CONFIDENTIAL

Invited Review Report on
North Cumbria University Hospitals NHS Trust

Cumberland Infirmary, Carlisle (CIC)
West Cumberland Hospital, Whitehaven (WCH)

Visit Date: 11-12 April 2017
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1. Introduction

1.1. The Royal College of Anaesthetists (RCoA) is committed to working with healthcare organisations to achieve and maintain high standards of perioperative and anaesthesia care. In line with this commitment, the invited review programme is an advisory service offered to NHS and independent healthcare organisations in the UK who feel that they would benefit from expert and independent advice.

1.2. This review has been commissioned by NHS Improvement. The RCoA received a formal request from NHS Improvement to conduct an invited review at the North Cumbria University Hospitals NHS Trust (NCUH) in February 2017.

1.3. The remit of this invited review includes the safety and sustainability of staffing for obstetric anaesthesia and intensive care as currently configured in the Cumberland Infirmary at Carlisle (CIC) and the West Cumberland Hospital (WCH) in Whitehaven.

1.4. The review will also present safe staffing recommendations for each of the three reconfiguration options as developed by the West, North and East Cumbria Success Regime.

1.5. The onsite review took place on 11 and 12 April 2017. The programme for the two-day visit was prospectively agreed with the Medical Director.

2. Invited Review Team

**Lead Reviewer**
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West Suffolk Hospital, Bury St Edmunds
RCoA Council member
Chair, RCoA Training Committee

**Clinical Reviewer**
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Past President, Obstetric Anaesthetists’ Association

**Clinical Reviewer**
Dr Chris Thorpe
Consultant in Anaesthesia and Intensive Care Medicine
Ystbyty Gwynedd Hospital, Bangor
Faculty of Intensive Care Medicine (FICM) Board Member
Past Regional Advisor and Training Programme Director for Wales
Examiner, Fellowship of Faculty of Intensive Care Medicine (FFICM)

**Lay Reviewer**
Mr Bob Evans
RCoA Lay Committee Member
Retired Chartered Town Planner

**Administrative Reviewer**
Ms Sharon Drake
RCoA Deputy Chief Executive and Director of Clinical Quality and Research
3. **Terms of Reference**

3.1. The aim of the invited and independent review is:

- To consider whether the current staffing arrangements provide a safe service to maternity and intensive care and what staffing changes, if any, are required to make the service safe.

- To consider whether the future proposed reconfiguration options 1 to 3 change the staffing requirements and safety to maternity and intensive care.

- To present staffing recommendations for each of the reconfiguration options that allows maternity and intensive care services to be delivered safely.

- To consider if there is any service provision that could be delivered by non-medical practitioners.

3.2. The Invited Review team was also asked to consider whether national standards as detailed in the RCoA Guidelines for the Provision of Anaesthetic Services (GPAS) and the Faculty of Intensive Care Medicine’s and Intensive Care Society’s Guidelines for the Provision of Intensive Care Services (GPICS) could be adapted in circumstances where a remote community with a small number of deliveries could safely maintain a consultant-led unit.

4. **Background and Context**

4.1. **North Cumbria University Hospitals NHS Trust**

4.1.1. The West Cumberland Hospital (WCH) was the first wholly-new hospital to be built since the NHS was founded and was officially opened in 1964. North Cumbria University Hospitals NHS Trust (NCUH) was formed in 2001 when Carlisle Hospitals NHS Trust merged with West Cumbria Healthcare NHS Trust.

4.1.2. The Trust became a University Hospitals Trust in September 2008. It provides services to approximately 327,000 patients predominantly from two sites; the Cumberland Infirmary at Carlisle (CIC) and the West Cumberland Hospital (WCH) in Whitehaven.

4.1.3. There is a birthing centre at Penrith.

4.1.4. CIC and WCH are 39 miles apart and approximately one hour away from each other by road.
4.2. Patient Population, Health Inequalities, Employment and Local Geography

4.2.1. The Sustainability and Transformation Plan (STP) population of West North East (WNE) Cumbria is geographically defined as the districts of:

- Allerdale. 96,471 residents.
- Copeland. 69,832 residents of which approx. 8,400 are in the Lancashire & South Cumbria STP area.
- Carlisle. 108,022 residents.
- Eden. 52,630 residents.

4.2.2. WNE Cumbria represents approximately 65% of the wider Cumbria population.

4.2.3. The population density is 80% lower than the national average and travel times to a GP are twice the England average.

4.2.4. Overall the health of the local population is not as good as in other parts of the country with high rates of obesity and smoking. In WNE Cumbria there is a high rate of almost all diseases compared to the national average and other similar areas.
Life expectancy within WNE Cumbria varies by almost 20 years between the areas where people live longest and those where life expectancy is shortest\(^1\).

4.2.5. By 2020 the total working age population of WNE Cumbria may fall and almost a quarter of all the people who live in WNE Cumbria are likely to be over 65 years old\(^2\). The health and social care needs of this growing elderly population will increase demand for health and social care services.

4.2.6. The major occupations and employers in the WNE Cumbria include tourism, the NHS, agriculture and the nuclear industry, namely Sellafield Ltd at Whitehaven. Sellafield is one of the two largest non-governmental employers in West Cumbria along with BAE Systems at Barrow-in-Furness. There are potential planned developments in Sellafield and BAE but the exact timing and details are unclear. In order to attract high calibre candidates to new employment opportunities in the area, high quality medical provision is likely to be a key factor.

4.2.7. Geography is an important factor. Despite being a largely rural county, many live in smaller, dispersed communities, which are geographically isolated from each other. Travel time and public transport are important issues for the local community. The A595 which links CIC and WCH is a single carriageway de-trunked road and weather or traffic problems could easily exacerbate travel times between the two main sites.

4.2.8. However, weather conditions are unlikely to impact on care overall, as the North West Ambulance Service NHS Trust (NWAS) has contingencies to move patients and mountain rescue can be utilised.

4.3. **Current Configuration of Maternity Services**

**Cumberland Infirmary Carlisle (CIC)**

4.3.1. The CIC at Carlisle is a Consultant Led Unit and has approximately 1700 deliveries per year. A 24/7 epidural service was only recently established in CIC in 2015.

4.3.2. There is a dedicated list each day for one elective caesarean section, with the potential for two sections on Wednesdays.

**West Cumberland Hospital (WCH)**

4.3.3. The WCH at Whitehaven is a Consultant Led Unit and has approximately 1250 deliveries per year. A 24/7 epidural service was established in WCH in 2001 and anaesthetic antenatal clinics were established in 2009.

4.3.4. There is a dedicated list every Tuesday and Thursday morning for elective caesarean sections with the potential of two planned per day, and on average three elective caesarean sections are carried out per week.

4.3.5. The Penrith Birthing Unit delivers approximately 50 women per year (2016) and transfers to the CIC, which is 23 miles away.

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\(^1\) The Future of Healthcare in West, North & East Cumbria, Public Consultation Document

\(^2\) The Future of Healthcare in West, North & East Cumbria, Public Consultation Document
4.4. Proposed Reconfiguration of Maternity Services

4.4.1. NHS England and NHS Improvement established the West, North and East Cumbria Success Regime in September 2015. It was comprised of local NHS partner organisations, including the NHS Cumbria Clinical Commissioning Group. One of the key aims of the Success Regime was to develop a sustainable clinical strategy that recognised the significant challenges in relation to the sustainability of clinical services, financial sustainability and workforce recruitment and retention.

