those patients who have been diagnosed with MND out of county. This is due to the life-limiting condition of this illness and hence avoidance of any delay in care. All available consultant capacity is being used to address PMWs, Ward FUs and MS.

A workshop took place on the 21st of March, which was led by NHS England with SaTH, commissioners and other providers to look at the future provision of Neurology Services across the region as a whole in response to the national challenges regarding neurology service provision. SaTH will actively engage in these discussions going forward. A request was made by all involved in the meeting that NHSE support be provided to the development of a Hub and Spoke model across Shropshire and Staffordshire.

Following the workshop Headache pathways have been shared with GPs to gauge their views on a preferred pathway. Following views sought, revisions will be made to the current headache pathway and implemented following agreement through USC Board and appropriate Commissioning Committees.

The Walton Centre have confirmed to SaTH that they are prepared to sign an SLA for 3 clinics per week (42 weeks of the year) as a minimum. A request was made for the SLA to stipulate 3 clinics per week in Year 1 and 6 in Year 2 however the Walton Centre have advised they cannot commit to this

due to staffing levels but would be keen to provide additional clinics should they recruit additional consultant staff.

The Walton Centre have also advised they would only want to deliver activity in the North of the county eg, Oswestry or Whitchurch. The Walton Centre also advised they would prefer to hold one contract across the health economy with the RJAH activity moving to SaTH. At the present time, and to avoid any delays to SLA/sub-contract sign off, the Walton Centre have confirmed they are happy to hold individual contracts, one with commissioners and one with RJAH. Contact has been made with Property Services to determine the possibility of clinic space being made available for the three clinics at Oswestry Health Centre from 1 October 2018.

As the capacity offer from the Walton Centre covers a quarter of that required by SaTH, and only in the North of the county, discussions have been commenced with UHB and UHNM to understand any support they may now be able to offer.

Following discussions with commissioners on Thursday, 11th May, the service remains closed to new referrals.

Next Steps:

1. SLA/sub-contract in draft format being presented to The Walton w/c 14 May. All parties acknowledge a timescale for sign off to be end of May 2018.
2. Discussions to continue with UHB and UHNM to determine feasibility of securing additional capacity.
3. Fortnightly conference calls with The Walton Centre scheduled to maintain momentum.
4. To continually monitor current activity, flexing existing capacity as required and reviewing possibilities for the service to re-open in partnership with local Commissioners.

3. Dermatology Outpatient Service

The Trust has been operating with a single consultant-led service for many years despite numerous attempts to recruit to a substantive Consultant Dermatologist post. Nationally there is a shortage of Consultant Dermatologists.

There is a GP with Special Interest Advanced Primary Care Service in Dermatology to provide additional capacity for the residents of Shropshire County. In addition, there is a Consultant-led Community Dermatology Service at St Michael's Clinic (previously Shropshire Skin Clinic) based in Shrewsbury. The Trust also uses St Michael's Clinic (SMC) 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 SMC via a subcontract relationship.

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 and study 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 was at 98.08% (end of April 2018).

Actions Taken

A service options appraisal paper was written following the resignation of the Trust Locum. Initially, St Michael's Clinic was approached with a request for them to provide Consultant cover as an in-reach service for leave/ sickness absence however they declined this offer. Consequently, the only viable alternative has been to recruit a Locum Consultant at above cap rates. This replacement Consultant started on the 2nd May 2017.

There is however, clearly still a risk associated with this service due to the reliance on Locum availability who contractually has 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. So far, the only agreement that has been reached is that there would be an element of business continuity support for a short period of time if absolutely necessary.

Advertisements for both a substantive consultant and a Trust locum post have been consistently placed without success. The Centre are currently advertising again for a substantive consultant.

The Trust has offered to support the existing locum to secure his CESR qualification to enable him to join the Trust as a substantive consultant, he has advised he is not interested in this offer.

Alongside this, discussions have been held with an alternative provider regarding support they may be able to offer to our Dermatology Service. However, due to concerns raised regarding quality of service delivery, SaTH and Commissioners have agreed not to pursue these discussions.

A further private company has written to SaTH to suggest they may be able to support with Dermatology delivery. It is however clear that this service does not provide consultant support which means SaTH would still need to secure a consultant to enable the service to run safely as this would leave it as a single-handed service.

Further recent discussions have taken place with SMC in an effort to determine their ability to provide substantive support from September 2018 as had previously been suggested. For various reasons cited by SMC, this does not appear to be a viable option for the Trust to pursue at this time. SMC are however willing to consider shorter term support and discussions continue with this regard to confirm sessions required and capacity available from SMC. Consequently, the Centre has commenced work with the contracting and procurement team to address the Trust's capacity issues. It is the Centre's intention to seek Executive support for the procurement process and advertise during May 2018.

