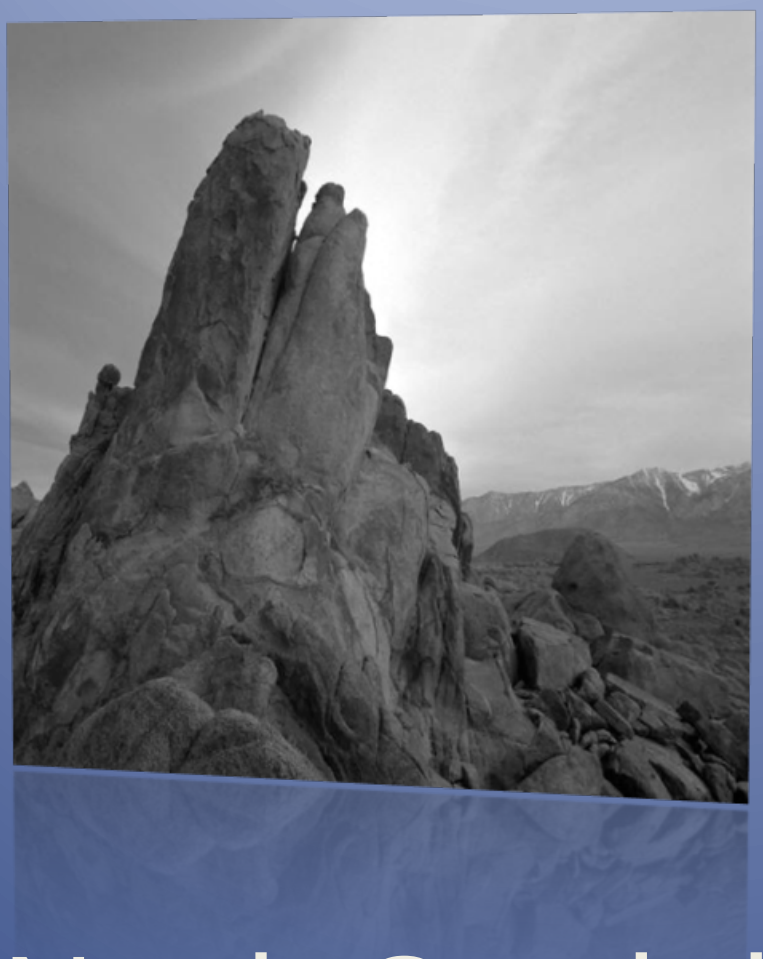
NHS
Northern England Clinical Senate



North Cumbria Services Reprovision Review (30th June – 2nd July 2015)

Northern Clinical Senate Review

Table of Contents

Summary

This report presents the Northern Clinical Senate's suggestions to NHS Cumbria Clinical Commissioning Group (CCG) on the developing high risk clinical pathways in North Cumbria University Hospitals NHS Trust (NCUHT). A glossary of abbreviations is provided on page 45 of this report.

The Clinical Senate was asked to carry out a further review and give clinical assurance on the pathway for acute stroke services. We were also asked to comment and advise on the proposed, developing pathways for the transfer of patients whose condition is deteriorating, and to do the same for the potential pathways for acutely ill children.

This is the second visit undertaken by a review team for the Northern Clinical Senate. The previous visit was in November 2014 and entailed consideration of proposed changes in elements of Cardiac, Upper GI, deteriorating patient and Stroke pathways and, subsequent to the visit , aspects of the respiratory pathway.

A review team drawn from the senate council, assembly and two experts from outside the region for their relevant expertise in the areas under review, explored the issues and formulated this advice. We are very grateful to everyone involved for the time they committed and the level of enquiry, expertise and objectivity that they brought. Over the course of two days we met many clinicians, CCG Leads, Trust Management Officers as well as members of the Overview and Scrutiny Committee, Health Watch and patient groups including the West Cumberland Hospital (WCH) campaign group. We are very grateful to them for the flexibility they showed in making time to see us and for the openness with which they shared their views.

There are very considerable challenges facing North Cumbria, due to the area covered, the isolation of the significant population centre of on the West Cumberland Coast in Whitehaven, Workington, Maryport and Egremont", poor staff morale and retention and a history of many management teams in the last 7 years. Recruitment of key medical staff is now in a critical position with many services significantly reliant on locum / agency staff. Both CCG and NCUHT have made great efforts to improve things, despite severe financial constraints. We recognise that the CCG and NCUHT have a shared aim to ensure a safe and sustainable service for their patients, and that the current arrangements for hospital services are not satisfactory. Acute medical services, for example, being deemed inadequate by the Chief Inspector of Hospitals, which gives urgency to the need for a change in the way patients are cared for.