4.4.2. The first iteration of the Clinical Strategy was produced in March 2016 and was then widened into a full range of proposals. A formal public consultation on the proposed changes ran from 26 September 2016 to 19 December 2016.

4.4.3. The options included in the public consultation are shown below:

<table>
<thead>
<tr>
<th>Maternity services options</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant-led unit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Alongside midwife-led unit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Standalone midwife-led unit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Antenatal and postnatal care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Special care baby unit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>


4.4.4. The preferred option as set out in the public consultation document was Option 2.

4.4.5. Respondents indicating a preferred option did not support the Consultation document preferred option for Maternity services.

4.4.6. The independent analysis of the public consultation found that only 57% of the respondents to the questionnaire indicated a preference against any one of the options, which were consulted upon. There was strong support for Option 1 over the other two options amongst the 57% of respondents indicating a first preference.

<table>
<thead>
<tr>
<th>Maternity services options</th>
<th>First preference</th>
<th>Second Preference</th>
<th>Third Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>85%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Option 2</td>
<td>11%</td>
<td>79%</td>
<td>7%</td>
</tr>
<tr>
<td>Option 3</td>
<td>4%</td>
<td>7%</td>
<td>88%</td>
</tr>
<tr>
<td>Total responses by preference</td>
<td>2097 (100%)</td>
<td>1479 (100%)</td>
<td>1463 (100%)</td>
</tr>
</tbody>
</table>


4.4.7. The view was consistent across all localities, age, gender and whether respondents have young children, but the strongest support for Option 1 came from respondents in West Cumbria.
4.4.8. A very significant number of responses rejected all three options, and put forward the view that they would like to retain the current model at the West Cumberland Hospital.

4.5. Recommendations for Maternity Services

4.5.1. As part of the decision-making process, the NHS Cumbria Clinical Commissioning Group held two Clinical Workshops to facilitate a consensus clinical view of the maternity options in light of consultation responses. The conclusion was to test further opportunities for transformational change that could support Option 1 but be in a position to implement Option 2 or 3 should Option 1 fail and to proceed on the basis of a collaborative and ‘co-production’ model both to make and to judge progress.

4.5.2. In the case of maternity services, the following recommendations were made:

- To test the viability of Option 1 - Consultant Led Unit alongside Midwifery Led Unit at WCH over a 12 month period.

- If option 1 is not proven to be desirable or sustainable then implementation of Option 2 - Consultant Led Unit alongside Midwifery Led Unit at CIC with standalone Midwife Unit at WCH at the end of the 12 months.

- Whilst testing Option 1, prepare for Option 2 by implementing a Midwifery Led Unit (MLU) in Whitehaven alongside the Consultant Led Unit, in order that the MLU can be audited as if it was freestanding.

- Implement option 3 if option 2 (Midwifery Led unit at WCH) is not deemed to be safe.

4.5.3. At the time of this report, the NHS Cumbria Clinical Commissioning Group Governing Body approved the recommendations for six service areas, although Cumbria County Council’s Health Scrutiny Committee voted to refer the CCG’s decision over maternity services to the Secretary of State.

4.6. Next Steps

4.6.1. Working in partnership through the STP governance mechanisms, NHS Cumbria Clinical Commissioning Group are tasked with developing a full implementation and delivery plan to enact the recommendations.

4.6.2. A newly formed Implementation Reference Group will oversee the approach to implementation across six service areas subject to public consultation and includes representation from the CCG, Ambulance Service, senior clinicians from the trust, public and patients and GPs. It reports to the West, North and East System Leadership Board (WNE SLB).

4.6.3. The Maternity and Paediatrics Independent Review Group will report to the CCG Governing Body and WNE SLB. It agrees the milestone criteria for sustainability, including timescales, reviews achievement of criteria and makes recommendation to the CCG Governing Body on likely sustainability of each option.

4.6.4. Implementation Groups will report to the Implementation Reference Group and develop implementation plans relevant to each service area.

4.6.5. The RCoA Invited Review report will be delivered to the Executive Medical Director and will feed into the above structure.
4.6.6. The West North & East Cumbria STP will continue under a System Leadership Board towards an Accountable Care Organisation.

4.7. Summary and Drivers for the Report

4.7.1. In summary, with a population of 327,000, approximately 3000 deliveries per year and a predominantly rural area where many live in smaller, dispersed communities, geographically isolated from each other, the challenges of providing a continuing high quality maternity service in CIC and WIC are:

- Ensuring Patient Safety
- Recruitment and retention of a high quality workforce
- Patient access to services

4.7.2. Patient safety is of paramount importance, although it should be noted that the challenges facing NCUH are not unique and many small units in remote and rural areas face similar concerns. Services need to be designed to maximise safety whilst being realistic about the availability of skilled and experienced staff.

4.7.3. Recruitment and retention of medical staff remains a challenge across West, North and East Cumbria and future plans will be contingent on recruiting new staff and retaining the existing anaesthetic workforce.

4.7.4. Access remains an important issue to patients. If services were only provided at CIC, 45% of patients in WNE Cumbria would need to travel over 60 minutes to access services and 20%, over 90 minutes (NCUH STP plan 2016-2021).

4.7.5. Finally, any change is set in a background of distrust from some members of the public, who have already seen services removed from WCH and are of the opinion that not enough has been done to protect and maintain their local services.

4.7.6. The Review team’s focus throughout this report is to present staffing recommendations for each of the reconfiguration options that allow maternity and intensive care services to be delivered safely, while taking into account the needs of the local population. Our recommendations will be underpinned by evidence-based standards, namely GPAS and GPICS and professional judgment, and will consider the practical implications for commissioners and healthcare providers.

5. Process of the Invited Review

5.1. The review team were selected through the RCoA Invited Review process. There were no conflicts of interests noted.

5.2. Prior to the onsite visit, the review team were provided with some preparatory documents and data. A full list of documents provided (pre and post visit) is included in Appendix 1.

5.3. The RCoA compiled the programme for the visit, which included a combination of face-to-face meetings and ‘walkabout’ sessions on each site. The review team specified in advance the expected attendees at each session, the details of which are included in the programme. (Appendix 2). The Executive Medical Director was available throughout both days and attended the majority of face to face meetings.

5.4. Two teleconferences were also conducted in advance of the Invited Review to understand the background to the review.
5.5. The Review team’s report is based on the information and data provided to the review team, meetings with staff at both sites and the professional expertise and experience of the review team.

6. **Visit Structure**

6.1. The visit took place over two days on 11 and 12 April 2017. The first day was spent at CIC.

6.2. The Executive Medical Director gave an introductory presentation to the reviewers detailing the challenges facing the trust. This was an interactive session where the visiting team were able to establish, in reasonable detail, the background leading up to the invited review.

6.3. There followed presentations from the Clinical Director for Anaesthetics and the Clinical Director for Obstetrics. The reviewers met with the Medical Director of NHS Clinical Commissioning Group, the Clinical Director for ICU, Director of Midwifery and the previous Obstetric Anaesthesia Lead.

