Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review

for

The Working Together

Programme for

Out of Hours Emergency

Care in Ophthalmology

Version 1.0

May 2015

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The Yorkshire and the Humber Clinical Senate
yhsenate@nhs.uk

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1. Chair's Foreword

1.1 The Senate thanks the Working Together Programme for the opportunity to review the proposals for out of hours emergency care in Ophthalmology services. Following a review of the evidence, the Senate is able to support the case for change and agree that the guiding principles for this work are robust. The limited information made available in our review has made it challenging to meet our brief, but the Senate was pleased to be able to provide a view on the preferred options which we hope will be of assistance in the further development of the Business Case.

2. Summary Recommendations

2.1 The Senate agrees that there is opportunity to improve working arrangements in out of hours emergency ophthalmic care and to reduce the use of locums and improve the quality of care to patients. The case for change and the guiding principles being applied to this work seem robust.

2.2 The Senate does have clinical concerns relating to Option 6, to maintain the status quo, which we feel will not address the concerns raised regarding safe service delivery. The Senate also was not supportive of Option 2 which would split the provision of out of hours emergency in-patient and out-patient services across 2 sites. Option 3 raised some concerns due to the higher proportion of patients travelling to receive treatment under this option and the impact on the vitreo retinal work. Option 4 is not supported due to the underutilised clinics it would create, but it could be used as a stepping stone to Option 1. Option 5 is not supported due to the inability of the Trusts to be able to maintain a high quality and consistent service across the region.

2.3 The Senate is supportive of Option 1 as the preferred option.

2.4 The Senate is concerned about the inclusion of Mid Yorkshire within the Working Together Programme (WTP) geography and urges commissioners to undertake a patient impact assessment on the preferred option in the next stage of this work.

3. Background

Clinical Area

3.1 The seven acute providers in South Yorkshire, Mid Yorkshire and North Derbyshire (SYMYND) have agreed to work together to improve the quality of care they deliver and to help meet the challenges posed by rising demand and increasingly tight resources. The Programme enables the providers to act on a larger scale to achieve transformation of systems and services not possible at an individual organisational level.

3.2 This paper focuses on the Ophthalmology project which is also a joint collaborative project with the Commissioner Working Together partnership. The aim of this project is to deliver a safe and sustainable out of hours service for Ophthalmology patients across the seven trusts (Sheffield Teaching Hospitals, Sheffield Children's Hospital, Chesterfield, Barnsley, Rotherham, Doncaster and Bassetlaw, Mid Yorkshire).

3.3 The Yorkshire and the Humber Clinical Senate was consulted for advice on the options developed for redesigning out of hours emergency care in Ophthalmology across the seven hospital trusts. The Senate received an options appraisal paper on 17th December considering five models for a redesigned out of hours service showing the potential number of patients affected by the options (taken from hospital data and prospective audit exercises).

3.4 The Senate was asked to provide their review by the end of January 2015 and to consider the following questions in our response:

a. Considering the areas of concern highlighted i.e. care quality, volumes and outcomes and sustainable workforce models, does the Senate consider that all the proposed new models will potentially address all the aforementioned issues to an equal extent?

b. Are there clinical concerns relating to any individual model?

c. In the Senate's view, from a clinical perspective, is there a preferred option or options?

3.5 The advice will be used by the Ophthalmology Clinical Group, the Medical Directors and Chief Executives of the 7 trusts involved, and commissioners, in order to help to identify the preferred model for improved sustainability, and improved safety. The Senate advice will also support the development of the Business Case that will need to be submitted to the Provider Programme Executive and Trust Boards and to the Commissioner Programme Executive and Collaborative Commissioning Groups (CCGs). Work will begin on clinical pathways and an operating policy as soon as there is clarity on a preferred option. In the interim, work has commenced on sharing management protocols and guidance.

Current Position

3.6 Currently each trust provides their own on-call service for Ophthalmology; the middle grade doctors are the first on-call, followed by the consultants who are the second on-call. The data demonstrates that very few patients require out of hours emergency care and the consultant is rarely called upon. As not all trusts can staff a two-tier on-call system, locums are used to fill the gaps, however locums do not provide the same quality of care as the substantive clinicians do. Therefore, currently there are concerns that the trusts are not all providing an efficient and sustainable service.

