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NCAT review

To: Cumbria PCT Closer to Home and
North Cumbria University Hospital Trust

Date: 8 March 2011

Venue(s): Penrith Community Hospital
North Cumbria University Hospitals, Carlisle

NCAT Visitors:

Dr Chris Clough, Chair of NCAT
accompanied by Dr Mike Cheshire, Medical Director NHS North West

Introduction:

This visit was planned as part of the requirements for meeting the recommendations for the NCAT report dated 21-9-10 and the need for NCAT to review the progress made by Cumbria PCT and North Cumbria University Hospitals Trust (NCUHT) in response to the conclusions from that report.

Documents Received:

North Cumbria Reconfiguration Plan Interim Clinical Strategy dated 5-2-11
Eden Assessment Service Operational Policy
Minor Injury Unit Policy Draft 1 – February 2011
Activity Data
- Alston MIU
- Keswick MIU
- Maryport MIU
- Penrith MIU

Accident & Emergency Attendances Summary
CPC Referrals by Source 17 January-27 February 2011

Programme for visit – see attached

Discussion

The main purpose of the visit and review of submitted information was to make a judgement on how the PCT and North Cumbria University Hospitals Trust had responded to the NCAT conclusions.

Firstly I would like to congratulate the PCT and Trust on their response to the NCAT report and a big thank you to all the staff who I met during the visit. Everyone I talked to showed a huge commitment to their patients and their organisations. All staff spoke very knowledgeably about how they approached the care of patients and had a sophisticated understanding of the difficulties posed by meeting the needs of a

rural population. What I witnessed were well-run units both at Penrith Community Hospital and the North Cumbria University Hospitals. I have taken each of the previous conclusions and the responses in turn.

1. *The Closer to Home strategy can be strongly supported but Cumbria PCT needs to establish whether the present model is both affordable and of high quality.*

   The plans that the PCT and Trust have developed to work together with primary and secondary care, particularly those for the development of minor injuries and the acute services are impressive and I would strongly support their implementation. The affordability issues still remain to be resolved; the PCT is presenting plans on 31 March. Both trusts, as part of the turnaround processes, are working together to ensure financial affordability. Thus a major caveat here will be whether the agreed plans are affordable and can be fully implemented. If not new plans for clinical services will need to be developed. If this occurs I have agreed with the SHA to undertake a further, possibly desktop, review.

2. *Community hospitals can support both urgent care and minor injuries units. Minor injuries units need to work in partnership with local emergency medicine acute providers to maintain standards of care and workforce competence.*

   There are now plans in place to move towards shared governance of urgent and emergency care. The PCT and acute trust should ensure there is continued working between primary and secondary care to make sure these links are strengthened and that shared governance does result.

3. *Community hospitals can deliver high quality inpatient care. This should be directed at intermediate care and palliative care. Intermediate and palliative care are active forms of care management enabling discharge to home or elsewhere, and needs to be supported by elderly care, palliative care and rehabilitation specialists who, although traditionally employed within secondary care, could be beneficially employed within the community or primary care.*

   I heard that a palliative care consultant is now involved with management of patients at the end of life admitted to the intermediate care facilities. Additionally that plans were being developed to ensure that elderly care consultants would be involved in intermediate care, for instance performing wards rounds and developing care plans within community hospitals. It is important that both trusts recognise there are enormous benefits to be gained by specialists from both primary and secondary care working together to develop common care pathways. Progress is being made in this direction.

4. *The plans to build a new hospital to replace ageing and failing old hospital buildings at Whitehaven can be supported. However the plans for the use of the hospital must be determined on the health needs of the population of Whitehaven and beyond. Whilst Cumbria PCT has been broadly supportive of the plans for development of the new hospital, there has been little thinking about what the clinical model of care should be and hence the configuration of services placed at Whitehaven. Thus whilst there have been some early discussions about how emergency care can be provided, there have been little recent discussions about other services such as maternity,*

acute medicine and surgery and paediatrics, and how these can be delivered by the acute trust from both sites.

Since the NCAT visit there has been a substantial amount of work done by the two hospitals to ensure there are single clinical strategies and development of single clinical services. Clinicians and others have been meeting regularly to agree on the clinical strategy. This is described within the interim clinical strategy document.

The concept of "one hospital two sites" can be strongly supported. Presently it has been agreed that consultant led and delivered services would continue on both sites for maternity, acute medicine, surgery and paediatrics. Whilst it is not entirely clear what rotas would support the working practices on both sites, and whether this would result in different patterns of working during the daytime and night time (rotas of trainees and consultant staff were not available), clearly both sites are strongly committed to making this model work.

