EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 AUGUST 2015**
SUBJECT:	**THE CHALLENGES AND COSTS OF MAINTAINING ACUTE ROTAS**
REPORT FROM:	**DIRECTOR OF STRATEGIC DEVELOPMENT AND CAPITAL PLANNING**
PURPOSE:	**Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The aim of this report is to highlight the current issues and subsequent impact of maintaining acute clinical services across three sites and specifically the challenges of providing compliant medical rotas. There are difficulties in all staff groups, but this paper concentrates on the medical workforce because of the high financial impact, difficulty recruiting suitable candidates, impact on patient care and the training environment. If the Trust was to lose local education status the Deanery would withdraw trainee doctors and the impact would be untenable from a financial and workforce perspective.

The challenges around workforce are a major component in the Trust case for change when considering the future clinical strategy. This has been articulated to the public and other stakeholders as part of the engagement to date.

SUMMARY:

This paper demonstrates the significant pressures the divisions are facing in recruiting a sustainable medical workforce across a range of specialties. The running of 3 hospital emergency medical multi-tier rotas and 2 A&E rotas is clearly a substantial issue for the UCLTC division and does not appear to be sustainable in its current format. The delivery of general surgery for the ECC and in-patients is a developing issue at K&CH because of changes to doctor's training.

The impact of being unable to recruit into the substantive posts is on:

- Patient Safety and Quality – It is not always possible to fill the vacancies with agency /locum doctors of a suitable standard. This may mean the team will continue with gaps putting pressure on remaining team members. Considerable time is spent ensuring locum doctors are inducted into the Trust systems but many temporary staff do not have the same commitment to an organisation's values and goals.

- Education and training - The main impact of insufficient numbers of junior doctors (training grades at F1, F2, MG and core trainees) is on the delivery of a clinical service. However because of broadening the

foundation programme, more F1 and F2 doctors will need to work in the community thereby reducing the numbers available for hospital specialities. If they are not available they are replaced with either Trust doctors or locums at considerable cost and at a detriment to the quality of the service. The remaining trainees have less supervision and training and are largely focused on service delivery. A recent GMC visit has highlighted that the F1s require direct supervision at all times and therefore an immediate change to rotas was mandatory. The Trust only has small element of control as the supply of Junior Doctors comes from a national resource.

If the Trust is not considered to be providing a quality education environment the impact could be the removal of the trainees and a resultant loss of the local education provider status. This would have then have a greater impact on the work force and service delivery and the cost to the organisation would be unviable.

- Trust reputation – without an appropriately skilled workforce the Trust is unable to deliver services as commissioned and achieve the access targets and quality standards which it aims for.

- Financial – Potential £6.048m additional cost over budget on agency and locum staff. This financial overspend is directly contributing to the current financial deficit the Trust is in and will impact how we deliver the service

RECOMMENDATIONS:
The Trust Board is asked to note the issues and their impact identified in this document

NEXT STEPS:
To be identified

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

SO1: Deliver excellence in the quality of care and experience of every person, every time they access our services

SO2: Ensure comprehensive communication and engagement with our workforce, patients, carers, members GPs and the public in the planning and delivery of healthcare

SO6: Deliver efficiency in service provision that generates funding to sustain future investment in the Trust

LINKS TO BOARD ASSURANCE FRAMEWORK:

AO1: Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness

AO2:Embedding the improvements in the High Level Improvement Plan to ensure the Trust provides care to its patients that exceeds the fundamental standards

expected

AO3: Delivering Improvements in patient access performance to meet the standards expected by patients as outlined in the NHS Constitution and our Provider Licence with Monitor.

AO4: Improving the Trust's financial performance through delivery of the 2015/16 Cost Improvement Programme and effective cost control

AO5: Developing, engaging and consulting on a clinically and commissioner supported strategy that achieves both medium and long terms clinical and financial stability

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:
If changes are not made the risks are:

- The financial expenditure on locum/ agency staff will continue to increase;
- difficult to recruit to areas may become impossible to staff;
- patient safety and quality of care may be impacted;
- access targets for 18 week RTT, cancer and A&E may be further impacted; and
- local education provider status may be withdrawn.

FINANCIAL AND RESOURCE IMPLICATIONS:

Expenditure could be reduced by reducing agency / locum doctor usage

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

The Trust has a legal duty to publicly consult on any major changes to services.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

ACTION REQUIRED:

(a) Discuss
(b) To note

CONSEQUENCES OF NOT TAKING ACTION:
Deteriorating workforce, education, quality and financial position.