Case for Change

3.7 Difficulties in recruiting into medical vacancies in Ophthalmology, particularly at middle/staff grade and to a lesser extent consultant grade, has led to a number of serious incidents occurring in Ophthalmology in South Yorkshire, linked to locums. It is expected that recruitment, particularly to middle grade non-training posts, will become increasingly difficult. This makes it more difficult and less cost effective to provide care out of hours, provide access to specialist opinion, sustain viable sub specialties and maintain skills.

3.8 The 7 Medical Directors in the Working Together Programme identified safe service delivery in Ophthalmology as an area of concern and expressed a wish to explore collaboration to overcome difficulties.

3.9 The Ophthalmology Clinical Leads from each of the 7 trusts have held a series of meetings to work through the issues and to identify potential solutions.

The following tables provide information on the 6 options under consideration.

Options Summary

OPTION 1

Weekdays (Mon – Fri)

Option 1 removes the middle tier of doctors.

0800-1800hrs	No change for patients: Local provision for emergency patients continues during the day, providing urgent/emergency clinics at each site.
1800-2100hrs	Emergency patients arriving at their local Emergency Department (ED) will be assessed and referred to a central urgent/emergency clinic if required. The clinic will be provided at the Hallamshire Hospital by all the consultants from the 7 trusts on a 1:40 rota. Patients from the region would need to travel to the Hallamshire Hospital to access the clinic. Patients, who need to be admitted, will be admitted to the Hallamshire Hospital.
2100-0800hrs	Urgent/emergency patients will be transferred to the Hallamshire Hospital to be looked after by the Sheffield Teaching Hospitals (STH) on-call.
2100-0800hrs	For non-movable patients requiring Ophthalmic opinion, the consultants for the District General Hospitals (DGHs) will be on a 2:30 rota covering the periphery hospitals. One rota will cover the northern area and one rota will cover the southern area of the patch.

Weekends

Friday 2100 to Monday 0800	Emergency patients arriving at their local Emergency Department will be assessed and referred to an urgent/emergency clinic if required. The consultants for the District General Hospitals will be on a 2:30 rota covering the periphery hospitals. One rota will cover the northern area and one rota will cover the southern area of the patch.
Saturday 2100-0800	The Hallamshire Hospital will provide one urgent clinic and an additional 2 clinics will be provided by the other District General Hospitals. Geographically, it would make sense for the other clinics to be held in Wakefield and or Doncaster. Urgent/emergency patients will be transferred to the Hallamshire Hospital and managed by the Sheffield Teaching Hospitals trauma team.
Sunday 2100-0800	The Hallamshire Hospital will provide one urgent clinic and an additional 2 clinics will be provided by the other District General Hospitals. Geographically, it would make sense for the other clinics to be held in Wakefield and or Doncaster. Urgent/emergency patients will be transferred to the Hallamshire Hospital and managed by the Sheffield Teaching Hospitals trauma team.

OPTION 2

Weekdays (Mon-Fri)

Option 2 removes the middle tier of doctors

0800-1800hrs	No change for patients: Local provision for emergency patients continues during the day, providing urgent/emergency clinics at each site.
1800-2100hrs	Emergency patients arriving at their local ED will be assessed and referred to a central urgent/emergency clinic if required. The clinic will be provided at The Rotherham Hospital by all the consultants from the 7 trusts on a 1:40 rota. Patients, who need to be admitted, will be admitted to the Hallamshire Hospital. Patients from the region would need to travel to the Rotherham Hospital to access the acute clinic. Patients who need to be admitted will be transferred to the Hallamshire Hospital.
2100-0800hrs	Urgent/emergency patients will be transferred to the Hallamshire Hospital to be looked after by the STH on-call.
2100-0800hrs	For non-movable patients requiring Ophthalmic opinion, the consultants for the DGHs will be on a 2:30 rota covering the periphery hospitals. One rota will cover the northern area and one rota will cover the southern area of the patch.

