Report to Trust Board of Directors

Date of Meeting: 25 March 2014
Enclosure Number: 11
Title of Report: Medical Director’s Report
Author: Dr Jeremy Rushmer, Medical Director
Executive Lead: Dr Jeremy Rushmer, Medical Director
Responsible Sub-Committee (if appropriate): Safety & Quality Committee

Executive Summary:
The report provides further information to Board members on the following issues:

a) Mortality: Board are asked to note the changes in the mortality framework implemented in Jan 2013 and the analysis of HSMR trends and their relationship to changes made.
b) Quality Panels: A report is provided of the Quality Panels held so far and the targets and actions agreed by the team.
c) Cancer Services Update: The report is presented for you to note the current performance and recommended actions from support services business unit. Whilst the trust position has improved it is unlikely that the 85% target will be met. The team are currently tracking individual patients to ensure that delays in complex pathways do not affect outcome. Please note the planned actions to recover the trajectory. Please note the ongoing risks and mitigations.
d) Trauma Peer Review: The Medical Directors met with Mr John Wayman to review data collated since the changes made to General Surgery on temporary safety grounds. It was agreed that overall, whilst detailed data was insufficient to recommend a separate consultation on making the move permanent there was sufficient evidence of improvement to suggest that the changes should not be reversed at this stage. The MDs agreed to take this discussion to the North Cumbria Strategic Programme Board to advise on next steps with regard to consulting as part of the 5 year planning process.
e) OOH GI bleeding: NCUH have had a response from CCG medical Director confirming our recommendations to move High Risk GI bleeding out of hours from the last week in March.

f) Dermatology: The Board is advised of issues raised in regard to GPSI’s raised by the MDT that are being investigated by CCG and the Cancer Network.

g) Medicine WCH: The medicine consultant report is noted for February. No locum replacements for the CT trainees have been identified. Recruitment strategies have been implemented and a General Manager is supporting the filling of the Trust rotas. This is under review on a weekly basis.

h) Education & Training: HENE visited in February where they received an update on Core Medical Training at WCH. Support is provided to the remaining trainees but HENE are keeping the situation under close review and that if suitable protection to the trainees is not forthcoming they will also be removed. This is under review on a weekly basis.

i) 7 Day Working: Sir Bruce Keogh and NHS England have proposed to introduce a plan to roll out seven day services across the NHS by the end of 2016/17. The report summarises the ten new clinical standards that have been developed with a supporting evidence base, as agreed with the Academy of Medical Royal Colleges. A process to produce a Trust plan is in place and is to be completed by early summer. There has been significant improvements in the last 12 months but there is more to do.

<table>
<thead>
<tr>
<th>Board Assurance Framework Reference:</th>
<th>Strategic Priority 1</th>
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<tbody>
<tr>
<td>Risk Rating (high, medium, low risk) and any recommended changes to risk rating:</td>
<td>High</td>
</tr>
<tr>
<td>Compliance, legal and national policy regulatory requirements:</td>
<td>CQC Outcomes NHS Standards Deanery Standards</td>
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</table>
**Financial Implications:**

| To be confirmed. |

**Actions required by the Board:**

| To approve: | Discussion and decision |
| To note: | Where the Board is made aware of key points but no decision required |
| For information: | For reading and consideration and for discussion by exception only |

The Trust Board is requested to note this report.

**Data quality:**

| Source: | Trust internal information |
| Validated by: | Dr Jeremy Rushmer |
| Date: | 18/3/2014 |
1. **INTRODUCTION**

The Medical Director’s report provides Board members with an update on key clinical issues, as follows:

a) **Mortality Update**

Trust HSMR has continued to improve. The data here for 2013 Q2-4 are not re-based (the rebased data is appended). Changes made in the last year are noted including data from NWAS on patient transfers from WCH to CIC.
The steep blue line represents in the graph below shows a drop in HSMR from 120 in 2011 to 80 based on the 2011 algorithm, ie a reduction of 30%.

I have written to all staff informing them of the changes to the trust Mortality Framework consulted on at February CPG. The weekly emails have started from the review team. The lessons learned will be updated on the intranet: http://nww.staffweb.cumbria.nhs.uk/safety-and-quality/Mortality-and-Reducing-Harm/Mortality-and-Reducing-Harm.aspx

There are three main outputs from each of the reviews which are completed:

- The case requires escalation and declared as a Serious Incident
- The case requires discussion and review at the MDT specialty level M&M meeting
- The case requires discussion and review at Clinical Policy Group

The reviews also identified any issues for Primary Care/Community Team which may need escalating or fed back to GP / Primary Care colleagues.

We have a master database set up to record each of the outputs and we report on these each month to the Safety and Quality Committee.

b) Quality Panels Update

To note: after intial meetings with 11 teams, as part of the quality panel process, a brief description of progress made. 3 teams have not yet attended and will be allocated a date by 1/5/2014: Gynaecology, Maternity, Paediatrics

The program cycle for the 14 teams will repeat from 1/5/2013 to 1/1/2014

Vascular Care - 20/11/2013
Clear KPIs described for vascular surgery in Everyone Counts- performance within expected limits. Awaiting report from Prof Stansby after review after
joining NE network for advice on strategic direction. Review arrangements for repatriating patients to WCH.
Long discussion re improvement opportunities for repatriation to WCH, where specialist nurses remained.

**Stroke Care - 20/11/2013**
Discussed – Thrombolysis & collection of national Stroke data. Results have not improved since 2013. Difficulties providing a stroke unit with consultant assessment on both sites noted, will discuss alternative strategies. Full Implementation of the early discharge team awaited.

**Trauma & Orthopaedics - 06/12/2013**
Agreed to discuss with DoN CIC ward nursing leadership in order to improve scorecards.
Issues relating to ward reconfiguration and lack of beds, site plan for CIC and how that impacts on T&O, causing cancellations of elective surgery.
Focus on reporting best practice #NOF now service reconfigured.

**Head & Neck - 18/12/2013**
**Improvement priorities :-**
1) Antibiotic Prescribing;
2) Measuring and reducing complication rates;
3) Reducing infections.

**Respiratory - 08/01/2014**
Talked about WCH service and the respiratory recruitment strategy and plan for 6 consultants. Plan integrates the service across both sites.
**Improvement priorities :-**
1) Focus on improving the number of core respiratory ward nursing staff. Percentage working on each shift. Specific nature of work as agency unsuitable unless specialty area of experience.
2) Staffing - aim to have right number of staff per shift;
3) To audit adherence to pneumonia care bundle and acute COPD and compliance.

**Cardiology - 08/01/2014**
CCU at WCH runs well, highly effective ward. Staffing on heart unit being pulled to other areas, concern regarding this and staff development.

**Improvement priorities**
1) Score more patients coming in as emergency admissions using TIMI Risk score.
2) To implement the Heart Failure bundle as agreed;
3) Reduce Mortality by using the bundle.