It should be noted that all local contracts relating to Dermatology services (commissioner held) end on 31st March 2019.

Following agreement at Planned Care Working Group to work together to develop a service model to meet the needs of the population a workshop was held on 9 May 2019. The workshop was attended by commissioners from both Shropshire and Telford, SaTH, St Michael's Clinic, Donnington Medical Practice and SMC, all of whom hold contracts with the CCGs for Dermatology Services. The outcome from the workshop is awaited, however there was general agreement that a new model does need to be developed with this model aligned across fewer contracts. SaTH's intention to undertake a procurement exercise for the capacity required was advised to all at the meeting. Following the

meeting SMC have approached SaTH to re-open discussions regarding support. These will be undertaken whilst the procurement process continues.

***Next* Steps**

- To continue to advertise for a substantive consultant on a rolling basis.
- To continue to develop the procurement documents and seek Executive approval to advertise for substantive service delivery in May 2018.
- While continuing with the procurement process, discussions with SMC to re-commence to understand whether they are now able to support SaTH at their request.
- To liaise closely with commissioners to understand future commissioning intentions.

4.0 Urology

In recent months there has been an increase in the number of patients referred with suspected prostate cancer due to abnormal PSA's.

Urology 2 Week Wait Referrals Q4 2017/18 / Q1 2018/19

	January	February	March	April
Total Referrals	208	246	283	286
Seen Within Target	192	227	265	TBC
Breaches	16	19	18	TBC
Performance	92.3%	92.3%	92.9%	TBC

This is believed to be associated with the change to the PSA assay used locally which now gives higher results (25-40%) compared with the previous assay used. This has increased the number of new two week referrals received as well as re-referrals of patients previously discharged for PSA monitoring in the community.

In addition to the above the pathological grading of prostate cancer has changed as a consequence of The Royal College of Pathologists issuing new guidance in 2017. The guideline suggested that certain types of histological patterns should be upgraded to higher grade prostate cancer and this has resulted in a significantly higher proportion of high grade prostate cancer patients who require treatment with either radiotherapy or surgery.

These two issues have led to a significant increase in the number of patients referred to urology and then subsequently requiring treatment.

Impact on 31 day DTT and 62 Day RTT Cancer Waiting Time Performance

The 31 day DTT standard was achieved in Q4 2017/18 but the 62 day RTT performance deteriorated mainly due to delays in the diagnostic component of the 62 day pathway and the surge in demand for TRUS biopsy.

Between January - December 2017 69 radical prostatectomies were performed by the only surgeon that performs these procedures. The number this year is likely to be significantly higher as we have

already performed c30 prostatectomies in the first 3 months. There has also been a significant increase in the number of patients referred for radiotherapy.

This increase in demand is likely to increase again significantly in near future due to:

- Increased public awareness of prostate cancer following recent reports of high profile celebrities being diagnosed with the disease. This has been reflected locally by the response rate to a screening session run by Ironbridge Lions and Rotary Clubs where 700 men attended for PSA screening. Traditionally about 15% of these patients are referred to local hospitals for further investigations after GP's have repeated PSA locally. There was no advance warning of screening session planned.

- The planned introduction of MR fusion and template biopsy. Each diagnostic modality has been shown to increase the diagnosis of prostate cancer by 10-15% each.

This increased demand in cancer workload is having a significant impacting on our ability to manage benign urology pathways. Routine surgery is being delayed and in some instances cancelled to allow us to free up theatre sessions for urgent cancer surgery.

The outpatient follow up backlog is also increasing as these appointments are displaced to accommodate new patients. As of 16.5.18 we have 554 past max waits that are currently being clinically validated.

Summary of Key Risks
- Inability to meet increasing demand due to workforce constraints
- Failure of 31day, 62 day and 2WW Cancer Waiting Time standards
- Increasing urology routine surgery backlog, currently 183 patients have waited in excess of 18 weeks.
- Follow up past max wait numbers have increased
- Current situation is impacting on health and wellbeing of staff
- Prostate cancer surgery provision is dependent on single handed surgeon

Action to Date
- Additional 2WW capacity is being scheduled
- Additional TRUS biopsy capacity is being scheduled
- CNS hours have been increased to support provision of additional results clinics
- Additional theatre sessions have been secured to bring urgent surgery dates forward
- Locum CVs have been requested, none received to date

Future Action
- Clinical validation of past max wait patients and formulation of plan to address
- Update urology demand and capacity model to reflect recent increase in referrals rates
- Confirm expected workforce requirements to meet service demand, develop business case and submit for approval.
- Strategic decision required regarding robotic surgery as it is believed we will not be able to recruit a second urology pelvic cancer surgeon without a plan to provide robotic surgery locally or via partnership working with a neighboring Trust.
- Consider employment of NHS locum to assist with backlog clearance
- Identify number of backlog patients that could be treated in independent sector and secure agreement to do so.