Weekends

Friday 2100 to Monday 0800	Emergency patients arriving at their local ED will be assessed and referred to an urgent/emergency clinic if required. The consultants for the DGHs will be on a 2:30 rota covering the periphery hospitals. One rota will cover the northern area and one rota will cover the southern area of the patch.
Saturday 2100-0800	The Hallamshire Hospital will provide one urgent clinic and an additional 2 clinics will be provided by the other DGHs. Geographically it would make sense for the other clinics to be held in Wakefield and or Doncaster. Urgent/emergency patients will be transferred to the Hallamshire Hospital and managed by the STH trauma team.
Sunday 2100-0800	The Hallamshire Hospital will provide one urgent clinic and an additional 2 clinics will be provided by the other DGHs. Geographically, it would make sense for the other clinics to be held in Wakefield and or Doncaster. Urgent/emergency patients will be transferred to the Hallamshire Hospital and managed by the STH trauma team.

OPTION 3

Weekdays (Mon-Fri)

Option 3 removes the middle tier of doctors

0800-1800hrs	No change for patients: Local provision for emergency patients continues during the day, providing urgent/emergency clinics at each site.
1800-2100hrs	Emergency patients arriving at their local ED will be assessed and referred to a central urgent/emergency clinic if required. The clinic will be provided at The Rotherham Hospital by all the consultants from the 7 trusts on a 1:40 rota. Patients from the region would travel to The Rotherham Hospital for the acute clinic. Patients who need to be admitted will be admitted to The Rotherham Hospital.
2100-0800hrs	Urgent/emergency patients will be transferred to The Rotherham Hospital.
2100-0800hrs	For non-movable patients requiring Ophthalmic opinion, the consultants for the DGHs will be on a 2:30 rota covering the periphery hospitals. One rota will cover the northern area and one rota will cover the southern area of the patch.

Weekends

Friday 2100 to Monday 0800	Emergency patients arriving at their local ED will be assessed and referred to an urgent/emergency clinic if required. The consultants for the DGHs will be on a 2:30 rota covering the periphery hospitals. One rota will cover the northern area and one rota will cover the southern area of the patch.
Saturday 2100-0800	The Rotherham Hospital will provide one urgent clinic and an additional 2 clinics will be provided by the other DGHs. Geographically it would make sense for the other clinics to be held in Wakefield and or Doncaster. Urgent/emergency patients will be transferred to the Rotherham Hospital.
Sunday 2100-0800	The Rotherham Hospital will provide one urgent clinic and an additional 2 clinics will be provided by the other DGHs. Geographically it would make sense for the other clinics to be held in Wakefield and or Doncaster. Urgent/emergency patients will be transferred to the Rotherham Hospital.

OPTION 4

Weekdays (Mon-Fri)

Option 4 removes the middle tier of doctors

0800-1800hrs	No change for patients: Local provision for emergency patients continues during the day, providing urgent/emergency clinics at each site.
1800-2100hrs	No change for patients: Each trust to provide on-call.
2100-0800hrs	Urgent/Emergency patients arriving at their local ED will be assessed and transferred to the Hallamshire Hospital to be looked after by the STH on-call.
2100-0800hrs	For non-movable patients requiring Ophthalmic opinion, the consultants for the DGHs will be on a 2:30 rota covering the periphery hospitals. One rota will cover the northern area and one rota will cover the southern area of the patch.

Weekends

0800-2100	Emergency patients arriving at their local ED will be assessed and will be seen locally by the consultant on-call if required. The consultants for the DGHs will be on a 2:30 rota covering the periphery hospitals. One rota will cover the northern area and one rota will cover the southern area of the patch.
2100-0800	Urgent/emergency patients will be transferred to the Hallamshire Hospital.
2100-0800	The non-moveable patients will be seen locally by the DGH consultant on-call.

OPTION 5

Weekdays (Mon-Fri)

Removes the middle tier of doctors

0800-1800hrs	No change for patients: Local provision for emergency patients continues during the day, providing urgent/emergency clinics at each site.
1800-0800hrs	No change for patients: Each Trust to provide on-call for urgent/emergency patients.