East Kent Hospitals University NHS
NHS Foundation Trust

The Challenges and Costs of Maintaining Acute Rotas

1. Introduction

1.1. The aim of this report is to highlight the current issues and subsequent impact of maintaining acute clinical services across three sites and specifically the challenges of providing compliant medical rotas. There are difficulties in all staff groups, but this paper concentrates on the medical workforce because of the high financial impact, difficulty recruiting suitable candidates, impact on patient care and the training environment. If the Trust was to lose local education status the Deanery would withdraw trainee doctors and the impact would be untenable from a financial and workforce perspective.

1.2. The Trust commenced a review of its clinical strategy in 2011 and at this time it was agreed that the strategy was to continue delivering emergency and specialty medicine from three sites. Over the past two years issues have started to emerge which potentially threaten the delivery of a safe, quality sustainable service.

1.3. Similar issues were identified in general surgery in 2014 and significant investment was provided to deliver additional resources so an emergency and high risk general surgical service could continue to be delivered on the two existing sites.

1.4. The Trust is currently facing significant work force and financial issues in the context of increasing activity and quality drivers in a range of specialties and staff groups across the Trust, especially when a service has to be replicated and expertise provided out of hours. In order to maintain patient safety the vacancies are filled when suitable replacements can be found however this is usually at a premium cost because of using agency and or locum staff

1.5. Medical staff replacement is the most difficult and expensive to source and whist an issue in all divisions the UCLTC is facing an immediate crisis. Some specific clinical and work force concerns have motivated the Urgent Care division to undertake a detailed risk assessment for each specialty to identify key areas of concern which should influence any future clinical strategy and may require mitigation ahead of any decision making process.

2. Urgent Care and Long term Conditions

2.1 This Division is responsible for the delivery of:

- emergency medicine which involves three acute medical rotas;
- 24 hour, 7days a week A&Es at WHH and QEQM with associated Minor Injury Units (MIUs);
- 24 hour, 7 days a week ECC at KCH which take medical emergencies and has an associated MIU;
- 12 hour, 7 days a week MIU at Buckland Hospital Dover; and

- general and specialty medicine which includes rheumatology, diabetes, gastroenterology, respiratory, HCOOP (including orthogeriatrics, osteoporosis and falls), cardiology, stroke and neurology on three sites.

2.2 An increasing pressure on workforce and quality is the developing complexity of each specialty, the provision of specialist knowledge 24/7 and the subsequent education and training required to meet national standards.

2.3 The risk assessment has identified considerable areas of concern and a number of common themes across all the medical specialties.

2.4 The priority issues are:

Issue	Impact
Inability to consistently maintain three compliant emergency medicine rotas	Replacement with locums / agency when able; Additional financial cost; Inconsistent quality of care; Inconsistent quality of training; and Pressure on substantive staff leading to increased sickness /absence.
Inability to recruit sufficient ED consultants to provide consultant cover in Emergency department (evenings and week-ends)	Replacement with locums / agency when able; Additional financial cost; Limited senior assessment leading to increase admissions and diagnostics; Lack of supervision for junior doctors; and Negative effect on A&E standards (60 minute, 4 hours and consultant sign off for high risk patients).
Availability of junior medical staff for A&E and emergency and specialty rotas	Replacement with locums / agency when able; Additional financial cost; Inconsistent quality of care; Inconsistent quality of training; and Pressure on substantive staff leading to increased sickness /absence.

Inability to provide a suitable education environment	Potential removal of trainees resulting in loss of the local education provider status. This then has a massive effect on the workforce and service delivery; and The cost to the organisation would be enormous.
Conflict between delivery of specialty work ((OP /diagnostics / ward rounds etc.) and emergency rota within current job plan	Achievement of access and diagnostic targets; Increased length of stay; and Pressure on substantive staff leading to increased sickness /absence.
Large number of locum doctors providing services	Inconsistent quality of care; Inconsistent quality of training; Increased financial cost; and Impact on patient care and the training of the available junior doctors which can then further impact fill rates if sub optimal training is experienced.
Inability to provide 24/7 specialty rotas and timely specialty in-reach to in-patients	Inconsistent quality of care e.g. cardiac and pulmonary intervention; Increased length of stay; and Variable clinical outcomes.
Inability to achieve quality standards such as CQUINS, best practice tariff and 7 day working	Inconsistent quality of care; Increased financial cost; Potential loss of commissioned service; Increased length of stay; Variable clinical outcomes; and Longer term Trust reputation.