5.0 Breast Services at SATH – Imaging

Background
Breast Surgery and Breast Imaging are inextricably linked and in order to provide a safe and effective service, adequate imaging provision is essential. We are facing changes in the radiology workforce due to consultants retiring. Whilst in the past this has been managed to achieve standards with little impact on the Cancer Pathway, this has been achieved by drawing on good will, over booked clinics and extra radiology sessions and is no longer sustainable, due to the impact on individual staff members.

In summary, we are facing the following pressures and constraints in Breast Services. Nationally there is a shortage of Consultant Breast Radiologists and Consultant Radiographers, against this backdrop, the following is relevant to SaTH:
Increasing TWW referrals for symptomatic service
From April 2017 to March 2018 there were a total of 6810 referrals to the breast service. Each week has maximum of 115 TWW slots (with mammography and ultrasound cover) and 20 TWW slots for under 39 years of age (with ultrasound only cover)
Retirement of consultant radiologist and possibility of a further retirement in November 2018
Decreasing threshold for imaging in those TWW patients e.g. for reassurance
Increasingly complex surgery by surgeons requires more intervention such as multiple wires, clips etc
Breast imaging is currently delivered on 2 sites – this reduces opportunities for flexing staff and equipment, and thereby reduces efficiency. Patients will now have to travel cross site on the day of surgery to have a wire placed by radiology, and then return to the other site for their operation. This introduces a further level of risk and is likely to reflect badly in Peer review.
There is an escalation in numbers of patients considered for neoadjuvant chemotherapy which has an additional impact on radiology, particularly MRI.
Expansion of Shropshire BSP, whilst successful, has also impacted on workload in order to meet national standards.

Our medical workforce for breast imaging currently consists of:
1 wte x Consultant Radiologist (also covering CT reporting, Gynae MDT, MRI)
0.5 wte x Consultant Radiologist
1 part time Consultant Radiologist – 6 months fixed term contract to November this year.
1 wte x Consultant Radiographer
1 wte x Locum Consultant – still in training in breast

Current (breast imaging) vacancies:
1 wte x Consultant Radiologist vacant (also covering CT reporting, Gynae MDT, MRI)
1 wte x Consultant Radiologist vacant (also covering CT reporting, Gynae MDT, MRI)

Actions taken so far:
The Centre is working on the following options to address these long term issues :
We have embraced skill mix, and are now trying to recruit an additional Consultant Radiographer
Training further mammographers in film reading, biopsy and ultrasound
Ongoing attempts to recruit to Consultant Radiographer and Consultant Radiologist posts
Appointed an overseas candidate into a breast imaging consultant radiologist job- no assurances of start date (COS restrictions)
A locum General Radiologist is currently being trained in post to carry out breast symptomatic imaging

Short Term Actions being taken to support the service:
Re allocation of the Breast Radiologist's general commitments for a short term until other solutions can be put in place. It is potentially easier to back fill general vs breast radiology.
Reorganise skill mix and utilise advanced practice – Consultant Radiographer to offer one TWW clinic
Bespoke recruitment campaign for Consultant Radiologist and Consultant Radiographer using Clear Design (in development)
Source agency consultant radiologists with expertise in breast radiology
Review of WLI payment to Consultant Radiographer in line with Consultant Radiologist (for doing the same work)
Move Tuesday breast clinic from PRH to RSH and MDTs to maximise throughput; this is possible but needs changes to a urology clinic
Trial magnetic breast markers

Potential Solutions Medium term
Explore new techniques, i.e. magnetic clips to allow more flexible working in radiology and reduce impact of 2 site working
Process map current procedures to evaluate service delivery – this is already planned for Breast Screening
Explore respectful team working

Potential Solutions Long term
Single site working – move to planned care site
Revisit management structure, linking breast surgery with breast radiology directly, making it easier to develop the service and achieve approval for appropriate funding for specific services
Obtain additional breast work station alongside the new ultrasound scanner.
Obtain additional monitors at PRH for film reading to increase flexibility in the current clinics.

Next Immediate Steps

Action	Lead	Comment	Timescale
Develop ACP for Breast Services	AR/GW/AM	On-going	June 2018
Acting up into ACP post whilst recruiting	AR	In progress	May 2018
Bespoke recruitment campaign with Clear Design including Consultant Radiologist, Consultant Radiographers, ACP's and Trainee ACP's	GW/AM/Clear Design	In progress. Meeting w/c 14th May to confirm dates	June 2018
Obtain additional ultrasound equipment for a pilot to support breast service (sources internally or hire short term)	AR/DS/GW	In progress	June 2018
Career Path for Radiology – Breast Services	AR/MM/GW/AM/SF	Meeting tbc	June 2018