Weekends

0800-0800hrs	No change for patients: Each Trust to provide on-call for urgent/emergency patients.

OPTION 6

Status Quo

Each trust provides their own on-call service for out of hours Ophthalmology emergency patients. The middle grade doctors are the first on-call and the consultants are the second on-call. Vitreo-retinal emergencies from District General Hospitals are already centralised at Sheffield Teaching Hospitals.

4. Recommendations

Questions and Assumptions

4.1 The Senate review group did find it somewhat challenging to fully assess the impact of these proposals with the slightly limited information provided. The Senate felt that for such a major decision on the delivery of emergency eye health, full information is required and the Senate has found it helpful to have the further information provided in March by the Working Together Programme (WTP) regarding:

- post holder numbers and vacancies in the 7 trusts (Chesterfield Royal Hospital and Doncaster and Bassetlaw Hospitals currently have 2 middle grade WTE vacant posts each, which are filled with locums. Doncaster and Bassetlaw Hospitals also has two vacant consultant posts)

- impact of treating non-movable patients on elective work in each of the 7 trusts (The numbers are so small that this will have no impact on elective work. Currently, in most institutions, this work is already absorbed within existing arrangements.) There is the provision for true emergencies that are non-movable, out of hours to be covered by the second regional on-call consultant.

- impact on training of ophthalmologists, nurses and other specialists (The WTP and lead clinician believes a more regionalised approach would concentrate and equilibrate the training opportunities)

- impact on patient travel times and Yorkshire Ambulance Services NHS Trust capacity (the patient travel times to and from each trust were cited from AA Route Planner)

4.2 The Senate notes that the proposals will be developed into a business case where there will be opportunity to give these issues further consideration.

4.3 With the exception of the status quo, the options all remove the middle tier of doctors out of hours. The middle grades will continue to remain employed by the 7 trusts and focus on Mon-Fri 0800 -18:00 workload and receive exposure to emergency cases during day time hours. As this is the case, then the Senate does not feel that this change will have a negative impact on middle grade training as the out of hours cases are in very low numbers. Health Education England have also confirmed that they are sighted on these proposals and have no concerns about the training implications. Maintaining the middle grades on day time hours would also mitigate against the potential impact of consultant gaps that may occur if consultants are called in overnight (particularly if Option 5 were retained).

4.4 The Senate noted that there is no model proposed where the middle tier participate in weekend acute clinics in Wakefield and or Doncaster, for example

4.5 It is not clear from the paper, but the Senate assumes, that Working Together have received significant buy in from clinicians from across the 7 trusts, thereby allowing for a rota of up to 40 Ophthalmic surgeons. However, the Senate is cognizant of the

fact that the clinicians from across the 7 trusts have been involved in a series of workshops and meetings from March 2014 to identify the current issues and to work up potential options.

4.6 The information provided does not consider the implications for training of junior doctors. However, the junior doctors will still have access to emergency Ophthalmology cases Mon-Fri 08:00-18:00 and potentially at the central hub or in emergency clinics and there is still an on-call service during the working day in all models and in evening sessions in some of the models. Commissioners will also want to consider the contractual arrangements of the doctors concerned and whether a long term staff grade with a contract to do on-call will still need to be paid for that even if they are no longer doing on-call, for example. Although a smaller consideration, travel expenses would also need to be considered within the models proposed and the mechanism for agreeing this. If it is the trust who normally employs the Ophthalmologist who covers the expenses, then it would cost larger providers more. Similarly, in the case of trainees, as most are employed by Sheffield Teaching Hospitals, even when on peripheral placements. The Senate understands that this has been identified as an issue and will be discussed with the project group, which will involve the trust General Managers and Account Managers. A detailed service model of the chosen option will clarify the travel expenses.

4.7 The Senate has sought clarification and understands that ED within the paper refers to 'Emergency Department'. The Doctor who sees the patient in the local emergency departments will be either a junior doctor, middle grade doctor or a consultant depending on location and time of day. Following clarification, it is also the Senate's understanding that Barnsley does not provide an Ophthalmology in-patient service and therefore, the Barnsley patients go to Rotherham to receive their service. We have therefore taken the Rotherham and Barnsley figures as one.