**Upper GI Surgery - 05/02/2014**
**Improvement priorities**
1) Improve Patient flow - inappropriate location of patients;
2) Increase day case of lap cholecystectomy
**Gastroenterology - 05/02/2014**

Concerns regarding senior medical cover and pathway GI Bleed.

**Improvement priorities**

1) CIWA training and pathway;
2) Staffing - substantive staff appointments.

**Elderly Medicine - 27/02/2014**

Conversation about medical staffing at WCH, Locums and Geriatric input.

1) Reduction in harm from falls;
2) Reduction in use of Catheters due to the number of incidents relating to this.
3) Staffing, improve nurse attendance on ward rounds as agreed.

**Urology - 17/03/2014**

The 2 key priorities for quality improvement identified were:-

- Recruitment of an additional urology consultant to support reduction in waiting list
- Development of robust outcome measures for individual consultants.

**Dermatology - 19/03/2014**

The panel asked if the team has regular meetings. The team confirmed that weekly meetings are held in the department. These meetings are becoming more formal to reflect the structure required to ensure safety and standards. Dr Hassan (AH) confirmed that Directorate meetings had diverged due to difficulty in the whole team being available. AH has advised he will attend the Dermatology weekly meeting.

Mortality acknowledged to be less applicable to Dermatology, however one patient in ‘observed Number of Deaths to be identified.

Report dashboard showed DMPU as compliant where data available.

No serious incidents were declared in the period for Dermatology.

Ian Donnan (ID) took an action to get information from Clinical Audit regarding national audits, and assign a lead to each, including National Skin Cancer Audit.

**Improvement priorities**

1. Reduction in access times (18 weeks)
2. Reduction in new to review ratio
3. Continued monitoring against national standards for skin cancer.

**c) Cancer Services Update**

The Cancer Services team has taken many steps to manage cancer performance and mitigate the risks and concerns highlighted by the 2013 Peer Review programme. This report provides assurance on the actions
taken to improve performance and updates on actions prior to reporting to the National Peer Review Programme by the end of March 2014.

Cancer Targets

This report details the first eight months of Trust performance against the 62-day cancer standard, the level of performance required for all cancers is 85%. It presents an analysis of the breaches incurred and identifies the individual pathway actions that are required in order to address poor performance.

Current Trust Performance

In the recent quarter the Trust has consistently met the 14-day and 31-day waiting targets but continues to fail in its achievement of the 62-day waiting target.

![62 day target - compliance over time](image)

(Source: Infoflex cancer database)

Individual Cancer Pathway Performance

Analysing cancer pathway performance demonstrates those pathways that are presenting the greatest risk are lower GI, upper GI, gynaecology, urology and lung cancer pathways based on monthly breach activity and total patient activity.
Forecast for Achievement of 62 Day Standard by Tumour Group

The Trust cancer MDTs currently deliver on average 66 “first definitive treatments” to patients per month within 62 days out of an average 83 patients on cancer pathways. In order to achieve the 85% standard, a maximum of 12 breaches can be tolerated per month. Based on current performance and in the absence of wholesale rapid turnaround the 85% standard is unlikely to be achieved for Q4.

There are a number of regular activities that are in place to manage patients that potentially could exceed the 62 day target.

- Cancer Pathway Coordinators and Imminent Referral Coordinators escalate individual patient issues on a daily basis to identify appointment slots and monitor capacity issues and to facilitate patients along the pathway.
- A twice weekly escalation sheet is circulated to OSMs identifying individual patient action needed.
- There is also a weekly PTL (Priority Tracking List) meeting whereby patient level information is reviewed to plan and escalate action.

The focus on individual pathway monitoring, currently resting with coordinators, is gradually transferring to the MDT leadership team to undertake root cause analyses (RCA) for breaches exceeding 80 days and take action to instigate improvements.

Information staff are supporting the Cancer Services team to improve the type and availability of cancer information to support OSMs in prioritising actions.

The table below outlines the required performance by tumour type by month that will enable recovery to achieve the 85% standard for the Trust by the end of Q1 2014/15. As listed above there are five pathways that present a risk due to inconsistent performance, for a variety of reasons, and so presents a challenge in predicting future performance.

<table>
<thead>
<tr>
<th>Site</th>
<th>Target</th>
<th>Dec-13</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
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<tbody>
<tr>
<td>Breast</td>
<td>85%</td>
<td>100%</td>
<td>100%</td>
<td>83%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Gyneacology</td>
<td>85%</td>
<td>71%</td>
<td>57%</td>
<td>100%</td>
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<td>70%</td>
<td>75%</td>
<td>85%</td>
</tr>
<tr>
<td>Head and neck</td>
<td>85%</td>
<td>100%</td>
<td>67%</td>
<td>67%</td>
<td>80%</td>
<td>80%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Lower GI</td>
<td>85%</td>
<td>100%</td>
<td>64%</td>
<td>67%</td>
<td>75%</td>
<td>80%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Lung</td>
<td>85%</td>
<td>67%</td>
<td>50%</td>
<td>40%</td>
<td>75%</td>
<td>75%</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Skin</td>
<td>85%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Upper GI</td>
<td>85%</td>
<td>100%</td>
<td>50%</td>
<td>100%</td>
<td>70%</td>
<td>70%</td>
<td>75%</td>
<td>85%</td>
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<tr>
<td>Urology</td>
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<td>90%</td>
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<td>85%</td>
</tr>
<tr>
<td>Total</td>
<td>85%</td>
<td>91%</td>
<td>72%</td>
<td>80%</td>
<td>82%</td>
<td>83%</td>
<td>86%</td>
<td>89%</td>
</tr>
</tbody>
</table>
The incremental performance required has been attributed based on the current status of performance and the degree to which pathway redesign and investment infrastructure is required. There is a reliance on achievement of 100% compliance in skin and breast tumours though given the sustained performance at 100% over recent months is not an unreasonable assumption. Other tumour site performance is not as consistent and prediction is based on full year average performance.

The plans below describe the steps required at corporate level and within individual MDTs to achieve incremental improvement prior to sustainable achievement of the 62 day target.

**Improvement Strategy**

There is still much to do in engaging the MDT leadership team of Lead Clinician, supported by a lead Clinical Nurse Specialist (CNS) and Operational Service Manager (OSM). A Cancer Operational Group has been convened, the first one held in March with the purpose of operationalising the cancer action plan. In the first quarter 2014/15 the Trust Cancer Strategy Group will re-launch, which is pivotal to achieving strategic involvement and engagement.

An offer of targeted support and in-depth pathway design has been offered to the Trust and, internal agreement has been reached to review urology and histopathology pathways in May 2014. Furthermore, a number of corporate actions identified at the Cancer Operational Group need to take effect to improve business functions of all MDTs including the turnaround of clinic and MDT letters – with the introduction of standards and performance monitoring.