6.4. Other attendees included lead midwives and a clinical risk manager.

6.5. The review team later went on an accompanied walkabout to maternity services and ICU and spoke to staff members on the ward.

6.6. The final session was with the Medical Directors and Managers and included the Chief Executive Officer.

6.7. The second day was spent at WCH. A Consultant Obstetrician, Consultant Anaesthetist and Clinical Director for Intensive Care each gave presentations.

6.8. Other attendees included the Obstetric Anaesthesia Lead, an ICU consultant, Director of Midwifery and the Midwifery Manager at WCH.

6.9. After lunch the review team went on an accompanied walkabout to maternity services and ICU and spoke to members on the ward, including the Lead Midwife.

6.10. A final open session was held with consultant representatives from Accident and Emergency (A&E), paediatrics and other members of the anaesthetic and ICU team.

6.11. The Review team would like to thank all participants for their engagement with the invited review process, their openness and their time.
7. Workforce and Staffing

7.1. Cumberland Infirmary Carlisle (CIC)

7.1.1. CIC is a provider of acute hospital services and is part of North Cumbria University Hospitals NHS Trust (hereafter referred to as the trust).

7.1.2. It is a general hospital providing 24-hour A&E with Trauma Unit status, consultant-led maternity services and a special care baby unit. It has 500 beds (410 of which are inpatient). It provides elective and emergency surgical services for paediatrics, major trauma, orthopaedics, general surgery, ICU, PCI cardiology, gynaecology, ENT, urology, vascular and oncology.

7.1.3. The trust’s Anaesthesia & ICM Department is one department, functioning over both CIC and WCH sites. There are 32 substantive consultants, who deliver a mixture of site specific and cross-site working. While new contracts will include cross-site working, currently cross-site working is only well developed for intensive care and few anaesthetists work cross-site. All intensivists are anaesthetists too.

7.2. CIC Anaesthesia Services

7.2.1. CIC has a 12-bed maternity unit across ten rooms.

7.2.2. At CIC 12 consultants cover the theatre and obstetrics rota and 8 consultants cover the ICU rota. 5 consultants cover elective work without on-call and there are 3 trust specialty doctors, 6 to 8 trainees, rotating from the Northern School of Anaesthesia and 2 to 4 MTI doctors. Presently, there is 1 locum consultant and 2 locum specialty doctors.

7.2.3. There are three Advanced Critical Care Practitioners (ACCPs) who work across both CIC and WCH sites.

7.2.4. There is an elective session each day (morning) for elective caesareans. An epidural service was only recently introduced in 2015 and is available 24/7. There is anaesthetic cover outwith the morning session from a middle grade with a consultant covering the CPEOD list and obstetrics, with separate ICU cover.

7.2.5. Out of hours, there are two non-resident consultant on-call rotas; one for theatre and obstetrics, and the other for intensive care. There are two doctors, one anaesthetist for theatre and obstetrics in addition to an ICU resident, who may be a non-anaesthetist.

7.2.6. There is a resident team for theatres, with two on-site ODPs to midnight, and a resident second team in the evening and weekend daytime. A second on-call team is available from 20:00.

7.2.7. The two tier resident rota will generally allow availability of anaesthetists for Category 1 emergency caesareans out of hours, but there may be some cases where immediate anaesthesia availability is not possible, needing to be provided by the non-resident consultant coming in from home.

7.2.8. CIC has a shortfall of two consultant anaesthetists for the theatre and obstetrics rota and two specialty doctors to cover the two tier resident 1:8 rota (allowing some variability with trainee allocations).

7.2.9. There has been recent successful recruitment to both Consultant and Specialty Doctor vacancies to support the two tier resident rota.
7.2.10. There is an obstetric anaesthesia antenatal clinic every two weeks at CIC and an Obstetric Anaesthesia Clinical Lead with dedicated SPA.

7.2.11. There is a cell salvage service, but this is only available for selected planned elective patients.

7.2.12. There is no dedicated obstetric theatre at CIC, and a lack of a second theatre presents some physical constraints at CIC. There is also a lack of recovery area in the labour ward.

7.3. CIC Intensive Care Services

7.3.1. The ICU is a 9-bedded unit with one cubicle. Beds are used flexibly for HDU and ICU and can manage level 2 and 3 patients. They are staffed for four level 3 and four level 2 beds and there is a 24/7 consultant led rota.

7.3.2. Total admissions for CIC in 2016 were 728 down from 780 in 2015.

7.3.3. There are two consultants on daytime working at CIC drawn from both sites. There is a total of 10 consultants each doing five ‘hot’ weeks, 8 of which are CIC based and 2 WCH based. This system promotes aligned clinical care across both ICUs. PA payment is provided within job plans to cover travel.

7.4. West Cumberland Hospital (WCH)

7.4.1. WCH is a provider of acute hospital services, serving mainly the Whitehaven and West Cumbria areas. It is a general hospital providing 24-hour A&E, a consultant-led maternity unit and special care baby unit. It has 239 beds (191 of which are inpatient). It provides surgical services for paediatrics (SSPAU and low acuity overnight), low risk trauma, elective orthopaedics, elective general surgery and ICU. Emergency surgery is already directed to CIC.

7.4.2. Non-planned orthopaedic and general surgical patients have been transferred directly to CIC since 2013-14.

7.5. WCH Anaesthesia services

7.5.1. WCH has six maternity beds, two of which are designated for the Maternity Led Unit.

7.5.2. 5 consultants are on the on-call rota. There is 1 consultant with elective sessions without on-call and 1 chronic pain consultant without on-call. This equates to 5.8 WTE of whom 5.3 WTE contribute to the on-call rota.

7.5.3. There are 5 SAS and specialty doctors, 2 long-term locum consultants and 3 long-term locum specialty doctors. There are no anaesthetic trainees at WCH.

7.5.4. WCH has a shortfall of 2.5 consultant anaesthetists and 3.5 specialty doctors and is more reliant on locum doctors than CIC.

7.5.5. There has been no successful substantive Consultant Anaesthetist recruitment in five years. A single specialty doctor has been recruited over the past four years, but was not retained and has now left.

7.5.6. There is a dedicated list every Tuesday and Thursday morning for elective caesarean sections with approximately three elective caesarean sections conducted per week. Approximately 75% of the elective cases on the Tuesday list are performed by the consultant obstetric anaesthetic lead, with the remainder of
cases spread between the other consultant and middle grade staff, with SAS anaesthetists performing approximately 30-40% cases. There is an epidural service available 24/7. There is anaesthetic maternity cover outwith the elective caesarean section list from a middle grade with supervision usually from a theatre-based consultant.

7.5.7. There is no dedicated duty anaesthetist available for obstetrics at WCH during the day and no dedicated obstetric theatre team at WCH outside of the two elective caesarean section lists. In the event of an emergency in the labour ward, theatre team staff would need to be pulled from elective operating sessions.