4.8 The Senate's assumption that this is over a 24 hour period has been confirmed as correct.

4.9 The inclusion of Mid Yorkshire within this model raises questions as this model presents a fundamental difference to the current working arrangements where patients from this trust would flow into Leeds for emergency Ophthalmic care. It is recognised that there is a proposed weekend hub in Wakefield but the Working Together programme are urged to consider whether this model provides the most convenient model of care to patients from Wakefield and the surrounding geography. These patients may prefer to attend a West Yorkshire hospital. This raises wider questions about the geography of the Working Together Programme but it is acknowledged that it was at Wakefield's request that they partake in the WTP as a whole and are active partners.

4.10 The Senate's understanding is that the children's service remains unchanged with Sheffield Children's Hospital and Leeds Teaching Hospital continuing to provide the emergency Ophthalmic services.

4.11 The Senate did consider the impact of these models on the ambulance service and have received advice that the proposals are feasible and unlikely to create additional work for the ambulance service, although it would be helpful for this to be explored further in the paper.

Questions

4.12 Taking each of the questions in turn, the Senate recommendations are detailed below:

a. Considering the areas of concern highlighted i.e. care quality, volumes and outcomes and sustainable workforce models, does the Senate consider that all the proposed new models will potentially address all the aforementioned issues to an equal extent?

4.13 The Senate supports the case for change and agrees that the guiding principles being applied seem robust. The main motivation for this proposed change in service is the rota vacancies and the serious incidents linked to dependence on locum staff. The Senate understands the concerns raised regarding recruitment of middle/staff grade and the expectation that this recruitment will become increasingly difficult. The Senate agrees that the recruitment issues make it more difficult to provide a safe on-call service across 7 sites and, provide access to specialist opinion, sustain viable sub specialties and maintain skills. The Senate agrees that there is opportunity to improve working arrangements to reduce the use of locums and improve the quality of care to patients.

4.14 The Senate sees considerable merit in the model of centralising emergency out of hours care and providing peripheral clinics in the North and South. Overall, we agree that these are sustainable workforce models, with manageable volumes of patients and that these models have the potential to improve outcomes for patients.

b. Are there clinical concerns relating to any individual model?

Of the 6 options under consideration, the Senate has clinical concerns in relation to the following 5 proposals:

4.15 Option 2 This option proposes the loss of the middle tier of doctors and Rotherham as the central urgent/emergency clinic for outpatients with patients who need to be admitted being admitted to the Hallamshire Hospital. The Senate is not supportive of this proposed spilt between inpatient and outpatient service and considers that this will create a confusing and impractical service which offers patients a poor out of hours experience.

4.16 Option 3 This option proposes the loss of middle tier of doctors and Rotherham as the emergency site from 6 pm for both outpatients and inpatients. The data shows that this option will create a higher proportion of patients travelling to receive treatment due to the number of admissions from Sheffield. The Senate is therefore less supportive of an option that creates the need for travel for a greater number of patients. The vitreo retinal work would remain at the Hallamshire, even if the trauma work is centralised at Rotherham. This represents no change to present arrangements, regardless of the model.

4.17 Option 4 By extending the local provision for emergencies to 9 pm, this option allows for more patients to receive their treatment closer to home and limits the number of patients requiring transfer. This option has the advantage of being the more patient centred option and gives peripheral hospitals continued exposure to urgent Ophthalmology patients which is important for skill retention. However, only 5-6 patients will present across the region during this evening time period, therefore this option would create clinics with significant under-utility unless combined with elective work. For this reason the Senate does not support this option but acknowledges that it could be used as a stepping stone to Option 1.

4.18 Option 5 Continues to provide a locality based service without the middle tier which could be a viable option. This would be a good option in terms of patient access, but with the relatively low volume of Ophthalmology emergencies, the Senate has concerns about the ability of the 7 trusts to be able to maintain high quality and consistent service across the region. It is known that Chesterfield Royal Hospital would struggle to sustain Option 5 as this would be detrimental to recruiting consultants who would have to deliver first on-call. The Senate is therefore not supportive of this option.