**Improvements by Tumour Sites**

**Lung cancer**

Challenges for reducing the waiting times for referral to first treatment result from the complexity of the lung pathway and the range of diagnostic tests required.

The redesign of the pathway has resulted in an acceleration of diagnostics (straight to test CT with 12 days shaved off pathway). The introduction of EBUS within 3 weeks of referral in North Cumbria, estimating a further 14-day reduction and, subject to access to 7-day turnaround, particularly for CT guided biopsy and head CT scans can be further reduced to 38 days. Lung cancer breaches continue to occur and an audit of the success of EBUS and the monitoring of the local 45 day target is being arranged with the information team.

Local access to radiotherapy or chemotherapy as the first treatment is problematic and improvement in access to oncologists is required. Recent recruitment of a medical oncologist will reduce the need for weekend clinics
staffed by oncologists employed by Newcastle. Further work is underway to improve access to radiotherapy services.

**Lower and Upper GI Cancer**

The North Cumbria element of the upper cancer pathway is elongated, with numerous diagnostics and staging procedures. The surgical element of this pathway is not provided locally due to population size, in line with NICE guidance. For upper GI the transfer point timescales for referral to the Newcastle MDT for patients with hepato-biliary (HPB) cancers is 21 days and for patients with oesophago-gastric (OG) cancers is 31 days. For lower GI improvement is required specifically in the time delay from initial investigation, sigmoidoscopy proceeding to colonoscopy, the current delay is approximately 4 weeks.

The local diagnostic element of the pathways must be reduced to a maximum of 21 days and access to endoscopy, and CT and histology turnaround times continues to be problematic. The OSM responsible for scoping has undertaken a number of actions:

*Scoping lists*

There are current issues with the number of consultant gastroenterologists, one substantive in post as of 6/3/14 across both sites and a substantive post is being advertised.

Increase of endoscopy capacity is required to meet demand, currently there is a shortfall of lists due to combination of nursing or endoscopist availability. A specialty doctor vacancy is being filled and lists have been reconfigured to provide a full day of scoping from 18/3/14. A reconfiguration of the endoscopy nurse rota has enabled the provision of an additional colonoscopy list to commence 3/4/14. Recruitment has commenced for additional endoscopy nurses to enable staffing to full capacity which will allow additional thirty scope lists at CIC, likely to take effect from May 2014.

*Outpatient clinics*

In terms of outpatient clinic space the consultant job plans have been amended to enable an extra two clinics to be established each week at CIC, likely to commence April 2014.

Outside of the control of the Trust is the requirement from the Newcastle MDT to request a CT scan, staging laparoscopy, EUS (examination under ultrasound) before the MDT will make any decision on treatment. It has been noted that patients may be discussed at the MDT on three occasions. EUS is currently undertaken at RVI which is something NCUH should consider developing to reduce the waiting times at front end of the pathway.

**Urology (Prostate) Cancer**

The predominant constraints affecting the prostate patient pathway can be attributed to internal capacity for TRUS (trans-rectal ultrasound). An increase
in biopsy clinic capacity whereby all consultants have been trained to perform TRUS and biopsy and an ultrasound scanner at WCH will improve waiting times for patients on a urology cancer pathway.

The Cancer Network is supporting in the delivery of a urology pathway review in May 2014.

**Gynaecological Cancers**

The main constraint within the gynaecological pathway is the lack of hysteroscopy and biopsy capacity resulting in some patients breaching the 62 day standard before diagnosis is confirmed. Whilst small numbers are referred to the tertiary centre at Gateshead, assessment and subsequent surgery can add a further six weeks to the patient pathway.

The transfer point for patients to the Gateshead MDT is by day 31 which is frequently not achieved, as histology is now undertaken in Gateshead with up to two week delay, and means that patients are referred later than is ideal to the MDT and subsequent breaches are “shared” with the tertiary centre.

A “one-stop” menstrual disorders/post-menopausal bleeding clinic comprising OP hysteroscopy, biopsy (or polyp removed totally as a treatments) and an ultrasound scan is due to start in April 2014 which will reduce the pathway time by several weeks.

Further action to reinstate histological investigation in North Cumbria will be considered during the review of histopathology being undertaken in May 2014 with the support of the Cancer Network.

**Peer Review Update**

The Trust underwent a Peer Review visit in November 2013, the areas assessed were dermatology, acute oncology and radiotherapy services and a number of immediate risks and serious concerns were raised.

The following report provides an update on current actions in place to mitigate the highlighted risks and concerns.

**Local Skin Cancer MDT**

**Immediate Risks**

1. It was reported to the reviewers that MDT decisions were not always followed by the local Model 1 community practitioner(s) affecting patient treatment and potentially outcomes.

A meeting with NHS Cumbria Clinical Commissioning Group was held on 24th Jan 2014 and it was agreed that any issues not in line with the service specification and/or NICE guidance will be raised with the CCG as commissioners. The skin cancer MDT lead, Dr Kim Varma, has taken action
on this and is formally reporting each incident. Dr Varma has raised a serious concern and the Chief Executive immediately requested an independent review by the Cancer Services Network Director. The Trust is formalising its arrangements with the CCG in respect of notification and required action.

2. *The reviewers were not assured that the arrangements for the management of skin cancers in the community are appropriate and clear or that the governance arrangements across the organisations concerned are robust, meaning that issues such as those in the second immediate risk (above) are not being appropriately escalated and effectively addressed.*

NHS Cumbria CCG are accountable for the clinical governance arrangements and the Trust requires further assurance that the GPs will conform to the NICE guidance. The Trust is formalising its arrangements with the CCG.

The Quality Director, NPRP does not intend to formally follow up these issues with the Trust providing all parties involved work together to resolve these matters.

**Serious concern**

The Quality Director, NPRP requires an update by the end of March 2014 on:

1. *This has been a locum led service which has resulted in a lack of leadership, development, governance and clarity for the skin cancer service. This concern may be mitigated by the appointment of a substantive consultant dermatologist who is due to commence December 2013 and is expected to take over as the lead for the MDT from early 2014.*

The skin cancer MDT lead, Dr Kim Varma, Consultant Dermatologist and Dermatological Surgeon commenced on 16 December 2013. Dr Varma is stringently applying NICE guidelines and has improved the MDT leadership and governance through the following:

- MDT process reviewed and improved since the appointment
- Incident forms are being generated regularly for practice outside of the guidance
- Regulatory bodies including CQC and NHS England have been briefed
- Dermatology department and skin cancer MDT have started to be cohesive and unified
- All cases discussed at the MDT are being reviewed monthly
- MDT outcomes communication has been significantly improved
- Histology process is being tightened
- Links with SSMDT at Regional centre is strengthened and functioning
- Audits have started to verify processes
- Effort is being made to appoint further Consultants in Dermatology.
Acute Oncology Service (AOS)

Immediate concerns

1. There is a lack of an metastatic spinal cord compression (MSCC) coordinator service. Patients presenting with MSCC are either referred locally to oncologists or to the spinal surgical team in Newcastle with the decision about who to refer to being made by the admitting team. Out of hours referrals may also go to the oncologists in Newcastle. MSCC cases should have their treatment decided through discussion between specialist clinical advisors in oncology, spinal surgery (and radiology if necessary). This could result in delayed or inappropriate first treatment for MSCC leading to patient harm in some cases.