The key findings of the review team are:

- As recognised by the Trust, there is still considerable work to be carried out in preparing for the implementation of any changes to the deteriorating patient pathway. The role of the Senior Decision Maker at WCH has been clarified but the review team remains concerned about the appropriateness and implementation of the Trust's preferred solution of appointing a tier of doctors at ST3 level to undertake this responsibility out-of-hours. Liaison with North West

Ambulance Service (NWAS) needs to be strengthened. The Trust has made it clear that NEWS will not be the only trigger / selection criteria for patient transfer and will use a mix of clinical criteria alongside NEWS. However, more clarity is required around who needs to be transferred from WCH and why, in terms of both clinical capacity and direct patient benefit.

- For the stroke pathway, whilst recognising that there has been much work done in preparing an outline business case, it would be helpful to include explicit assumptions regarding activity for patients whose symptoms mimic stroke, and the capacity and financial implications for these patients. There also appears to be further work needed on the number of consultants, bed capacity and establishment of Early Supportive Discharge team. The review team is fully supportive of the direction of travel and can give assurance regarding the acute part of the pathway provided all the issues identified above and within the detailed section are satisfactorily resolved.
- For Paediatrics this was the first time the review team had visited the service and as such it is probably too early to consider comments as key findings. Rather they are detailed observations and, hopefully, some helpful pointers to aspects which require further careful consideration particularly relating to nationally agreed standards. One critical path issue for Paediatrics, however, is the final agreed model for Obstetric services. This was outside the scope of this review but it was very obvious from our observations that the obstetric model will influence the Paediatric service significantly .For purpose of this review we have assumed an 'as is' approach, i.e, with the Obstetrics service at WCH.
- Several emerging themes and suggestions are explored in a later section of this report.

The health economy in North Cumbria faces a major dilemma because it would appear to be impossible to find a universally accepted, evidence based model which can 'fit' North Cumbria without bringing potential disadvantages in access to services. Addressing both access and patient safety for WCH needs to lead to a statement of the vision of services for WCH which takes best advantage of its excellent facilities, the skills of its staff and the needs of its patients.

We very much hope that the implementation of the Success Regime will facilitate the development of an innovative, locally espoused and robust model involving all stakeholders which fits the unique geography and people of Cumbria.

Background

In November 2014 a Senate Review team visited North Cumbria, at the invitation of the CCG, to review four high risk acute pathways

- Cardiac
- Stroke
- GI bleeds
- Emergency care (subsequently described as the Deteriorating Patient pathway).

A further pathway, Respiratory, was included in the scope of the review immediately after the visit; this pathway was assessed through a combination of a desk top review and a lengthy telephone conversation.

A report was submitted following the visit and can be accessed through the CCG's website.

A great deal of documentation was considered during the November 2014 review. Some of this material was also used to inform the June/July 2015 visit but it is not intended to include that documentation in this report as it is readily available on the CCG website.

The key findings for the 2014 visit were that the proposed changes around primary PCI, concentrating high risk services at CIC and Upper GI surgical service, also centralising urgent bleeds at CIC, were both supported by the review team subject to a few outstanding issues being addressed.

Evidence was presented by the CCG on 30th June 2015 to demonstrate all outstanding issues have been resolved. In November 2014 it was concluded that the case for change for acute stroke care and high risk medical management was less well developed and needed further work.

Finally the post visit review of the respiratory pathway was supportive and the review team were informed during their visit that implementation was due to start in early July 2015.

Terms of Reference

The process to formulate advice was led by Professor Andrew Cant, Chair of the Northern Clinical Senate. Draft terms of reference were developed in discussion with the NHS Cumbria Clinical Commissioning Group.
(Appendix 1)

Review Process

The following review team members were drawn from the senate council, assembly and from outside the region.

Andrew Cant (Chair)	Clinical Senate Chair and Consultant in Paediatrics Immunology and Infection , Newcastle upon Tyne Hospitals Foundation Trust
Alison Featherstone	Network Manager for Cardiovascular and Cancer, Northern England Strategic Clinical Networks
Andrew Simpson	Consultant in Accident & Emergency Medicine, North Tees & Hartlepool NHS Trust
Chris Plummer	Consultant Cardiologist, Newcastle upon Tyne Hospitals Foundation Trust
Jeff Perring	Consultant Intensivist Associate Medical Director Sheffield Children's NHS Foundation Trust
Jon Scott	Stroke Consultant, South Tyneside NHS Foundation Trust
Paul Fell	Consultant Paramedic, North East NHS Ambulance Service Foundation Trust
Robin Mitchell	Clinical Director, North of England Strategic Clinical Networks
Rollo Clifford	Consultant Paediatrician , Dorset County Hospital Representative from Royal College of Paediatrics
Roy McLachlan	Associate Director, Northern England Clinical Networks & Senate, NHS England
Suresh Joseph	Clinical Senate Vice Chair and Consultant Psychiatrist, Northumberland Tyne and Wear Foundation Trust

Background information was collated by the sponsoring organisation and was presented to the senate review team before the visit . This information included demographic data, organisational information, site maps, and other information that the sponsoring organisation felt would help the reviewers understand the issues surrounding the services under review.