4.19 Option 6 The senate is not supportive of the status quo as this will not address the concerns raised regarding safe service delivery. WTP is in agreement with this and the Medical Directors from the 7 trusts have agreed to remove this as an option.

c. In the Senate's view from a clinical perspective, is there a preferred option or options?

The Senate is supportive of the following options:

4.20 Option 1 The Hallamshire Hospital already has an established separate emergency eye department and therefore there is some logic in utilising this to maximum potential. This option has the potential to provide a quality out of hours and weekend service to patients and addresses the concerns raised with the current service. It is reported that the Hallamshire Hospital has the capacity to absorb the additional cases between 21:00-08:00, however, the evening clinic delivered by all the consultants would be established to assist the Hallamshire Hospital with the additional pressure. The numbers suggest that a 3 hour evening clinic could absorb the capacity if 3 times the number of patients than expected presented

Additional General comments

4.21 The Senate review group also considered the use of data and information sharing in their review of the proposals. A patient with a new problem could feasibly be seen in any Ophthalmic department as there would be no previous notes, but those with diseases such as diabetic retinopathy, uveitis, glaucoma, corneal grafts or post-operative complications would benefit from care in the Eye Service which sees them regularly. It is often difficult, locally, to access notes in the middle of the night on-call, but there is electronic access to previous letters, dates of surgery, immediate discharge letters, previous ocular and radiology imaging and reports and previous blood tests, all of which are hugely important in diagnosis and management. Commissioners will wish to consider how on-call teams spread across the region are able to access this information under the Options 1 to 5 proposed. Commissioners will also wish to consider how the data and images for those patients with new emergency diseases which are collected during their emergency admission, will then be transferred back to their local trust in a timely manner and in a form that is compatible with local software.

4.22 The Senate review group agreed that it would be helpful to have more consideration given to the safety of the models. Examples provided by a review group member are the transferring of a patient with a retinal artery occlusion who requires urgent paracentesis and a patient with a severe chemical injury. In each case urgent intervention is needed before transfer and it needs to be clear how the covering consultant will deliver this care overnight in trusts away from the admitting hospital. The Senate understands that the WTP is, at present, gathering the operational policies and clinical guidance available across the 7 trusts as well as other collaborative models, such as Birmingham. This will further guide the pathways that need to be in place, including any emergency treatment that has to be delivered in a time critical fashion.

4.23 It is also not clear whether the data includes ward referrals to Ophthalmology from patients with other medical problems who then get an eye disease. There is a demand on staff to see these patients admitted to other wards who cannot be moved. The agreed model needs to include planning for how the consultants will provide for this service, particularly if they may be stretched covering several trusts and potentially in the wrong place at the wrong time. Although this is a small number, the detailed service model would need to include a contingency plan for how these patients would be managed in a time critical fashion.

4.24 The Senate notes that it is the intention for work to commence on clinical pathways and an operating policy, and we agree the need to develop a strong governance framework to underline the working arrangements. This will need to give consideration to what happens in the situation where two hospitals in the given area are requesting cover from the on-call doctors at peripheral hospitals at the same time.

4.25 The Senate also gave consideration to the different patient groups affected by this proposal and the need to be able to differentiate and respond to these different patient groups in evenings and weekends. An 'urgent treatment pathway' needs to address the differing needs of those patient groups, including those fit to travel who are newly presenting or currently receiving active treatment and those who are unable to attend the emergency Department without assistance. It is not clear from the information provided, who decides whether the patient is fit to get to the transfer centre independently. Many patients will not be able to drive with eye pathologies and public transport is often not that feasible late at night. Access to electronic records is obviously a key component in offering high quality care to patients as previously discussed in this paper. Any chosen option would need engagement with the public.

5. Summary and Conclusions

5.1 The Senate agrees that there is opportunity to improve working arrangements in out of hours emergency Ophthalmic care and to reduce the use of locums and improve the quality of care to patients. The case for change and the guiding principles being applied to this work seem robust.