There is no current MSCC lead, however Helen Roe, Consultant Cancer Nurse has taken a number of actions:

- When a patient is admitted to the Trust with possible MSCC they are referred directly for a MRI scan and to ensure that this is achieved within 24 hours there are now available slots on weekends at CIC.
- The Newcastle team has embedded their MSCC service and the local pathway is currently being developed in collaboration with the Newcastle team. This will ensure that there is specialist clinical advisor discussion about treatment options for patients,
- The pathway will accommodate this discussion both in-hours between the admitting team local oncologist and surgical input from Newcastle. Out-of-hours provision will include both surgical and oncological input from Newcastle.
- The local pathway will also form the audit tool for both evaluating embedded practice (discussion/scan/treatment) and providing data for the Network Metastatic Spinal Cord Compression audit.
- An outstanding action is to implement the Network approved Metastatic Spinal Cord Compression education programme, discussions regarding this are underway.

An update is required by the Quality Director, NPRP ensuring the timely discussion of all MSCC patients by the two, or if appropriate three, specialist clinical advisors by the end of March 2014

Serious Concerns

1. Acute oncology patients do not have the opportunity to be reviewed by a Consultant Oncologist and there are no plans to provide this in the future. Optimum clinical management may be compromised as a result of lack of specialist consultant oncology input.

- The AOS service is currently suspended across the Trust due to current nurse skill-mix. A minimum service will be reintroduced during March 2014 consisting of AOS nurse review of patients within the required 24 hours timeframe following admission (Monday-Friday).
- Patient review will be undertaken by the AOS nurse with support by the oncologists and haematologist who will be available to discuss the management of the patients.
- A plan to provide a fully operational nurse-led service will be produced by 31 March 2014.

2. **There is a lack of identification of staff requiring acute oncology training and no clear plans to address training needs, including consultant medical staff, which may result in patients not receiving timely or appropriate treatment for their acute oncology presentation.**

The AOS e-learning package is currently being developed by the AOS lead and Trust e-learning lead for implementation by May 2014. During this time the AOS lead will continue to deliver AOS face to face training sessions and record attendance.

3. **The patient flagging system is able to identify oncology and haematology patients but details of their condition and treatment are not readily available meaning that admission teams are not accessing appropriate information on their patients.**

Symphony/PAS/iSoft systems highlight to staff when a patient presents on admission that they are a cancer patient of the Trust. These systems are hyperlinked to the RAPA system, which in turn sends an alert to the AOS team.

The Trust informatics team are exploring options to develop links between the cancer database and PAS to enable A&E and admission staff to have access to cancer patient status and treatment plan on admission. The Trust will assess system functionality by 31 March 2014.

An update and robust action plan is required by The Quality Director, NPRP by the end of March 2014.

**Radiotherapy Services Update**

A decision on how future radiotherapy services will be provided in Cumbria is to be made by Spring 2014 in conjunction with NHS England. The proposal made is for a phased approach and we are reaching the end of the initial phase where Newcastle have supported lung and gynaecological cancer pathways. The Trust is a decision on the next phase, by 1 April 2014, regarding the plans for a short term 2-year partnership to ensure resilience and robustness around clinical oncologist cover. The final phase will be a long-term partnership arrangement to support the running of the full service and this decision will have a positive impact on the serious concerns raised and some action completion dates are be reliant on this.
Radiotherapy (General)

A summary of the actions is given below.

**Serious concerns**

1. *The lack of consultant clinical oncology provision has prevented medical staff from providing proactive on-treatment clinical reviews which may compromise the quality or outcome of patient care.*

A Speciality Doctor was recruited in March 2014. Proactive on-treatment clinical reviews will form part of her job plan and her appointment will also release pressure on the existing team to be able to reinstate on-treatment review. Part of the longer term strategy is to train therapy radiographers in on-treatment review.

2. *Staffing levels for therapeutic radiographers and physicists are below nationally recommended levels potentially making the service vulnerable to interruption and placing undue pressure on staff. Whilst the team has developed a business case to address this issue, low staffing levels were also raised at the peer review visit in 2010 and the business case has not yet been approved, meaning there are currently no timescales for resolution.*

The business case has been updated to meet nationally recommended staffing levels and will be re-submitted to EMT as current staffing levels are at least 7 WTE short, based on benchmarking against other two linear accelerator centres and calculated using the WiPT workforce planning tool. However, the date for resubmission will be subject to the decision on partnership arrangement by NHS England as described above.

To support in the mitigation of this concern staffing levels have been risk assessed and updated to the Business Unit risk register. The staffing implementation strategy and workforce plans will be reviewed and updated by the end of April 2014.

3. *The department has not reviewed the relation of clinical target volume to planning target volume despite this being raised as a serious concern at the peer review visit in 2010. This has left the department, over a significant period, having no assurance whether its practice is internally consistent or up to date in this area of safe treatment margins.*

In March 2014 the oncology department recruited a Quality System Manager who will be responsible for commencing audit of set-up uncertainties based on data obtained from on-set imaging. One of the outcomes from this work will be to derive CTV to PTV margins for comparison with current protocol and with the literature. The audit methodology will also be compared with other providers within the NECN and audits will be completed by year end 2014.
4. There is no agreed equipment replacement programme in place for the two linear accelerators that are approaching the end of their useful clinical life potentially leading to service interruptions and patient delays affecting treatment.

The Business Unit Oncology Directorate reconfiguration plan is currently being drafted and the business case for linear accelerators form part of this plan. The key risks to radiotherapy service provision in North Cumbria relate to the timescales due to the protracted lead times for such a replacement and North Cumbria require such clarity from NHS England and the CCG on the preferred way forward.

5. Limited progress has been made to address the poor environment and inadequate patient facilities since the last peer review visit in November 2010. At present there are no changing cubicles, no gowns available for patients and inadequate facilities to accommodate patients who are unwell all of which impacts on patient privacy and dignity.

- The department is currently carrying out a comprehensive review of the space usage and patient flow across the oncology and medical physics departments with a view to making the best use of the current facilities, these findings will be worked into the Business Unit’s Oncology Directorate reconfiguration plan by end of March 2014.
- Patient gown are currently being sourced and will be procured by end of March using charitable funds.
- Layout of department is unsuitable for patients to change into a gown and then have to walk across a public corridor into the treatment room. A screened area inside the treatment room has been evaluated and procurement is underway using charitable funds.
- Unwell patients to be accommodated in a clinic room where they will come under the care of the clinic nurse. Seriously unwell patients would be transferred to A&E. Procedure to be written into QART documentation.