7.5.8. Out of hours, there is a single non-resident consultant on-call for obstetrics, ICU, theatres, A&E and acute pain. First on-call is a resident specialty doctor on a full-shift who covers ICU and obstetrics in addition to calls from A&E and any emergency theatre provision. There is a third on-call hybrid non-resident anaesthetic rota to cover multiple emergencies. It was noted that the third on-call had been introduced in January 2015 and used 12 times in 2016, mostly to cover transfers. 4.5 consultants and 4.5 specialty doctors contribute to the third on-call rota.

7.5.9. There is a resident theatre team with a second on-call team from home.

7.5.10. There is an obstetric anaesthesia antenatal clinic, four weekly at WCH which is approximately 80% full, allowing for the potential insertion of an urgent referral. The Obstetric Anaesthesia Clinical Lead has a dedicated SPA session. The obstetric consultants maintain close liaison with the obstetric anaesthetists regarding high-risk patients.

7.5.11. There is no cell salvage on the WCH site.

7.5.12. There is no CEPOD list at WCH. If there were an ectopic pregnancy, the patient would have to wait for a daytime list if stable, be treated during weekday normal operating hours by interrupting an elective list if unstable, wait until the evening emergency list is available or be transferred to CIC if an emergency.

7.6. WCH Intensive Care Services

7.6.1. The ICU is a 6-bedded unit with cubicles that can be used flexibly. It is staffed for 5 ICU beds and can be used flexibly for HDU and ICU patients. There are two consultant intensivists who provide the majority of day time cover on the unit, and who partake in the CIC rota during their ‘hot weeks’.

7.6.2. Admissions have stayed at approximately 300 patients annually, 95% of which are medical with the occasional obstetric patient. WCH ICU provides a valuable back up to acute and ward medicine and the ED. There are some transfers to CIC for upgrade of care.

7.6.3. There is one consultant for daytime working at WCH. Approximately 20% of weekdays are delivered by non-intensivists.

8. Clinical Governance

8.1. There is a quarterly obstetric anaesthesia meeting where difficult cases are discussed. There are two appointed Anaesthesia Governance Leads who are responsible for incident reporting. Governance reports are fed into the divisional and departmental meetings, which happen every four to six weeks. Incident reporting is discussed at weekly meetings.
8.2. There was evidence of multi-disciplinary morbidity and mortality meetings at CIC, which feed into the Obstetric Risk Group, but the meetings are not currently minuted. Bi-annual multi-disciplinary team meetings were established at WCH from 2000 and ran until 2012, but have now been lost.

8.3. An obstetric anaesthetist at WCH regularly takes part in multi-disciplinary ‘labour ward forum’ meetings, when the rota will allow but attendance at these meetings is not ring-fenced.

8.4. For Intensive Care, there are monthly cross-site meetings, morbidity and mortality meetings, audit activity and a monthly newsletter.

8.5. There was evidence of clinical audit at both sites but it was reported that an increased focus was needed and an audit midwife should be appointed.

8.6. On-going audit of patient satisfaction with the obstetric anaesthesia service is undertaken via the listening service and the midwifery team.

8.7. There is regular access to CPD opportunities across both sites and anaesthetists contribute to the education and update of midwives, ODPs, anaesthetic nurses, ACCPs and obstetricians.

8.8. There are well-established tertiary channels for paediatrics, cardiac and neurosurgical referrals.

9. Recruitment and Retention of Workforce

9.1. There is an under supply of consultants and an over reliance on locum doctors at WCH. WCH is dependent on two locum consultants for the provision of their anaesthetic service. There has been a focus on making locums substantive which would also have the benefit of financial savings, but this has not proved successful.

9.2. Therefore, the relatively high cost of locum support adds to the fragility of the current arrangements and creates more uncertainty. Furthermore, given that the trust has already seen the number of locum physicians providing general ward based medicine reduced due to high costs, there is the possibility that the number of locum anaesthetists may also be under threat.

9.3. Factoring in expected consultant retirements over the next five years, the current staffing arrangements are highly likely to be unsustainable at the WCH. CIC has a more favourable prediction.

9.4. The requirement to attract obstetric anaesthetists who can manage the ICU makes recruitment more difficult. That said, more imaginative ways of recruiting and retaining staff are being considered.

9.5. A representative from the NHS Cumbria Clinical Commissioning Group reported that there is both public criticism and adverse comment from some staff that insufficient effort has been made to explore alternative means of provision and recruitment for anaesthetic staffing.

9.6. Nationally, fill rates for anaesthesia in the Northern School of Anaesthesia have been consistently low for the last few years. Fill rates for ST3 training posts in 2016 were 68% up from 55.56% in 2015 but lower than the average UK fill rate of 89% in 2016. UK wide approximately 70% of trainees stay in their specialty training school area for consultant
posts. Thus a poor fill rate will reflect in a smaller pool staying in the Northern Local Education and Training Board (LETB).

9.7. The trust has successfully trained three ACCPs who work across sites and two more are due to start training at Northumbria University. These ACCPs will support the intensive care consultants in delivery of medical care.

9.8. There is a developing partnership with the trust and University of Central Lancashire (UCLan) Medical School in Preston to train physician associates and provide joint posts with clinical service and teaching components. This is part of the trust’s plan to develop a ‘composite workforce’, that includes ACCPs and physician associates under consultant supervision. However this will have no impact on delivering anaesthesia services.

9.9. 43% of midwives are over 50 and more retirements are expected in one or two years.

9.10. However, the introduction of midwifery-led pathways may attract more midwives.

9.11. It has proved difficult to recruit experienced ODPs and scrub nurses and a presence in local schools and colleges may result in improved recruitment. There have been no problems with recruiting recovery nurses although they have tended to be recruited from the existing ODP workforce, and hence depleting the supply of ODPs.

10. Obstetric Anaesthetic Statistics and Maternity Dashboard

10.1. The review team were presented orally with data and the trust maternity dashboard for the period April 2016 to February 2017. Analysis of the maternity dashboard plus previously supplied data reveals that:

10.1.1. At CIC:

There are estimated to be 518 caesarean sections in the last year with approximately 40% of these being elective, thus an average of four electives per week.

Of all these LSCS cases the general anaesthesia rate appears to be around 10%.

The epidural in labour rate is 8.5%.

10.1.2. At WCH:

There are estimated to be 300 caesarean sections in the year with approximately 50% being elective, thus an average of three electives per week.

Of these LSCS cases the general anaesthesia rate appears to be around 13%.

The epidural in labour rate is around 13%.

10.1.3. Delays performing emergency caesareans:

The review team were informed that at CIC, eight cases were delayed over the stipulated time in 2016, only one attributable to anaesthesia. At WCH, there were no reported anaesthetic delays.

10.2. The RCoA publication ‘Raising the Standard: A Compendium of Audit Recipes 2012’ provides standards for anaesthetic care including obstetric anaesthesia. From the raw data from both sites it appears that the general anaesthesia rate for caesarean sections overall at both sites is at the higher end of UK practice. In addition the epidural rate on both sites is below national averages. It must be stated that the introduction of the epidural analgesia service at WCH in 2001 and CIC in 2015 are decades behind the majority of obstetric units in the UK.
10.3. It must also be stated that this review could not investigate the quality of anaesthetic care provided and that the above figures from NCUH do not demonstrate substandard practice, just a benchmark against national practices.