5.2 The Senate sees considerable merit in the model of centralising emergency out of hours care and providing peripheral clinics in the North and South areas of South Yorkshire. Overall, we agree that these are sustainable workforce models, with manageable volumes of patients and that these models have the potential to improve outcomes for patients.

5.3 The inclusion of Mid Yorkshire within this model causes questions as this model presents a fundamental difference to the current working arrangements and these patients may prefer to attend a West Yorkshire hospital. This raises wider questions about the geography of the Working Together Programme and the rationale for this is not clear from the information provided. Any chosen option would need a full patient impact assessment.

5.4 In summary, the Senate did raise clinical concerns relating to Options 2, 3, 4, 5 and 6 but was supportive of Option 1.

5.5 The Senate also raised a number of other points which may be useful to consider in the further development of the clinical pathways and the Business Case:

- the use of data
- the governance framework for these arrangements
- the consideration needed to be given to the different patient groups affected by this proposal, particularly the inclusion of Mid Yorkshire in the geography of the Working Together Programme and the concern of the Senate as to whether this will result in patients from Wakefield and the surrounding geography having access to a convenient local service.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Senate Council Members

Jon Ausobsky
Consultant General Surgeon, Bradford Teaching Hospitals NHS Foundation Trust

Hugh Butcher
Patient Representative

Senate Assembly Members

Stephen Clark
Chair, West Yorkshire Eye Health Network, Clinical Adviser in Optometry, NHS England (West Yorkshire)

Pierre-Antoine Laloe
ST7 Anaesthesia, Ignaz Handbook Project Manager, Health Education Yorkshire and the Humber

Graham Venables
Clinical Director, Strategic Clinical Networks, NHS England and Consultant Neurologist, Sheffield Teaching Hospitals NHS Foundation Trust

Louise Downey
Consultant Ophthalmologist, Hull and East Yorkshire NHS Trust with a specialist interest in Medical Retinal diseases.

Elise Hollowell
Optometrist, Moorhouse Opticians

Co-opted Members

Ben Burton
Honorary Senior Lecturer UEA, Consultant Ophthalmologist, James Paget University Hospital NHS Foundation Trust

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

None declared

Appendix 3

TERMS OF REFERENCE

Template to request advice from the Yorkshire and the Humber Clinical Senate

Name of the lead (sponsoring) body requesting advice: Working Together Programmes (South Yorkshire, North Derbyshire, Wakefield)

Type of organisation: Provider and Commissioner Collaborations

Name of main contact: Will Cleary-Gray

Designation: Programme Director Commissioner Working Together Partnership

Email:willcleary-gray@nhs.net **Tel: 07540080994** **Date of request:**

Please note other organisations requesting this advice (if more than the lead body noted above):

Joint Collaborative Project with seven Hospital Providers, NHS England and 8 CCG Commissioning organisations across South Yorkshire and Bassetlaw North Derbyshire and Wakefield.

Is the Senate being consulted for advice or as part of the formal assurance process?

Consulted for advice

Please state as clearly as possible what advice you are requesting from the Clinical Senate and what documentation you propose sharing with the Senate.

A document is attached regarding options for redesigning out of hours emergency care in Ophthalmology involving seven hospital Trusts (Sheffield Teaching Hospitals, Sheffield Children's Hospital, Chesterfield, Barnsley, Rotherham, Doncaster and Bassetlaw, Mid Yorkshire). The paper outlines five models for a redesigned out of hours service and shows the potential number of patients affected by the options (taken from hospital data and prospective audit exercises).

1. Considering the areas of concern highlighted i.e. care quality, volumes and outcomes and sustainable workforce models, does the Senate consider that all the proposed new models will potentially address all the aforementioned issues to an equal extent?

2. Are there clinical concerns relating to any individual model?

3. In the Senate's view from a clinical perspective, is there a preferred option or options?

Please state your rationale for requesting the advice? (What is the issue, what is its scope, what will it address, how important is it, what is the breadth of interest in it?).