Thus I judged that progress had been made to develop more collaborative working across the two sites, but it is too early to say whether the outcome from this work will lead to sustainable models on both sites. I was reassured by the Medical Director at NCUHT that the consultants involved would do everything within their power to make this model work. There must be some risk, particularly in the areas of obstetrics, paediatrics and acute medicine, that this doesn't produce a long term model of care. Nevertheless, with this high level of commitment, my conclusion was that this work should continue and every chance given to those involved to make it happen.

5. *A clearer model of care for North Cumbria needs to be developed in partnership between the commissioning GPs and PCT with the main acute trust, ie North Cumbria University Hospitals. This should look at services that are provided across the trust so that sustainable high quality models of care can be provided at both the main hospital sites of the trust.*

   I have concluded that this has been provided by the interim clinical strategy, and confirmed with my discussions with staff.

6. *There was little evidence of working across the trust (North Cumbria University Hospitals;); one might have expected more evidence of single clinical management units across the trust to help better liaison to support sustainable services. Whilst one recognises the lengthy travel times between Whitehaven and Carlisle, other trusts with similar dispositions of services in England have managed to create single clinical services. The present situation is one where there appears to be two hospitals providing separate services rather than a single trust. Working as a single trust should help the work that needs to be done to create fairer services for all in North Cumbria*.

   As above, I was impressed that a significant amount of work had been done since the NCAT visit to ensure that the two hospitals work as one.

7. *Service change should be led by clinicians working in partnership with their patients and the public and supported by strong management. Presently there was little*

evidence of this going on in many specialty fields. Thus while the plans for the new hospital may produce greater efficiency, both clinical and financial, it essentially was not providing a new model of care, but more of the same. There must be a question as to whether this model of care is sustainable in the long term. I would have concerns about the long term provision of obstetrics with an obstetric led unit and of acute inpatient paediatrics with this model because of the workforce required to provide a consultant led and delivered service and the ability to recruit and retain consultants and middle tier staff. New models need to be considered. Whilst I am not in a position to support alternate models, and it is conceivable that all concerned stakeholders will agree that the existing status quo must prevail, there must be an open and transparent debate and agreement of the right way to proceed. The final agreed model may mean that additional resources are diverted to Whitehaven, in which case the public will need to understand that this will mean less resources for healthcare services elsewhere with the trust.

I continue to have concerns about the long term provision of an obstetric unit on the Whitehaven site and I heard that the NCUHT obstetricians may have similar reservations. Nevertheless, the Trust and PCT is committed to this model and we now need to wait and see whether a sustainable model does emerge.

8. *Acute medical care planned at the new hospital needs to be sustainable and safe. Whilst there is little evidence presented that this is presently not the case, the unit needs to look to the future and ensure that patients presenting acutely ill at Whitehaven are able to access the best of modern forms of care. If not, patients will need to be stabilised at Whitehaven Hospital and transferred elsewhere, or ambulances will need to ensure that patients are transferred immediately to the appropriate care centre. Thus the acute trust needs to work through the consequences of providing modern care in a number of disorders such as stroke, acute coronary syndromes and trauma. Additionally working through what this may require to provide the support for patients with acute respiratory difficulties and acute bleeding problems from the upper and lower gut. This will require the support of high dependency and intensive care units but also specialist care such as thrombolysis in stroke and acute coronary intervention. Trust-wide clinicians need to lead clinical workstreams centred on these exemplar and other diagnostic groups.*

I have formed the opinion that emergency care and acute medical care at the Carlisle Hospital site was of good quality. Clearly there are more difficulties in providing sustainable services on the Whitehaven site. The plan for an emergency floor at Whitehaven, with medical staff from both primary and secondary care working together, does appear to be a safe, sustainable model and can be supported. The clinical workstreams are working through the consequences of working in this new way and the need for patients to be transferred from the Whitehaven site to the Carlisle site when necessary.

The key consideration here will be whether safe and sustainable critical illness services can be delivered on the Whitehaven site, that is the provision of anaesthetic cover, high dependency and intensive care units. If they cannot, that will have a significant impact on the types of patients that can be managed on the Whitehaven site. It would mean diverting patients who are acutely ill, using ambulance services and public awareness campaigns, and the ability to stabilise patients at Whitehaven Hospital prior to transfer. It is important that this work is done quickly, as the provision of critical care services is pivotal to the delivery of most acute hospital services.

I was pleased to see the work that had been done on developing the care pathways in stroke, acute coronary syndromes and a better awareness of the trauma strategy. Similarly the NCUHT has now common rotas in gastroenterology and other areas. The Trust will need to continue to keep an oversight of this work and build on it.