11. Patient Satisfaction

11.1. The review team was advised about the invaluable contribution made by the Labour Ward Forum and its lay members. This group had been involved in the consultations and it is hoped that full opportunity would continue to be given to this forum in continuing development of proposals within the trust.

11.2. There are generally high levels of patient satisfaction in intensive care, maternity and Special Care Baby Units across the two sites. The figures below are illustrative of the levels recorded by ‘Patient Perspective Ltd’ and ‘Patient Experience’ who carried out customer service surveys based on ‘Friends and Family’ and ‘Two Minutes of your Time’ systems. The survey results are selective but are indicative of the general responses given and were all undertaken within the last few months. One WCH patient commented that she would not wish to travel to Carlisle every day.

<table>
<thead>
<tr>
<th></th>
<th>ICU</th>
<th>Maternity</th>
<th>SCBU</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIC</td>
<td>91% (30/12/16)</td>
<td>100% (19/12/16)</td>
<td>100% (12/12/16)</td>
</tr>
<tr>
<td>WCH</td>
<td>100% (29/11/16)</td>
<td>100% (13/3/17)</td>
<td>97% (17/3/17)</td>
</tr>
</tbody>
</table>

Source: Friends and Family and Two Minutes of your Time results; NCUHNHST 2016/1017

11.3. The figures above represent the percentage of respondents who would be highly likely or likely to recommend the Ward to their families and friends.

11.4. With regards to transfers between WCH and CIC, Patient Perspective Ltd carried out a patient survey in 2016 with the following headline results:

- 89% said they were given an explanation of why they were being transferred
- 87% said their relative, friend or carer was informed of their transfer
- 63% said they were told how long they should expect to wait for the transfer vehicle to arrive
- 72% said they did not experience pain during the transfer
- 63% said they felt the transfer made it difficult for visitors to come and see them in hospital
- 70% said their overall experience of transfer was either excellent, very good or good
- 89% said their care at CIC was either excellent, very good or good
- 77% of patients surveyed said they would highly recommend the WCH Maternity Ward to friends and family (Patient Experience Survey Nov 2016)
- 69% said they felt staff took into account how far they lived from the hospital when planning discharge
- 93% said their overall care from the trust was excellent, very good or good.

11.5. Whereas the results look satisfactory on the whole, the implication is that up to 30% of transferred patients who responded did not find the transfer either excellent, very good or good. Similarly, although 72% said they did not feel pain during the transfer, the implication is that 28% of the respondents may have felt pain. Whether this pain was different from their pain had they not been transferred is not known.
11.6. There are a number of comments from responding transfer patients who were negative about the journey; and about the impact on visiting relatives. An action plan has been drawn up to pursue the various issues raised but it appears unlikely that all matters could ever be entirely resolved.

12. CQC report

12.1. NCUH was one of the Keogh 14 Trusts and was the longest trust in Special Measures, exiting in March 2017 following publication of the CQC report.

12.2. Overall, the trust has maintained a rating of ‘requires improvement’ but the recent CQC inspection in December 2016 saw the majority of services being rated as “good”.

12.3. Intensive care has been rated as good in all domains in both units.

13. Patient and Public Considerations

13.1. During the two-day visit the Review team did not hear from patients and the public directly, but the review team were very aware of the strength of feeling amongst the community from previous reports and following discussions with staff at both sites.

13.2. West Cumberland Hospital was the first wholly-new hospital to be built since the NHS was founded and opened in 1964. This was because of the relatively remote nature of the town and probably took into account the national investment in nuclear power installations existing and proposed in the area along with the additional development expected to be provided.

13.3. In the event, such expansion did not happen in the way expected and there is still some doubt about additional energy investment in the area. The result was that there has been a hospital offering a higher order of facilities than might otherwise have been the case. The creation of a trust further reinforced the status of WCH. Meanwhile CIC was an early adopter of the PFI method of improving hospital development comprising a scheme with some drawbacks that still present serious problems for the now combined trust for both hospitals. For example, CIC construction did not include adequate fire protection. This defect now has to be rectified with financial and operational issues for the trust, including possible temporary transfer of some services to WCH during remedial works.

13.4. The review team was presented with evidence of the strong community spirit in both areas, but particularly in Whitehaven and the more remote villages, which look to WCH for services. The net result is that the town has not expanded as much as might have been expected; the hospital has lost a number of services and generally is not able to retain or recruit substantive consultant staff across many specialties.

13.5. The apparent decline in status and services offered, have been perceived as a betrayal of local residents. Against a background of favourable ‘Friends and Family’ and ‘Two Minutes of your Time’ customer service ratings, the latest proposals affecting maternity and intensive care services are seen as the latest and most serious reductions in service at WCH.

13.6. The Review team heard that some patients already travelled an hour to reach Whitehaven from the south and therefore are two hours away from Carlisle.
14. Options appraisal

14.1. The remit of the Invited Review was solely to determine the anaesthetic and critical care implications of the reconfiguration options for the future of maternity service with an emphasis on patient safety.

14.2. One of the specific questions the Review team were asked to address was whether national standards as detailed in GPAS could be adapted in circumstances where a remote community with, typically, a relatively small number of deliveries could safely maintain a consultant-led unit.

14.3. For each of the options the Review team have considered in detail the staffing requirements needed to provide a safe service to maternity and intensive care. The Review team has also considered if non-medical practitioners as requested in the terms of reference could deliver any of the service provision.

14.4. The Review team also considered the impact of options 1 & 2 (and hence 3) on ICM provision since the anaesthetic department provides all of the medical intensive care staffing, and hence anaesthesia and intensive care services are intrinsically linked.

Option 1 - Maintain two CLCs at CIC and WCH with alongside midwife-led units

14.5. This option will leave the trust with two small consultant-led units (approximately 1700 deliveries at CIC and 1250 at WCH).

14.6. There does not appear currently to be a dedicated obstetric anaesthetist for the labour ward at either site, (as mandated in GPAS for an Obstetric Population 2017, Requirement 1.2) with the exception of the weekday morning session at CIC. On the occasions when a consultant or specialty doctor is allocated to carry out elective caesarean sections, they are still not immediately free to attend a maternity emergency. Typically, out of hours, the anaesthetist covering the labour ward is also allotted to theatres at CIC, or in a general emergency capacity covering, inter alia, ICU, calls to the Emergency Department (ED), occasional gynaecology emergency cases and resuscitation at WCH.

14.7. While no measurable (or only measured since the introduction of the maternity dashboard in 2014), maternal or neonatal morbidity or mortality has arisen from this, there are signs that lack of a permanent anaesthetic presence has had an impact, as indicated by the high general anaesthetic rate for caesarean sections at both sites (approximately 10% at CIC and 13% at WCH), the fact that there was no epidural service at all at CIC until 2015, and the still very low epidural rate at CIC (but rising) and moderately low rate at WCH (12% in 2016).

14.8. Additionally, opportunities for maintenance of skills and for training are very limited by the low number of interventions at each site. There is an approximate average of 1.4 Caesareans (including elective) and 0.3 epidurals per day at CIC, and 0.7 Caesareans and 0.4 epidurals per day at WCH. These may be reduced even further by the current development of ‘alongside’ MLUs at both sites.