6. There is no funding available for the role for a quality systems manager and this is currently being undertaken out of normal working hours by the Head of Radiotherapy Physics. This is clearly unsustainable and may be to the detriment of the health and well-being of the individual concerned.

The funding for this post was approved by the executive management team and the post recruited to on the 6th March 2014.

7. The team is planning to implement single PTV for neck cancer and brain tumours with outside support from a neighboring radiotherapy center using the current technology and equipment. However, the reviewers were not assured this development plan has been agreed by the network radiotherapy group and with specialised commissioning.
The Trust has been instructed by NHS England that, at this juncture, we are to continue with IMRT for prostate cancers only. We will require approval by NHS England for any further development in IMRT to occur.

Radiotherapy (Brachytherapy)

**Serious Concern**

1. *The number of patients receiving brachytherapy insertions is significantly below the required 50 per year as specified within the cancer measure.*

   - The oesophageal service is robust (25 patients in last 12 months) and we provide a service to patients from South Cumbria and Lancashire which we would be reluctant to withdraw. The service for oesophageal brachytherapy is therefore still being utilised and whilst this means that the Trust is performing less than 50 insertions per year the treatment is based on a protocol of standard plans and is therefore not considered to be technically complex.
   - All patients requiring gynaecological brachytherapy treatment are being referred to a neighbouring centre for treatment.
   - The long-term provision of the brachytherapy service will be subject to review and is largely dependent on substantive consultant clinical oncologist appointment and/or a partnership with a larger centre.

d) **Trauma Peer Review 5/2/2014**

I have notified the CCG regarding review of head injury protocol.

I am awaiting a detailed action plan regarding the outcomes from the review from our Trauma leads, but I can confirm that there is already a discussion and plan around radiology support and a move to 24/7.

Newcastle Hospitals have been in contact with via MD and CEO in regard to head injury pathways and have offered their support for any changes recommended by network.

The Review Team Recommends that:

For Cumberland Infirmary Carlisle:

- Improved emphasis on TARN data collection. The reviewers would expect to see the completeness score at 50% within 6 months and achieving the NTS desired 80% within 12 months
- Support the plans for a CT radiographer onsite overnight
- Nighthawk reporting needs to be reviewed to ensure quick turnaround of CT reporting
- Further work to be done regionally, by NTS, on the use of rehab prescriptions
- Ensure all specialities are aware of the regional transfer protocols
- Head injury pathway should be reviewed regionally by the NTS CAG. Additionally the Trust should review whether these patients are admitted to WCH.
- Massive Haemorrhage Protocol needs updating to bring into line with current standards. A standard version will be shared from the NTS CAG for use by trusts.

For West Cumberland Hospital:

- Improved emphasis on TARN data collection. The reviewers would expect to see the completeness score at 50% within 6 months and achieving the NTS desired 80% within 12 months.
- Nighthawk reporting needs to be reviewed to ensure quick turnaround of CT reporting.
- Head injury pathway should be reviewed regionally by the NTS CAG. Additionally the Trust should review whether these patients are admitted to WCH.
- Continue to explore options for transferring patients between sites and to RVI – including a dedicated transfer service.
- Review the acute medical input needed at WCH noting that without acute medicine on site that there will likely be an increase in deaths from elderly trauma patients.

The reviews have highlighted the need for further standardisation of protocols and this will be picked up by the NTS CAG over the coming months. As a region there are specific areas of concern around the deskilling of staff in trauma units, this is something that the Northern Trauma System (NTS) Executive Group and Clinical Advisory Group are looking at. The NTS Clinical Advisory Group are also looking to implement a process for raising clinical issues, we would also encourage you to take incidents to the RVI trauma MDT and the NTS Clinical Advisory Group. In the meantime if there are any issues these can be raised with Dr Jackie Gregson, Chair of the NTS Clinical Advisory Group or Karen Portas, NTS Network Manager. Additionally, across the region, provision of rehabilitation has been highlighted as a gap and is part of the Northern Trauma System work programme.

Overall we were very impressed with the service at North Cumbria and from discussion with the staff we met on the visit we are aware that what we are recommending is known to be required.

e) Medical Staffing (End February 2014 for Medicine)

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CIC Medicine | Internal | 72 | 60.4 | 10 | 11 | 81.4 | Total | 120 | 104.1 | 27 | 21 | 152.1

Adverts and agency requests have been placed for replacement for the 3 CT trainees removed by HENE and consultants recently departed. The new GM for medicine (Michael Smith) has been allocated to West Cumberland hospital to help directly manage the recruitment requests and to ensure back of house and on call rotas are filled. As yet no suitable replacements for the junior staff lost have been identified.

Education and training report. Dr Orugun has agreed to move to back of house wards to help support junior staff. The staffing situation has been identified by NHS England LAT and CCG. Requests have been made directly and via TDA to explore other temporary recruitment strategies. Zeiglers International have been appointed and are advising the Trust. A project manager is in place, supported by HR lead for TDA who will advise us on strategies for getting control of the medical workforce issues.

I am advised by the CD for anaesthetics that there are further vacancies caused by sickness at consultant level (3 CIC, 1 WCH) and difficulties at middle grade (1 WCH, 1 Agency doctor coming off nights and one trainee leaving at CIC) that if not covered at locum level may cause further difficulties covering the rotas either for elective or out of hours care.

There have been permanent appointments made at panels in February to consultants in: Chemical Pathology, WCH Anaesthesia/ITU and paediatrics CIC. Dr J Cox has started a 2 year consultant consultant secondment in Elderly Care at WCH.

One of the elderly care locums identified at CIC has started orthogeriatric assessments.

A more detailed report is attached overleaf
Directorate of Human Resources & Organisational Development

Executive Management Team (EMT)

MEDICAL STAFFING WEEKLY UPDATE w/c 17th March 2014

Current Position

Attached is an overview of current recruitment activity by Business Unit:

- Medicine and Emergency Care
- Emergency Surgery and Elective Care
- Child Health
- Clinical Support

This report will be updated and submitted to NCUH’s EMT on a weekly basis for discussion and follow up of any outstanding actions.

Colour code =
- White (in progress)
- Peach (Appointed with start date either provisional or confirmed)
- Green (Commenced in post)

Key contacts are as listed below:
Northumbria Appointments

MEDICINE AND EMERGENCY CARE
Claire Coe, HR Administrator Tel: (0191) 2031414
Claire.coe@nhct.nhs.uk

Jarek Buszta, HR Administrator Tel: (0191) 2031857
Jarek.buszta@nhct.nhs.uk

EMERGENCY SURGERY AND ELECTIVE CARE:
Lois Greason, HR Administrator Tel: (0191) 2031418
Lois.greason@nhct.nhs.uk

CHILD HEALTH
Maureen Stenhouse, HR Administrator Tel: (0191) 2031425
Maureen.stenhouse@nhct.nhs.uk

CLINICAL SUPPORT:
Lois Greason, HR Administrator Tel: (0191) 2031418
Lois.greason@nhct.nhs.uk

June Lillford, Recruitment Team Manager: 0191 2031445
Kelly Angus, Head of HR Services & Development: 07920 284020

Please do not hesitate to contact any of the above if you have any queries or if you have identified any information which needs to be updated.
It is planned that this information will be added to with a summary of locum activity as per business unit and an overview of the forthcoming recruitment and media campaign which we are currently finalising details for.