2.5 The Division runs a range of different specialty rotas all of which are required to operate 24 hours a day, 7 days a week and 52 weeks of the year. The rotas listed in the table below have a number of recurrent gaps which have required the use of a combination of agency, locum and premium payments to ensure there is a compliant rota in place and sufficient medical cover for the in-patient wards.

UCLTC Division Medical Staffing Gaps & Additional Expenditure Incurred

Rota Type[1]	Number required	Gap	Budgeted cost £	Actual cost £	Overspend Cost £
Consultant General Medicine	8 x 3 sites = **24**	3	396,000	598,000	202,000
Consultant HCOOP	8 x 3 sites = **24**	2	414,000	585,000	171,000
Consultant A&E	10 for 2 sites = 10	4	252,000	393,000	141,000
Consultant Stroke	4 x 3 sites = 1**2**	5	198,000	275,000	77,000
Middle Grade A&E	10 x 2 sites = **20**	12	1,746,000	2,739,000	992,000
Middle Grade General Medicine	10 x 3 sites = **30**	21	814,000	1,642,000	828,000
Junior Doctor General medicine	20 x 3 sites = **60**		1,156,000	2,537,000	1,381,000
Foundation Doctor General medicine	**32**	0	369,000	369,000	0
TOTAL					**£3,792,000**

2.6 The aim is to fill all of the gaps on the rotas to ensure the service is as safe as possible and the costs in the above table reflect a 100% fill rate. However this is not always possible due to the availability of appropriately qualified staff. A&E for example, is only filled 90-95% of the time with the registrar and junior doctor element of the rota being particularly hard to fill at an average of 68%. This puts additional pressure on substantive staff and can compromise quality of care. In the future, the Trust knows that the national plan is to reduce the allocation of junior doctors to hospitals meaning the

[1] The rotas that have not been identified in the table are the gastro-intestinal bleeding rota, neurology, PPCI and junior doctors in A&E rotas as no premium costs have been incurred at this stage.

situation will only deteriorate. The running of three hospital emergency medical multi-tier rotas is clearly a significant pressure on the Division and is not a sustainable model of care for the Trust in the future.

2.7 The expectations of Health Education Kent Surrey and Sussex (HEKSS) and General Medical Council (GMC) have changed and the Middle Grade (MG) rotas in medicine have been increased from 10 doctors to 15 doctors at this level. Therefore an additional 25 MG in A&E and general medicine will need to be found across the 3 sites, in areas that are difficult to fill and costing £1,820,000 in locum/agency replacements

3. Surgical Division

3.1 The Surgical Division delivers a range of elective and emergency services including general surgery, urology, vascular, trauma and orthopaedics, head and neck surgery, critical care and anaesthetic services.

3.2 In 2014 the RCS review of general surgery in EKHUFT, together with an internal analysis, clearly identified urgent need for improvement in service provision and set out some specific steps, particularly in relation to the provision of high risk emergency general surgery.

3.3 The Trust at this time looked at a range of options in order to ensure safe surgical services were provided. This resulted in an investment that increased the number of general surgical consultants at both QEQM and WHH hospitals. Whilst this has resolved the immediate issues in general surgery, the Division still faces a range of workforce issues and at this time has 29.50 WTE vacancies across a range of specialties, 23 of which are junior doctor grades. These vacancies again need to be covered by agency and locum doctors and incur financial spend over budget. As with the other divisions it is not always possible to recruit suitable agency / locum doctors and while every effort is made to ensure the best quality workforce is available, a temporary workforce will be an unknown quantity. The additional cost to the budget was £381,000 in Q1, pro-rata.

3.4 Areas within surgery that are causing particular concern are trauma and orthopaedics who are currently carrying a vacancy rate of 8 WTE at middle grade and junior doctor level. Urology also has 5 vacancies which is directly impacting the access to urology cancer service and subsequently the Trust access targets. As highlighted earlier 71% of the vacancies requiring agency / locum cover are junior doctors; this has a significant impact in being able to provide a sustainable rota and a quality training environment which will affect future recruitment. The following issues have been highlighted

Issue	Impact
Inability to consistently recruit substantively to Trauma and Orthopaedic, Anaesthetic middle grade (MG) and junior doctor posts and Urology MG posts	Replacement with locums / agency when able; Additional financial cost; Inconsistent quality of care; Patient access (urology waiting lists) Inconsistent quality of training; and Pressure on substantive staff leading to increased sickness /absence.
Vascular MG and junior doctors at K&CH are no longer dual trained e.g. General Surgery and vascular	Difficulty providing general surgical opinion and care for ECC and in-patients out of hours Inconsistent quality of care Additional time commitment for dual trained vascular consultants
Inability to maintain stable workforce in high volume areas	Failure to achieve elective RTT in T&O, General Surgery and Ophthalmology Increased outsourcing of elective activity incurring additional financial cost by £1,000,000
Locum/ agency doctors providing services which is likely to increase in the future	Inconsistent quality of care; Inconsistent quality of training; Increased financial cost; and Impact on patient care and the training of the available junior doctors which can then further impact fill rates if sub optimal training is experienced.