14.9. The challenge with units of this size is that a permanent consultant-led anaesthetic presence is still necessary to maintain maternal and neonatal safety. A 24/7 anaesthetic presence on the labour ward means, critically, that Category 1 Caesarean sections (which can come out of the blue) can be achieved within 30 minutes from decision to delivery. But also, it means that anaesthetists can participate in planning activity, predict problems, see antenatal and postnatal patients, take women to theatre for perineal trauma or retained placenta, and act rapidly in major obstetric haemorrhage or other emergency (not to mention audit, quality improvement, clinical governance, teaching and training).
14.10. On a unit delivering fewer than 2000 women, this will, as can be seen, mean significant periods of clinical inactivity between moments of high intensity.

14.11. In order to ensure the presence of a consultant anaesthetist on the labour ward in these circumstances, as mandated by GPAS standards, the trust might consider the idea of them attending in time for the morning labour ward round, then staying in a suitable co-located office space where, when not needed, they could be fulfilling some of their CPD or other activities compatible with being physically on the labour ward. Allowance could be made for this by allocating this time as part-PA, part-SPA. If elective sections are taking place, then this should, of course, be full direct PA time, and they should then be supported by a second, obstetric-competent anaesthetist to cover the labour ward. At other times, they could be a sole presence.

14.12. In order to maintain skills, the elective section sessions could be allocated in turn to all anaesthetists who are expected to work on the labour ward as part of their duties.

14.13. CIC should consider ‘packaging’ their elective sections (currently one each day and two on Wednesdays) into two or three sessions, as already planned by WCH. To achieve an effective cross-trust service, this could be achieved by having caesareans on Mondays, Wednesdays and Fridays at CIC, and Tuesdays and Thursdays (as current) at WCH.

14.14. All future medical staff providing maternity related services should have job plans that cover cross working on both sites.

14.15. Out-of-hours, whoever is covering anaesthesia on the labour ward also needs to be immediately available. This might be achieved at one or both locations by covering ICU with ACCPs (not an easy option in itself) and ensuring that the A&E’s department and the cardiac arrest team were aware that the anaesthetist’s first priority would always be the maternity unit. However difficulties can be predicted if the sole resident anaesthetist is also providing anaesthesia in theatre.

14.16. Consideration will need to be given to the availability of the obstetric theatre team. Theatre team staff are often pulled from other operating lists, hence increasing risk on those surgical lists and causing potential delays in obstetrics.

**Impact on Intensive Care Medicine**

14.17. Safe staffing will need to be maintained on the Intensive Care Units in both sites. Currently CIC and WCH combine to provide a daytime dedicated intensivist service and this is a model that could be developed to include weekend daytime working.

14.18. The trust would need to add a second resident in WCH. This could be an ACCP for ITU, as long as there is an airway-trained person also resident within WCH. The on-call team would then comprise the current resident anaesthetist as the airway trained person and a second resident who could potentially be non-airway competent such as an ACCP, clinical fellow or staff grade. The blurring of the silo roles typically used in larger hospitals is an inevitable part of ensuring remote and rural hospitals remain safe.

14.19. The GPICS standard specifies dedicated cover to ICM. However, a dedicated ICM consultant on-call rota at WCH is unlikely to be a practical development. Current evidence supports that as long as there is dedicated daytime intensivists cover, night-time cover would not seem to confer extra advantage. Therefore the benefits of the proposed model of on-call, despite not meeting the current GPICS standard, outweigh the risks of having no critical care support. However to ensure this model remains safe, the trust should maintain or develop, where necessary the following aspects of team working:
- Daytime cover with dedicated intensivists
- Structured handover between daytime and night-time staff
- Continued CPD, including morbidity and mortality meetings for all participants involved in the provision of ICM. This could be by joint meetings, possibly video-linked, with CIC
- Continued strong links with CIC ICU and some job plans that involve working on both sites where feasible
- Availability of advice from Intensivists where needed, including transfer if required
- Clear, easily accessible guidelines for important aspects of care. This is important for standardising care at all times of day and night.

Positive aspects of Option 1

- Full choice for all parturients, including midwifery-led or consultant-led care at each site. The exception would be the recognised high-risk patients from WCH as WCH is a ‘de-risked’ unit. Planned delivery at CIC is currently the option for these mothers.
- Achieves the desired outcome of the local community in Whitehaven.
- No need for long transfer to CIC of women originally planning to deliver in the WCH MLU but who then need their care escalated to a CLU.

Negative aspects of Option 1

- Need for considerable financial investment in order to get anaesthetic cover up to an acceptable level.
- Difficulty and current failure in recruiting and retaining anaesthetists, particularly in view of the unattractiveness in working in a very small maternity unit with low activity rates and the need to retain three on-call rotas. More imaginative recruitment strategies would be required and a good recruitment campaign may help. More cross-site working will need to be put in place.
- Maintaining the status quo of running two very low volume consultant units with insufficient activity to maintain the skills required for obstetric anaesthesia.
- Risk associated with immediate theatre staff availability for obstetrics remains.
- Risk of other surgical specialty support urgently available on site being absent remains. There is no surgical support after 5pm and at weekends at WCH.
- Risk associated with the one resident anaesthetist being first on-call for obstetrics, A&E and ICM remains.
- Low delivery rate negatively impacts on junior anaesthetic training at CIC.
- High costs of attracting locums upon which obstetrics and gynaecology and anaesthetics both depend (enhanced salaries for obstetrics and gynaecology were mentioned).
- Feasibility of medical obstetrics at WCH continuing with five locum and no permanent consultant physicians in post. (This is only ‘not a problem’ with option 3 unless antenatal cross-cover in medicine is instituted, for example, diabetic care).
- Risk remains of the anaesthetist being responsible for neonatal resuscitation during a caesarean section. Less likely for this occurrence on a single CLU on CIC.
- Given all the historic, geographical, financial and recruitment issues, there may be still uncertainty over the longer term future of a CLU at WCH. This uncertainty will continue to hang over the community and be a further threat to recruitment.

Additional staffing required for Option 1

Taking a standard consultant job plan as six sessions plus on-call commitment, the following additional sessions would be needed:

- 8 sessions at WCH at consultant level (1.25 WTE)
- 5 sessions at CIC at consultant level (0.83 WTE)
Option 2 - CLU with alongside MLU at CIC, stand-alone MLU at WCH

14.20. This should result in an estimated 400-500 women booking for maternity-led care at WCH, with 2400-2500 booking at CIC, either midwifery or consultant-led. Approximately 40-100 women would probably need to be acutely transferred annually between WCH and CIC, usually in labour and by dedicated ambulance, with a journey time of approximately one hour.

14.21. There would be no anaesthetic input into the MLU at WCH, and no requirement for an anaesthetist to be involved in transferring to the CLU at CIC, a task that would be undertaken by midwives. Resident anaesthetic cover out-of-hours could then be provided to ICU and A&E by a single resident anaesthetist, and second on-call by a non-resident single consultant.

14.22. With an increased number of deliveries at CIC, a full-time labour ward anaesthetist would be justified, and this individual’s increased workload would provide better opportunities for training and skill maintenance. As per national guidelines, this should be at consultant level during daytime working hours.