9. *Surgery and orthopaedics do not have a cohesive plan for delivery across both sites. The provision of acute and out of hours surgery and orthopaedics will require cross site arrangements to ensure that both sites can deliver a safe service in and out of hours. There may be opportunities with reconsidering the configuration of services to split acute and cold site surgery/orthopaedics to the benefit of the trust and patients*

   The clinical workstreams are developing appropriate strategies for orthopaedics in relation to the trauma centre and for NCUHT to become a trauma unit. The trauma unit will be based on the Carlisle site thus the fallout from this will be to work out what orthopaedic cover will be required on the Whitehaven site as both sites will not be trauma units.

   Similarly plans for surgery cover on both sites are underway. Acute surgery will not take place out of hours on the Whitehaven site.

Conclusions

North Cumbria PCT and North Cumbria University Hospitals NHS Trust have responded appropriately to the NCAT report and together have made substantial progress, in particular in developing a clinical strategy. Whilst it would have been preferable to see these plans fully developed and supported by workforce plans and rotas at both sites, I fully understand the difficulties in doing this and accept this must be an iterative process with constant testing of the robustness of the clinical plans that emerge. This will be an example of learning from action and, from a pragmatic point of view, does seem to be a sensible way forward.

This is a difficult time with great uncertainty for NCUHT. There is a requirement for the Trust to identify a partner to advance plans for the achievement of Foundation Trust status in keeping with the Secretary of State's intent that all hospital trusts achieve foundation status by 2013. It is possible this could result in different plans emerging for the future of the trust and its two sites. Hence it would seem appropriate for any clinical strategy at this point to have some flexibility.

When reviewing the Secretary of State's criteria it can be judged that these plans do now have the support of their local general practitioners. The clinical strategy can be supported and the plans continue to support patient choice. the coming months will prove to be fraught and tricky as the PCT and Trust together try to see their way through some difficult decisions. The coming together of the PCT and the acute trust to develop clinical work streams has given me the assurance that both trusts are doing all they possibly can to ensure that patients in North Cumbria receive high quality services now and sustainable for the future.

The crucial deal breaker with all these plans will be the financial position – there will be scrutiny of these plans to decide whether they are affordable. If the judgement is that they are not, both the PCT and acute trust will need to return to the drawing board. The agreed financial envelope will then lead to a different set of priorities and may again lead to revisiting some difficult decisions. Thus whilst I can say that the

clinical model is acceptable (with certain provisos as above) all bets will be off if the work commissioned through the turnaround process or the SHA's review of that work makes the judgement that these plans are not affordable. If restructuring is required – in particular a revision of services provided on the two hospital sites either in the face of financial uncertainty or a breakdown in clinical commitment to these ongoing plans – a further NCAT review will be required to ensure the clinical safety and quality of any new arrangements.

Recommendations

1. The PCT and NCUHT proceed with their clinical strategy and response to NCAT's input.

2. NCAT is kept informed of progress and is asked to review if significant changes in the clinical plans emerge following review of the PCT and NCUHT financial position.

3. If there are continuing concerns about the safety and sustainability of the Whitehaven site NCAT should again visit, focussing on Whitehaven Hospital.

North Cumbria University Hospitals NHS
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Programme for the Visit of Chris Clough & Mike Cheshire

Tuesday 8th March 2011

9.00am	Welcome. Lonsdale Unit, Penrith Hospital. Irving Cobden. Medical director
9.15am	Penrith Community Hospital (and community services). Visit and discussion with Helen Jervis, GP Clinical Lead, Justine Anderson, Locality Manager and Nigel Maguire, Chief Operating Officer.
10.30am	Travel to Carlisle
11.30am	Clinical Strategy and Clinical Leadership. Discussion with Mike Walker, Medical Director, NCUHT and Irving Cobden, Medical Director, NHS Cumbria. Medical Directors Office. Pillars Building. Cumberland Infirmary
12.30pm	Lunch, Mike Walker's Office
1.00pm	Meet Caroline Griffiths, Director of Planning. Mike Walkers Office. Cumberland Infirmary, Carlisle.
1.15pm	Meet Dr Denis Burke (Associate Medical Director Medicine). Mike Walkers Office. Cumberland Infirmary, Carlisle.
2.00pm	TOUR OF CIC hosted by Barbara Monk (Divisional General Manager, Medicine). To include; meetings with senior clinicians from A&E (Mr Foxworthy), Medicine, Radiology and Stroke.
4.45pm	Meet back up with Dr Denis Burke (in OP clinic)
5.30-6.30pm	Plenary discussion with Medical Directors and Chief Executives, NCUHT and NHS Cumbria, Board Room, Cumberland Infirmary. Carole Heatly, Mike Walker and Denis Burke NCUHT Sue Page, Irving Cobden, John Howarth NHS Cumbria