The Shrewsbury and Telford Hospital NHS Trust

SERVICES UNDER THE SPOTLIGHT

September 2017

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.

1.0 Emergency Departments – Reduced 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.

1.1. 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 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. There are 4 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.

	Required	In post Substantive Consultants	Locums	Total	Gap
SaTH In-Hours	20	5	4	9	-11
	Required	**On Call Substantive Consultants**	**On Call Locums**	**Total**	**Gap**
SaTH On Call	20	4	4	8	-12

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 regularly results in 3 of the substantive consultants picking up extra on call shifts. The resignation of a substantive Consultant would move the frequency to a 1:7, which moves the percentage of cover by Locums to 63%. In addition only 1 out of 4 CV's are usually suitable and we then compete in a very competitive market. The Trust cannot continue to carry this level of risk.
Additionally the Trust is consistently failing to deliver the A&E 4 hour patient safety standard.

To improve this position, the medical workforce needs to be realigned to meet demand at different times of the day. Without increasing the already unattractive working pattern and risking further resignations of substantive staff, the plan is to appoint Locum Consultants to work evenings. Of the 4 in post, 2 had agreed however 1 is now not currently available and the other 2 have declined to work this shift pattern. Reliance on a temporary workforce to deliver an improvement in a safety standard is not a sustainable position as they only need to provide 1 weeks' notice of annual leave or resignation from post. Locum Emergency Department Consultants are not easy to recruit, come at a premium cost, and are of variable quality.

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.

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

Site	Required Number of posts	Substantive in post	Locums	Total	Gap
RSH	16	4	1	5	-11
PRH	16	5	2	7	-9
Total Trust	32	9	3	12	-20

There are not currently any substantive Locum Middle Grade Doctors employed, instead multiple shifts are covered by various locum doctors provided by agencies. 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 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. 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. It also compromises the training and supervision of Junior Doctors within the department overnight.

This position is unexpectedly now impacted even further by the recent resignation of one of the Middle Grade doctors reducing that team further still. This will impact in October 2017. A recent advert resulted in a successful candidate being offered a post.

1.3. Registered Nurse Staffing Vacancies

Nurse staffing levels, whilst not in itself a reason to close an Emergency Department, are also a concern due to the level of vacancies and agency cover. Currently the permanent and temporary gaps are the highest the Centre has seen.

1.4 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;
- Increasing registered nurse vacancies;
- Increasing number of Middle Grade resignations.

1.5 Action Taken to Date:

- Continued rolling national and international recruitment;
- Consider enhanced rates to attract doctors into emergency medicine – not progressed due to financial pressures;
- 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. Regular meetings are being held between the Medical Directors of SaTH and UHNM who are keeping the situation under review;
- Recent agreement to re-advertise for a joint Consultant appointment SaTH and UHNM is being progressed;
- Progressed joint CESR recruitment plan with UHNM – advertised but no applicants;
- 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. All have declined to take on a Trust post.
- NHS locum posts being offered accordingly;
- Bank and agency cover for registered nurses;
- Workshop held 18th September to consider University Hospital of Leicester's approach to internal international recruitment. SaTH's specific plan now being developed.

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 took place to follow up on the agreed actions on the 11th of August.

An update on progress towards developing the service continuity plan is being presented to Trust Board 28th September 2017. A further stakeholder workshop has been arranged for 13th October 2017.

Should the Trust receive a resignation from a substantive Consultant the plan will need to be enacted. Equally should the Trust reach a position where the Middle Grade vacancies are such that senior cover is not available overnight for the foreseeable future this would also trigger the enactment of the plan.

2.0 Ophthalmology – No Change

Recruitment campaign now underway – 5 applications received. However, no interested party for glaucoma.

Plans going forward:

- Confirmed alternative insourcing providers for a single source support; Additional insource confirmed for commencement on 14th September 2017. Cataract surgery targeted to reduce 300 cases from the backlog.
- Continue with locums in high risk areas; paediatric locum secured from 1st September to mitigate the risk in this service.
- 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; this will be discussed with commissioners at the Task and Finish group.
- Paper being developed to propose the next step in reconfiguring the service with consultation process confirmed.

3.0 Neurology Outpatient Service

See separate paper.

4.0 Dermatology Outpatient Service – Reduced Risk

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 but 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.

4.1 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.

4.2 Current performance

Cancer Performance Targets are continually maintained in all target areas and RTT currently stands at 100% (end of August 2017).

4.3 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 of May and was due to leave on 29 September. Following discussions with him, his agency contract has been extended to the end of December 2017. 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. 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 were placed during August 2017 for both a substantive consultant and a Trust locum post. The Trust locum post received no applicants despite our existing locum being actively encouraged to apply with the Trust offering to support him to obtain his CESR qualification. The substantive consultant vacancy closed on 14th September with no applicants.

In an effort to further mitigate the risks associated with the service, St Michael's Clinic (SMC) has been approached again with a potential offer of an increased transfer of activity on the basis that they would provide further support and capacity for SaTH patients, which would include capacity for Multi-disciplinary Team cover and ward cover during times of consultant leave. Despite this previously having been declined, St Michael's Clinic is now willing to consider this. SMC have indicated that this support would require them to employ an additional consultant and having additional room capacity. They have advised that this would be at SMC and they would not want to make use of any clinic space at SaTH. SMC are currently developing their building to ensure they can manage additional capacity and have advised that any such changes to activity would not be possible until early January 2018.

4.4 Next steps

- To continue to support the current locum in achieving his CESR application, as he has indicated he would then be interested in applying for the substantive post at SaTH.
- To continue discussions with St Michael's Clinic regarding support from January 2018.

5.0 Spinal Service – no change

Due to the unexpected sudden illness of our only spinal surgeon at SaTH in February of this year, we were unable to provide a full spinal service within the organisation.

SaTH have worked in partnership with Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) to manage this position on a temporary basis by negotiating an agreement for the spinal service to be transferred to RJAH from 1st April.

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

The SaTH spinal surgeon returned to work on 16th June 2017, indicating that he did not wish to continue to operate, offering instead to undertake OPD and teaching. The number of patients that were operated on at PRH was an average of 9 a year.

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 has been prepared jointly by SaTH and RJAH and is currently being considered by RJAH with an expected decision on 1st October 2017.

Should there be agreement to develop a hub and spoke model the full transfer of the service would happen on 1st January 2018, following due process within SaTH.

The Trust would of course ensure that it complied with its statutory duties under Section 242 of the NHS Act 2006 and HOSC will be approached with regards to the need for consultation.

Patients would still attend PRH for their outpatients appointment but any surgery would be undertaken at RJAH.

Debbie Kadum
Chief Operating Officer
September 2017