14.23. Elective caesarean sections could all be delivered at CIC, requiring up to five added dedicated consultant or equivalent sessions weekly. Equally – although more controversially – some or even all straightforward elective caesarean sections could still be done at WCH. The latter suggestion would need discussion with paediatric services to ensure appropriate provision of caesarean neonatal resuscitation.

14.24. A dedicated rapid-transfer ambulance with a paramedic would need to be immediately available for urgent maternity transfers from WCH to CIC. The Review team were informed that this is achievable.

Positive aspects of Option 2

- There would still be a facility for women who preferred to deliver in Whitehaven, albeit for low-risk women only.
- Antenatal and postnatal care for women needing or wanting consultant-led care could still be delivered at WCH, with travel to Carlisle only needed for delivery.
- Economies of scale and centralisation of the service at CIC would mean optimum use of a scarce anaesthetic resource, with better opportunities for training and skill maintenance.
- Assuming that emergency gynaecology moved with the obstetricians to CIC, then there would be no need for an out-of-hours resident theatre team at WCH, with occasional surgical demand managed by a non-resident on-call team instead.
- There would be no interruption of elective surgery to provide theatre staff for emergency Caesarean sections.
- A single resident anaesthetist could provide out-of-hours support for ICU, resuscitation and A&E at WCH.
- Recruitment and retention of Consultant anaesthetists with an interest in obstetrics would be more likely than now at CIC due to the increased maternity workload.
- Increased opportunities for training in obstetric anaesthesia at CIC at core, intermediate and higher level due to higher number of deliveries.

Negative aspects of Option 2

- Women from the Whitehaven area having to deliver a long way from home if they want or need consultant-led care.
- Potentially added risk to mothers and babies during long transfer in labour from WCH MLU to CIC CLU (this risk has not, however, been quantified).
- Not what the local community currently served by WCH wants.
- Plans needed for potential need for second obstetric theatre availability at CIC.
There is a lack of recovery area in the labour ward and patients are taken to the main theatre ward. There is no maternity HDU.

Additional staffing required for Option 2

Taking a standard consultant job plan as six sessions plus on-call commitment, the following additional sessions would be needed:

- 0 sessions at WCH
- 5 sessions at CIC at consultant level (0.83 WTE)

Option 3 - CLU with alongside MLU at CIC, no delivery unit at WCH

Positive aspects of Option 3

- There would be an increased number of deliveries at CIC, which would make consultant obstetric anaesthesia posts more attractive and recruitment and retention of consultant anaesthetists more likely.
- Increased opportunities for training in obstetric anaesthesia at CIC at core, intermediate and higher level due to higher number of deliveries.
- Economies of scale and centralisation of the service at CIC would mean optimum use of a scarce anaesthetic resource, with better opportunities for training and skill maintenance.
- Women from WCH would not have to be transferred during advanced labour from the MLU.
- Antenatal and postnatal care for women needing or wanting consultant-led or midwifery-led care could still be delivered at WCH, with travel to Carlisle only needed for delivery.
- Assuming that emergency gynaecology moved with the obstetricians to CIC, then there would be no need for an out-of-hours resident theatre team at WCH, with occasional surgical demand managed by a non-resident on-call team instead.
- There would be no interruption of elective surgery to provide theatre staff for emergency Caesarean sections on the WCH site.
- A single resident anaesthetist could provide out-of-hours support for ICU, resuscitation and A&E at WCH.

Negative aspects of Option 3

- Women from the Whitehaven area having to deliver a long way from home.
- It is estimated that between two and three women per day will need to travel to CIC for their delivery. It is likely that many of these would be in early labour and would need to travel further than the current distance to WCH.
- Not what the local community currently served by WCH wants.
- If there were no deliveries on the WCH site at all, this may impact on the ED and preclude in-patient paediatric surgery, which is currently provided.
- Plans needed for potential need for second obstetric theatre availability at CIC.
- There is a lack of recovery area in the labour ward and patients are taken to the main theatre ward. There is no maternity HDU.

Additional staffing required for Option 3

Taking a standard consultant job plan as six sessions plus on-call commitment, the following additional sessions would be needed:

- 0 sessions at WCH
- 5 sessions at CIC at consultant level (0.83 WTE)

Intensive care provision and emergency theatre cover at CIC seem adequate.
15. Other Points

15.1. Options 1 and 2 should allow for local obstetric anaesthetic clinics for high-risk patients, in keeping with the maintenance of consultant-led antenatal care at WCH in option 2. This is currently achieved with one clinic every two weeks at CIC and one every month at WCH.

15.2. The current system for non-resident anaesthetic out-of-hours cover at WCH appears to be arduous and is unlikely to be sustainable in the long run. One of the advantages of option 2 is that it would allow the current ‘third on-call’ anaesthetic rota to be dropped.

16. Other Considerations

16.1. While it is not appropriate in this review to explore in detail the arrangements for paediatric provision, the review team did note that the paediatric service appears to be dependent on a continued obstetric presence at WCH. If WCH moves to a Midwifery Led Unit then this is likely to lead to no resident paediatric cover.

16.2. The ED also requires continued paediatric and anaesthetic presence.

16.3. Although strictly outside the remit of this invited review, there are a number of longer-term recommendations, which could be pursued:

- There should be liaison with the local Police service to provide without delay escorts for the most urgent emergency transfers to CIC if Option 1 cannot be maintained.

- Consideration should be given to re-instating national trunk road status to the A595 to ensure good maintenance and a clear route for emergencies.

- Much was made of the close knit community spirit and mutual support of the Whitehaven population. However a review of the hospital websites does not show any information about a community car scheme for transportation of visitors to the hospitals, nor for patients attending clinics or out-patient appointments. There is mention of a car service on a local volunteering website but there is little evidence of an integrated volunteer car service serving CIC from Whitehaven. Some pump priming funding from local authorities could help with establishing (or expanding any existing) such service.

- Notwithstanding current uncertainties over further nuclear energy developments in the area, local authorities should use development-related powers to raise more local funds for resourcing, particularly at WCH to support higher levels of patient safety whatever option is pursued.

16.4. As a further recommendation, the Review team suggest that a national study should be undertaken by the relevant national bodies, NHSI and Royal Colleges, which looks at how services can be delivered in remote and/or rural areas, taking into account patient safety issues. This study should build on the published report, Acute Care in Remote Settings: Challenges and Potential Solutions, published by the Academy of Medical Royal Colleges and The Nuffield Trust.