Ann Stringer  
Executive Director of HR/OD  
Northumbria Healthcare NHS Foundation Trust  

17th March 2014
### MEDICINE AND EMERGENCY CARE

Key Contacts:  Jarek Buszta, HR Administrator, Northumbria (0191) 2031857

**Consultants**

Advertised as Northumbria (with agreed secondment into North Cumbria)

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**EMERGENCY SURGERY AND ELECTIVE CARE**

Key Contacts:  Lois Greason, HR Administrator, Northumbria (0191) 2031418

**Consultants**

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### Clinical Support

**Key Contacts:** Lois Greason, HR Administrator, Northumbria  
Tel: (0191) 2031418

#### Consultants

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#### Consultants

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#### Consultants

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**Non-Consultant Recruitment**

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## CHILD HEALTH

Key Contacts: Maureen Stenhouse, HR Administrator, Northumbria (0191) 2031425

### Consultants

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<td>261-14-008</td>
<td>Specialty Doctor – Paediatrics</td>
<td>1.0</td>
<td>1</td>
<td>CIC</td>
<td>05.03.2014</td>
<td>07.03.2014</td>
<td>1</td>
<td>Dr Surabhi Choudhary apt - start date tbc</td>
</tr>
</tbody>
</table>
f) Out of Hours GI Bleeding

After being informed of the recommendation made by Trust Board in February, Dr D Rogers has replied to acknowledge the need to:

- Continue to provide emergency endoscopy lists at WCH Mon to Friday
- Move high risk patients to CIC out of hours using the algorithms proposed.
- The new arrangements are fully explained to all staff
- We work to a sustainable solution as part of our joint work on service consolidation
- He has asked that the GI team ensure they audit the experience and outcomes of all transferred patients.

g) Skin Cancer Pathway and Dermatology

Since holding a review meeting with GPSI’s in Dermatology with members of the Dermatology MDT and arranging for the cancer network to review and support referral pathways into the MDT, issues continue to be raised by the MDT in regard to adherence of GPSI’s to cancer protocols. The Chief Executive requested the Cancer Network Director to independently review these concerns and advise on next steps. At the behest of the cancer network Dr Peter Barrett of County Durham and Darlington has met with some members of the teams to help mediate. Cases reported within North Cumbria have been reported to CCG MD for investigation. There remain outstanding matters of concern and agreed governance to clinicians on both sides which remain under investigation and discussion, which will be independently reviewed. The CCG continues in its desire to deliver an integrated service for skin cancers and dermatology along the lines agreed in other health economies (eg Durham and Darlington).

h) Medical Education and Training Report

The Medical Education and Training Report is outlined overleaf.
Report to Trust Board
Medical Training
North Cumbria University Hospitals
March 2014

Dr Chris Tiplady
Interim Director of Medical Education

My apologies for not being there

Haematologist in Northumbria
Regional Advisor for Education in Health Education North East (the organisation that oversees doctor training in the region)
Interim Director of Medical Education in North Cumbria since Dec 2012

Contact:
christopher.tiplady@nhs.net OR
@christtiplady
Important to describe Medical Training

Overseen regionally by Health Education North East

- Who are responsible for
  - Recruitment
  - Employment
  - Training standards
  - Revalidation (the Postgraduate Dean is the Responsible Officer for ALL trainees)
  - Report directly to GMC
Employment to these training posts

- Run nationally
- That means doctors apply to the REGION and not the Trust

- Placements rotate around the region but you don’t go everywhere
  - Foundation Years – based in one Trust
  - Core Training – based in one or two Trusts
  - Specialty training – rotates between several Trusts/ GP practices

Training Posts

- A training post is one that has been through an accreditation process.

- The total number/ type of training posts is decided nationally and allocated to regions

- Payment of doctors in training is part from HENE and part from the Trust (sliding scale according to grade)
Training Posts

- HENE approve Trust posts for training based on Quality Management Processes:
  - Training opportunities and facilities
  - Quality of Educational and Clinical Supervision
  - Training and curriculum delivery
  - Feedback from trainees
  - Trust annual Self Assessment Reports and visits
  - GMC surveys
  - Responding to and supporting trainees in difficulty

Allocation to Posts

- Managed by the Training Schools (anaesthesia/ paediatrics etc)

- Based on quality management processes

- The Schools have to make sure trainees complete their training in safe, supported jobs

- They manage gaps in recruitment
Regional recruitment

- Allocation to the region you choose and allocation to training placement is based on interview or other scoring systems.

- This means that the best trainees go to their ideal jobs

- For foundation trainees it means we get trainees who may not have even wanted to work in the region, never mind travel to Whitehaven.

Supervision Quality

- The GMC set the standards for what is required of supervisors as well as defining the responsibilities of HENE and Trusts

- Recognise the key role of Supervisors in the delivery of safer patient care as we rely on trainees for so much of the clinical service
Supervision Standards

- GMC states all supervisors must be trained in
  - ensuring safe and effective patient care through training
  - establishing and maintaining an environment for learning
  - teaching and facilitating learning
  - enhancing learning through assessment
  - supporting and monitoring educational progress
  - guiding personal and professional development
  - continuing professional development as an educator

Ensuring standards of Supervision

- Role of HENE

- My role as the Director of Medical Education

- Have to be trained, have time in the job plan and be appraised in the role

- Two types – clinical supervisors (day to day monitoring) and educational supervisors (overview of a trainees whole placement)
Supervisors

• LOCUM doctors do not / are very unlikely have this training

• LOCUM doctors do not provide continuity of supervision for trainees

• As such training placements relying on the presence of locums are not regarded as suitable for training

West Cumberland Hospital

<table>
<thead>
<tr>
<th>GRADE</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation Year one</td>
<td>15</td>
</tr>
<tr>
<td>Foundation Year two</td>
<td>7</td>
</tr>
<tr>
<td>Core Medical Trainees</td>
<td>6</td>
</tr>
<tr>
<td>GP trainees</td>
<td>9</td>
</tr>
</tbody>
</table>

The direct clinical supervision of the 6 Core Medical Trainees was put at risk in February by the announcement of the departure of three consultants.
Consequences

- HENE were made aware of these changes

- An urgent meeting was held on 13.2.14 between the chief executive, the medical director, the postgraduate dean, other HENE staff, the DME and NHS England

Consequence

- The training programme for three trainees could no longer be delivered and these three trainees are to be removed at the end of March to complete their training elsewhere in the region
Consequence

• The planned move of CMT doctors to Carlisle in August 2015 (required to retain them as national directives indicate that we need 9 CMT trainees to run a CMT programme) has been brought forward to August 2014.