The seven acute providers in South Yorkshire, Mid Yorkshire and North Derbyshire (SYMYND) have agreed to work together to improve the quality of care they deliver and to help meet the challenges posed by rising demand and increasingly tight resources. The Programme enables the providers to act on a larger scale to achieve transformation of systems and services not possible at an individual organisational level The Ophthalmology project is also a joint collaborative project with the Commissioner Working Together partnership

The aim of this project is to deliver a safe and sustainable out of hours service for Ophthalmology patients across the seven Trusts. Difficulties in recruiting into medical vacancies in Ophthalmology particularly at middle/staff grade and to a lesser extent, consultant grade, has led to a number of Serious Incidents occurring in Ophthalmology in South Yorkshire linked to locums. It is expected that recruitment particularly to Middle Grade non-training posts will get no better but become increasingly difficult. This makes it more difficult and less cost effective to provide care out of hours, provide access to specialist opinion, sustain viable sub specialties and maintain skills.

The 7 medical Directors in the WTP identified safe service delivery in Ophthalmology as an area of concern and expressed a wish to explore collaboration to overcome difficulties.

The Ophthalmology clinical leads from each of the 7 Trusts have held a series of meetings to work through the issues and to identify potential solutions. An options appraisal is being carried out on five different options, with the six option being the status quo.

What is the purpose of the advice? (How will the advice be used and by whom, how may it impact on individuals, NHS/other bodies etc.?).

The advice will be used by the Ophthalmology clinical group, the Medical Directors and Chief Executives of the 7 Trusts involved, and Commissioners in order to help to identify the preferred model for improved sustainability, and improved safety..

Please provide a brief explanation of the current position in respect of this issue(s) (include background, key people already involved).

Currently each Trust provides their own on-call service for Ophthalmology; the middle grade doctors are the first on-call, followed by the consultants who are the second on-call. The data demonstrates that very few patients require out of hour emergency care and the consultant is rarely called upon. As not all Trusts can staff a two-tier on-call system, locums are used to fill the gaps, however locums do not provide the same quality of care as the substantive clinicians do. Therefore we are currently providing an inefficient and unsustainable service.

When is the advice required by? Please note any critical dates.

The advice is required as soon as possible in order to assist in determining any options that should not be considered, identify a preferred option and to support the development of the Business Case that will need to be submitted to the Provider Programme Executive and Trust Boards and to the Commissioner Programme Executive and CCGs.

The advice for the preferred option would be useful in advance of the next Clinical Reference Group meeting (which involve the Medical Directors from each of the seven Trusts) who provide the Clinical recommendations to the Provider Programme Executive. The meetings dates are as follows:

Programme Executive (Providers)– Monday 5th January, Monday 2nd February 2015

Programme Executive Group (Commissioners)- Monday 19th January, Monday 16th February 2015

Clinical Reference Group – Friday 30th January 2015

Has any advice already been given about this issue? If so please state the advice received, from whom, what happened as a consequence and why further advice is being sought?

An option appraisal is in process. The Ophthalmology clinical group has reviewed the options. A Trust perspective from the Chief Executives and Medical Directors is also being sought along with an external view

As part of the service change process, and taking into account the cross organisational impacts, a clinical view from the Senate would be welcomed

Is the issue on which you are seeking advice subject to any other advisory or scrutiny processes? If yes please outline what this involves and where this request for advice from the Clinical Senate fits into that process (*state N/A if not applicable*)

Commissioners will be reviewing the potential impacts for patient access to establish the level of public engagement and consultation required

Please note any other information that you feel would be helpful to the Clinical Senate in considering this request.

Paper on options and impacts attached.

Work will begin on clinical pathways and an operating policy as soon as there is clarity on a preferred option. In the interim, work has commenced on sharing management protocols and guidance.

*Please send the completed template to:*joanne.poole1@nhs.net. *For enquiries contact Joanne Poole, Yorkshire and the Humber Clinical Senate Manager at the above email or 01138253397 or 07900715369*

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Appendix 4

BACKGROUND INFORMATION

The only information considered in this review was the Specialty Collaborative Working – Ophthalmology options paper Dec 2014 and the additional information forwarded in March 2015.