16.5. Such a study would not inform the urgent issues requiring resolution at WCH, but would assist other Trusts with similar issues in the future.
Appendix 1 Information Sources and Reference Documents

A 1.1 The following standards apply to or are referenced in the review


A 1.2 The following documents were provided by the trust:

- Latest CQC reports
- Sustainability and Transformation Plans
- Clarification of Public Consultation Decision
- Staffing, recruitment and retention data
- Last 6 months staffing rotas
- General data on hospitals and workloads
- Out of hours provision for surgery trauma medicine
- Appraisal and governance overview
- Details of mortality and morbidity reviews
- Minutes from NHS Cumbria CCG meetings
- Serious incident data
- Maternity dashboard data
- Induction information for locum staff
- Patient questionnaire and feedback
- Caseload data
- Minutes from the Maternity Services Liaison Committee
- List of Guidelines and departmental protocols
- Details of ITU transfers
- Results from Patient Experience Transfers Survey
- Self-review against GPAS Obstetric recommendations
- Self-review against GPICS recommendations
- Copies of CIC Intensive Care Newsletters
- Maternity News Magazine
Appendix 2

Onsite Review Agenda

SERVICE INVITED REVIEW
North Cumbria University Hospitals NHS Trust

On-site Review Agenda

Practical requirements:
- Dedicated and secure meeting room during the review to be provided by host trust
- Refreshments and lunch provided as required
- Computer that has hospital intranet access, with a large screen, to view policies and documents
- Greeting on arrival.
- All relevant staff have been advised of the review
- A staff member will be escorting the team at all times

DAY ONE (11th April) – Cumberland Infirmary, Carlisle

09.30 – 10.00 Arrival, Briefing and Housekeeping
- The reviewers will arrive at the hospital and be greeted by member of staff.
- The lead reviewer will give an introduction and briefing of the remit of the invited review.
- The objectives for each section of the review will be briefly clarified.
- Opportunity to highlight any changes to be made to the programme. Adjustments to be made accordingly.
  
  Expected attendees: Executive Medical Director, Clinical Director for Intensive Care, Others from the department are also welcome to attend

10.00 – 11.30 Presentation from host department
The host department to provide a presentation to the review team. Presentation slides can be used. Please include structure, staffing, facilities and recognised issues.

  Expected attendees: Executive Medical Director, Clinical Directors

11.30 – 11.45 Reviewers Discussion and Refreshments
The review team will use the time to discuss the morning session. This will present the hosts with an opportunity to make necessary arrangements for the afternoon sessions.

Please provide a dedicated meeting room or area where food/drink can be consumed and private discussion can take place

Expected attendees: Review team only

11.45 – 13.00 Classroom session dedicated to Maternity Services
The host department to provide a briefing to the review team of the Maternity services. Presentation slides can be used. Please include structure, staffing, facilities and recognised issues.

The review team will like to meet with the obstetric staff during this session for an informal discussion. The host department to ensure staff are made available to attend this session.

Expected attendees: Executive Medical Director, Obstetric staff (including midwives, anaesthetists, trainees, SAS doctors)

13.00 – 13.30 Reviewers Discussion and Lunch break onsite
The review team will have lunch on-site and use the time to discuss the morning session. This will present the hosts with an opportunity to make necessary arrangements for the afternoon session.

Please provide lunch onsite in a dedicated meeting room or area where food can be consumed and private discussion can take place

Expected attendees: Review team only
13.30 - 14.45 Accompanied walkabout to Maternity Services
The review team will make their way around the Obstetric Unit. Please make sure there is someone available to accompany the group. There will be no requirement to observe patients.
*Expected attendees: Executive Medical Director, Obstetric lead*

14.45 – 15.30 Accompanied walkabout to Intensive Care Unit
The review team will make their way around the Intensive Care Unit. Please make sure there is someone available to accompany the group. There will be no requirement to observe patients.
*Expected attendees: Executive Medical Director, Clinical Director for Intensive Care*

15.30 – 16.00 Reviewers Discussion and Refreshments
The review team will use the time to discuss the morning session. This will present the hosts with an opportunity to make necessary arrangements for the afternoon sessions.

Please provide a dedicated meeting room or area where food/drink can be consumed and private discussion can take place
*Expected attendees: Review team only*

16.00 -17.00 Medical Director, Managers and open forum
Room to be made available.
These meetings last into the early evening to allow those finishing lists the opportunity to attend.
*Expected attendees: Medical Director, Clinical Director and Managers working in the department/any member of staff to drop in and speak to members of the review team about the hospital*

Day one at the site will conclude

18.30 Reviewers’ Meeting
Reviewers will discuss the afternoon session separately. Information gathered during the afternoon session will inform decisions about which areas to look at the following day.
*Expected attendees: Review team only*

DAY TWO (12th April 2017) – West Cumberland Hospital, Whitehaven

08.00 – 08.15 Arrival, Briefing and Housekeeping
- The reviewers will arrive at the hospital and be greeted by member of staff.
- The lead reviewer will give an introduction and briefing of the remit of the invited review.
- The objectives for each section of the review will be briefly clarified.
- Opportunity to highlight any changes to be made to the programme. Adjustments to be made accordingly.
*Expected attendees: Executive Medical Director, Clinical Director for Intensive Care, others from the department are also welcome to attend*

08.15 – 09.30 Classroom session dedicated to Maternity Services
The host department to provide a briefing to the review team of the Maternity services. Presentation slides can be used. Please include structure, staffing, facilities and recognised issues.

The review team will like to meet with the obstetric staff during this session for an informal discussion. The host department to ensure staff are made available to attend this session.
*Expected attendees: Executive Medical Director, Obstetric staff (including midwives, anaesthetists, trainees, SAS doctors)*

09.30 – 10.45 Classroom session dedicated to Intensive Care Services
The host department to provide a briefing to the review team of the Intensive Care Unit. Presentation slides can be used. Please include structure, staffing, facilities and recognised issues.

The review team will like to meet with the ITU staff during this session for an informal discussion. The host department to ensure staff are made available to attend this session.
Expected attendees: Executive Medical Director, Clinical Director for Intensive Care, Intensive Care staff

10.45 – 12.00 Accompanied walkabout to Maternity Services
The review team will make their way around the Obstetric Unit. Please make sure there is someone available to accompany the group. There will be no requirement to observe patients.
Expected attendees: Executive Medical Director, Obstetric lead

12.00 – 12.30 Reviewers Discussion and Lunch break onsite
The review team will have lunch on-site and use the time to discuss the morning session. This will present the hosts with an opportunity to make necessary arrangements for the afternoon session. Please provide lunch onsite in a dedicated meeting room or area where food can be consumed and private discussion can take place.
Expected attendees: Review team only

12.30 – 14.00 Accompanied walkabout to Intensive Care Unit
The review team will make their way around the Intensive Care Unit. Please make sure there is someone available to accompany the group. There will be no requirement to observe patients.
Expected attendees: Executive Medical Director, Clinical Director for Intensive Care

14.00 – 15.30 Medical Director, Managers and open forum
The review team will like to meet with the medical director and managers during this session for an informal discussion. The host department to ensure staff are made available to attend this session.
Expected attendees: Medical Director, Clinical Director and Managers working in the department/any member of staff to drop in and speak to members of the review team about the hospital including paediatricians

15.30 – 17.00 Reviewers’ feedback and debrief
The review team and the host will reconvene to talk about the review. Recommendations may be made.
The host will feedback to the review team about their experience of the day. The review team will debrief, outlining what the next steps will be.
Expected attendees: Clinical Director, Medical Director, department leads (if applicable), anyone else from the department who would like to attend

IMPORTANT NOTICE: The review team will treat any information gathered during the on-site review with professionalism and the necessary level of confidentiality. The review team are obliged to raise any serious failings that they find to the Trust/Board/Hospital medical director, or as otherwise directed by Good Medical Practice.