Consequence

• Concerns about clinical supervision for the foundation doctors who rely on core medical trainees.

• Concerns about losing the other trainees.

• Concerns about supervision for the GP trainees.

• What this means is concern about patient care.
Risk

- Failure to recruit suitable locums in next 2 weeks
  - Perceived lack of support and training for Foundation Drs in medicine/acute care
    - REMOVED
  - Perceived lack of training and support for GP trainees in medicine/acute care
    - REMOVED
  - Ability to deliver acute medical care in Whitehaven virtually removed

Fill the gaps - Recruitment?

- As of 13.03.14 we have not filled the three junior vacancies with locum grades

- Consultant recruitment – Dr Cox, Respiratory Dr and adverts for remaining vacancies

- Further retirements coming in August
Regional Recruitment

- Remember our trainees have applied to the region
- Centralised on Newcastle which is where many already live.
- Rotations to Carlisle and especially Whitehaven are already less attractive, if the training is poor they become even worse.

### Current and Future Medical and Foundation Placements - a plan?

<table>
<thead>
<tr>
<th>Region</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>NorthEast</td>
<td>Medical Directors Report</td>
<td>Public Trust Board</td>
<td>March 2014.doc</td>
</tr>
</tbody>
</table>
Concerns

- Current plans depend on filling posts with substantive grade Consultant Doctors

- The current national picture is one of great difficulty

What can be done?

- Massive, active recruitment strategy
  - OK for long-term
  - Immediate short term concerns

- Accept removal of trainees and recruit to non training posts. Developing North Cumbria as an employer of choice for Staff and Associate Specialists

- Consider alternative ways of delivering acute medical care to North Cumbria that do not depend on trainees
i) 7 Day Working

Key Points:
- This paper includes a gap analysis contributed by (individual) clinical teams against the 7 day standards
- The next steps are to review and validate that gap analysis. This will occur by discussion with the business units and feedback to CPG, and be coordinated by the director of strategy.
- This will be used to develop a plan to bridge the identified gap to deliver 7 day working that will be incorporated into the annual planning round and act as an input into the NCUH and Cumbria 5 year strategy.

Seven Day working is about equitable access, care and treatment, regardless of the day of the week: there is a compelling case for change including addressing higher mortality rates and less favourable clinical outcomes associated with weekends. The level of service provided should ensure that the patient has a seamless pathway of care when accessing services no matter what day of the week. As a Trust in Special Measures it is more than likely to be a key area of interest in our forthcoming Chief Inspector of Hospitals visit.

The NHS Services Seven Days a Week Forum, chaired by the National Medical Director, Sir Bruce Keogh was established in February 2013 to provide an insight and evidence into how to improve access and outcomes, and consider how NHS services can be improved to provide a more responsive and patient centred service across the seven day week. The Forum was asked by NHS England to focus as a first stage on urgent and emergency care services and their supporting diagnostic services.

The Forum’s review points to significant variation in outcomes for patients admitted to our hospitals at the weekend across the NHS in England. This variation is seen in mortality rates, patient experience, and length of hospital stay and readmission rates. The introduction of 7 day services across the NHS is aimed at reducing this variation in outcomes for patients admitted to hospitals at weekends as displayed by these measures.

Sir Bruce Keogh and NHS England have proposed to introduce a plan to roll out seven day services across the NHS by the end of 2016/17. The table below summarises the ten new clinical standards that have been developed with a supporting evidence base as agreed with the Academy of Medical Royal Colleges. Each of the standards aims to address a specific aspect of care:
Table 1

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patient Experience – involvement in choices and decision making supported by clear information</td>
</tr>
<tr>
<td>2.</td>
<td>Time to first consultant review – emergency admissions to be assessed within 14 hours of arrival</td>
</tr>
<tr>
<td>3.</td>
<td>Multidisciplinary Team review – for complex or on-going needs and integrated management plan</td>
</tr>
<tr>
<td>4.</td>
<td>Shift handovers – led by a senior decision-maker and supported by clear, standardised policy</td>
</tr>
<tr>
<td>5.</td>
<td>Diagnostic services – inpatients to have 7 day access to scheduled services, tests and reporting</td>
</tr>
<tr>
<td>6.</td>
<td>Interventions / key services – inpatients to have 24hr access to consultant directed interventions</td>
</tr>
<tr>
<td>7.</td>
<td>Mental Health Services – psychiatric liaison assessment within timescales set in line with need</td>
</tr>
<tr>
<td>8.</td>
<td>On-going review – high dependency patients to be seen by a consultant twice daily</td>
</tr>
<tr>
<td>9.</td>
<td>Transfer to community, primary and social care – support services to be available 7 days</td>
</tr>
<tr>
<td>10.</td>
<td>Quality improvement – all involved in acute care must participate in patient outcomes and reviews</td>
</tr>
</tbody>
</table>

The *NHS Improving Quality (IQ) Partnership* is supporting this work and in its report published in November 2013 described 5 levels of service provision:
<table>
<thead>
<tr>
<th>Level 0</th>
<th><em>Five days a week e.g. Monday to Friday, 9am - 5pm, 8am – 4pm</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Routine eight hour services</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 1</th>
<th><em>Monday to Friday at departmental level, extended hours e.g. 8am – 8pm</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Services limited to one department or a service that is beginning to deliver some services beyond 8am - 6pm Monday to Friday services. This could be extended working days and some weekend services; however does not deliver equitable services irrespective of the day of the week.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2</th>
<th><em>Services delivered 7 days a week, but limited range of services at weekend</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Services that are delivered seven days per week, but not always offering the full range of services that are delivered on week days. This limited range of services goes beyond “on call” and emergencies only and facilitates some clinical decision making and discharge, though is likely to be one service and not integrated with other service delivery, (e.g. pharmacy services offering a limited range of services with several staff available, radiology offering weekend lists for inpatients).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3</th>
<th><em>Services offered seven days a week with several departments working together to provide services across the organisation</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A whole service approach to seven day service delivery that requires several elements to work together in order to facilitate clinical decision making or treatment, often covering more than one workforce group (e.g. stroke services integrating acute stroke clinicians, imaging, specialist nurses, TIA clinics, thrombolysis).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 4</th>
<th><em>An integrated seven day service across the organisation</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A whole system approach to seven day service delivery by integrating the requirements for elements of seven day services across more than one speciality area (e.g. across several departments and services within an acute trust, integration of several services across health and social care to reduce admission to the acute sector).</td>
</tr>
</tbody>
</table>