3.5 Surgical Services Division Medical Staffing Gaps & Additional Expenditure Incurred

Specialty	Site	Staff Group	Vacancies covered by Agency/Locum	Additional cost over Budget Q1	Year End Additional Cost if no change Q1 X 4
			WTE	£'000	£'000
Urology	K&C	Consultant	2.00	32	128
Urology	K&C	Middle Grade	3.00	90	360
Vascular	K&C	Middle Grade	1.00	23	92
General Surgery	QEQM	Middle Grade	2.00	20	80
General Surgery	WHH	Middle Grade	1.00	20	80
General Surgery	WHH	SHO	2.00	0	0
T&O	QEQM	Middle Grade	2.00	45	180
T&O	QEQM	SHO	2.00	30	120
T&O	WHH	Middle Grade	2.00	45	180
T&O	WHH	SHO	2.00	0	0
Ophthalmology	WHH	Consultant	1.00	10	40
Ophthalmology	WHH	Middle Grade	1.00	13	52
Max Fax	WHH	Consultant	1.00	17	68
Anaesthetics	K&C	Middle Grade	1.00	9	36
Anaesthetics	QEQM	Consultant	1.00	0	0
Anaesthetics	QEQM	Middle Grade	3.00	0	0
Anaesthetics	WHH	Consultant	1.50	27	108
Anaesthetics	WHH	SHO	2.00	0	0
TOTAL			**30.50**	**£381,000**	**£1,524,000**

4. Clinical Support Services Division

4.1 The Division is responsible for the delivery of Pathology, Radiology, Pharmacy, Outpatient and Therapy services.

4.2 There are a number of areas which are difficult to recruit to and have required agency and locum staff to ensure a safe service is delivered. CSSD is required to deliver diagnostic services to support both the emergency access standard and cancer standards. Pharmacy has had particular difficulties to date but has a recruitment plan which will resolve agency and locum usage by August 2015. Therapies while still working within their budget have specific issues around recruiting enough staff to work in an environment of fluctuating demand e.g. temporary and H&SC beds. Radiology has a number of sub specialties which can be difficult to recruit to.

5. Specialist Services Division

5.1 The specialist division provides Obstetrics, Gynaecology, Child Health, Dermatology, Renal and Cancer services.

5.2 There are a number of Junior Doctor vacancies in Renal medicine and Children's and Women's health due to unfilled positions, sickness and maternity leave which have required locum/ agency cover. This has resulted in a combined overspend against the divisional budget of £195,000 YTD. These posts have been filled to ensure adequate medical cover during the day as well as filling any gaps in the on-call rotas.

6. Financial Cost

In summary the additional financial cost per division for 2015/16 based on Q1 for the use of agency / locum doctors to support vacancies which will then cover rotas and patient care is:

Division	Additional cost over budget Q1	Year-end additional cost if no change
UCLTC	£948k	£ 3,792k
Surgery	£320k	£ 1,280k
Specialist	£195k	£ 780k
Clinical Support	£ 49k	£ 196k
TOTAL	£ 1,512,000	£ 6,048,000

7. Conclusion

In conclusion this paper demonstrates the significant pressures the divisions are facing in recruiting a sustainable medical workforce across a range of specialties. The running of 3 hospital emergency medical multi-tier rotas and 2 A&E rotas is clearly a substantial issue for the UCLTC division and does not appear to be sustainable in its current format. The delivery of general surgery for the ECC and in-patients is a developing issue at K&CH because of changes to doctor's training.

The impact of being unable to recruit into the substantive posts is on:

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- Education and training - The main impact of insufficient numbers of junior doctors (training grades at F1, F2, MG and core trainees) is on the delivery of a clinical service. However because of broadening the foundation programme, more F1 and F2 doctors will need to work in the community thereby reducing the numbers available for hospital specialities. If they are not available they are replaced with either Trust doctors or locums at considerable cost and at a detriment to the quality of the service. The remaining trainees have less supervision and training and are largely focused on service delivery. A recent GMC visit has highlighted that the F1s require direct supervision at all times and therefore an immediate change to rotas was mandatory. The Trust only has small element of control as the supply of Junior Doctors comes from a national resource.

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