**Note:** The levels of service should not be interpreted as levels of progression. Some services may only need to be provided at agreed levels e.g. Level 1.
Nationally proposed timescales for change:

- Year 1 (2014/15) – local contracts should include an action plan to deliver the clinical standards within the service development and improvement plan section of the contract. Use of local CQUIN schemes encouraged, based on the clinical standard for time of arrival to initial consultant assessment
- Year 2 (2015/16) – those clinical standards which will have the greatest impact should move into the national quality requirements section of the NHS standard contract
- Year 3 (2016/17) – all clinical standards should be incorporated into the national quality requirements section of the NHS standard contract with appropriate contractual sanctions in place for non-compliance, as is the case with other high priority service requirements
- Basing access to the Better Care Fund for CCGs and local authorities on provision of demonstrable evidence of effort to address national conditions around seven day services

A Board report to NHS England proposed that:

- The CQC should consider how to assess implementation as part of its ratings inspections – preliminary discussions with the CQC indicate that this will be incorporated into the hospital assessment process. The view from the CQC is that for acute services to be judged safe, they have to be safe 24/7.
- Health Education England (HEE) should be asked to ensure that education contracts include consultant availability to provide adequate supervision of doctors in training seven days a week in line with the clinical standards.
- Consultant contracts be reformed including changing the balance between part time and premium time payment to minimise cost implications of introducing seven day services

In addition to these proposals, NHS England is commissioning pilots across England during 2014/15 through a £50m Challenge Fund set up to improve access to general practice. Nine pioneers will be established in different parts of the country covering at least 500,000 people with the first wave of these pioneers to be announced in March 2014. NHS England will evaluate these pilots to identify the most effective ways to improve access to routine primary care and support a more integrated approach to urgent care services in 2015/16.
NHS Improving Quality (NHS IQ) is proposing to introduce a new large scale transformational change programme to support the spread of seven day services.

2.0 Local Commissioner Agreement

14/15 Contracting negotiations with the CCG have agreed delivery of an Action Plan by 31 May 2014 - Appendix 1 provides the detailed Action Plan requirements for implementation of 7 day working in line with the Contract Service Development & Improvement Plan. It is expected that the baseline report is completed by the 31 May and presented to the Urgent Care Working Group by the 30th June 2014.

Additionally, there is a specific 7 day working standard CQUIN agreement in relation to a baseline for the Standard 2 14-hour assessment, with a CLIC (Cumbria Learning and Improvement Collaborative) facilitated RPIW (Rapid Process Improvement Workshop) event in Q1 followed by targeted improvement in Quarters 2-4.

3.0 Trust Initial Baseline Assessment

Clinical Directors, supported by the OSMs were asked to complete a baseline assessment of their services in relation to each of the standards. They were also asked to identify the implications of the required changes, the resultant benefits, obstacles, and associated dependencies. A summary of this initial gap analysis against each standard is provided at Appendix 2.

The information provided to date is not complete or comprehensive in all areas but provides a good starting point to take the work forward.

It should be noted that in the past 12 months significant service changes have been made which go a long way to providing safe 7 day working. These include:

- centralised trauma arrangements at CIC
- centralised high risk emergency surgery at CIC
- first phase of plans to formalise out of hours (OOH) arrangements for high risk GI bleeds
- new front of house arrangements using acute care physicians (ACPs)
- vascular services centralised at CIC
Services are generally reported as at Levels 1-2 but it should be noted that in a few areas, and in particular in medicine at West Cumberland Hospital, teams are currently struggling with Level 0 provision. A number of issues were identified by completing Clinical Directors and Teams:

(a) **Benefits of 7 day working:**

- Improved patient flow especially following weekends
- Reduced lengths of stay relating to: timely operating, proactive discharge etc
- Reduced NEL admissions and readmissions
- Reduced cancelled operations
- Increased elective capacity and reduced elective waiting times
- Improved safety eg timely access to anaesthetist, medicine related harm reduction, reduced post-op infection from earlier operation, and improved patient experience
- Better use of ICU beds and reduced ICU transfers
- Reduced mortality (particularly at WCH) [cited in cardiology]
- Ability to meet constitutional standards, Best Practice targets and NICE standards
- Better integrated care
- Improved health promotion activities
- Improved recruitment
- Enabling changes across wider system

(b) **Implications of 7 day working for Service Planning:**

- Additional staffing requirements for both medical and nursing staff (including nurse practitioners). Includes extra capacity in some specialties to comply with compensatory rest requirements and impact on elective work
- Consultant job plans need to accommodate requirements including consultant-led ward rounds in the morning/evening and at weekends,
time for improvement activities; formalised on-call rota in some areas; introduction of shift patterns and possibilities of 3 session days.

- 24 hour pharmacy to allow evening discharges of weekend day time admissions
- Enhanced levels of (and access to) clinical support staff/services – including anaesthetics, and AHP services
- Changes to emergency theatre management
- Some specific service changes including additional tier ICU, no operative trauma at WCH including minors
- Some physical space requirements – expansion and reconfiguration
- Better systematisation of handover and discharge
- Networked solutions

(c) **Some Key Interdependencies:**

- Clinical support services – impact 2-way
- Access to community and primary care services including social services and care packages at weekends
- Community Hospital inpatient beds
- Patient transport
- Pharmacy
- Community based and interface services at WCH eg, Hub working, social services, palliative care, physiotherapy and OT,

(d) **Likely Obstacles to Achievement**

- Funding - additional staffing and equipment,
- Capacity of current workforce
- Ability to recruit and/or ability to grow new skills and competencies in-house
- Departmental space
- Lack of community capacity including Nursing Home beds to facilitate safe complex discharges at weekends
Staff resistance to change

Current contractual arrangements (eg existing consultant contract)

Current staff relationship with management - ‘another thing we’re asked to do’

(e) Elements Requiring a Corporate Trust Approach

- Need for clear vision and 5-year clinical strategy
- Board/System approval of required service changes esp. in relation to WCH
- Whole system approach including response to training issues
- Focus on wider team and especially support staff not just consultants
- Dialogue with HENE, Deanery re. recruitment and training issues etc
- Recruitment

4.0 Next Steps

Further progression of this work will be led by the Medical Director and Business Unit Directors, overseen by the Trust Clinical Policy Group and EMT; it will need to deliver against the contractual requirements as noted above and in Appendix 1:

- Business Units to review this initial baseline and complete comprehensive baseline by end May 2014
- Business Units to draft prioritised Action Plans in line with commissioning requirements by beginning July 2014
- Clinical Policy Group & EMT to recommend Trust-wide Plan July 2014
- Board approval end July 2014

Work must be fully aligned to financial planning: currently assumptions have been built into the 2 Year operational plans for delivery of 7 day working. These assumptions will need to be tested and adjustments made as appropriate during more detailed plan development.

2. RECOMMENDATIONS

The Trust Board is requested to note this report.

Dr Jeremy Rushmer
MEDICAL DIRECTOR