The review team came together in Cumbria on the evening of 30th June 2015 to meet the sponsoring organisation to receive an update on progress from the November 2014 visit. They were also briefed on issues around the three pathways included in the current visit. A second meeting was also held with three General Practitioners from Whitehaven to gain a primary care perspective on services at WCH and relationships with NCUH. Over the following 2 days Reviewers met with Clinical Directors and clinical colleagues across both hospital sites (CIC and WCH) and met the Medical Director, Nurse Director, CCG leads, CPFT Medical Director and Associate Nursing Director, Overview and Scrutiny Committee (OSC) Chair and vice chair, GPs, Healthwatch, and patient groups.

The Senate Review panel met with the following people:

On 30/06/2015

- David Rogers (Medical Director, NHS Cumbria CCG) ,David Stout (Director for Transformation, Cumbria CCG) ,Kirsty Roberton (Transformation & Delivery Programme Manager ,North of England Commissioning Support (NECS)
- Dr. Helen Horton,(GP, Hinnings Road Surgery) ,Dr. Jose Fidalgo(GP, Lowther Surgery), Dr. Juliet Rhodes (GP lead for Copeland, Cumbria CCG).

On 01/07/2015

- Dr Debbie Freake,(Director of Strategy, North Cumbria University Hospitals NHS Trust) and Julien Auckland-Lewis (Interim Director of Service Transformation, North Cumbria University Hospitals NHS Trust)
- Team 1 Paeds (at WCH) - Les Morgan (Director of WCH Redevelopment) and Jason Gane (Paediatric consultant)
- Team 2 Stroke (at WCH) – Dr Olu Orugun (Consultant) and Rachel Glover(Specialist Nurse)
- Team 3 – Det Patients (at WCH) - Charles Brett ,James Hayton and Claire Summers (A&E Consultants at WCH)
- Team 1 Paeds team (at CIC) - Jonathan Cardwell (Business Director), Paul Whitehead (Consultant) , Sara Jones (General Manager) , Mahfud Ben-Hamida (Clinical Director) , Eleanor Hodgson (CCG), Neela Shabde (CCG), Marl Alban (GP), Wendy Rankin (CPFT)
- Team 2 Stroke (at CIC) - Paul Davies (Consultant, Stroke) , Lisa Pearce (Stroke Specialist Nurse) , Gemma Richardson (CT Section Lead Radiographer) (Stroke team at CIC)
- Dr Jeremy Rushmer, (Medical Director, North Cumbria University Hospitals NHS Trust) , Gail Naylor (Director of Nursing, North Cumbria University Hospitals NHS Trust)

On 02/07/2015

- Sally Pilcher (Associate Director of Nursing, CPFT) and David Lewis (Associate Medical Director, CPFT)
- Group 3 Deteriorating Patient (at CIC) - Mike Hodgson, (Consultant Anaesthetist) , Stephanie Preston(Deputy BU Director) , Denis Burke, (Business Unit Director) , Kath Martin,(General Manager) , Diane Murchison (Matron, Critical Care)
- Mrs. Carol Woodman and Mr. Mahesh Dhebar (White Haven Action Group)
- David Blacklock (CEO of Healthwatch Cumbria) and Cllr Neil Hughes, (Chair of Cumbria Health Scrutinee Group)
- (Via teleconference) Bob Williams and colleagues , NWAS
- Dr. Jim Shawcross (Consultant, Acute Medicine, CIC)

Timescales

Review Visit, 30th June, 1& 2nd July 2015
Draft Report to sponsoring organisation by Wednesday, 22nd July 2015
Final report : 4th September 2015

(Appendix 2 – Timetable for visit)

Limitations

The pathways reviewed were:

- Acute Stroke Care
- Management and transfer of Deteriorating Patient
  (both of the above pathways were considered as part of the November visit)
- Paediatric Pathway
  (This is the first review of proposed changes to the Paediatrics pathway)

Out of scope

- Obstetrics and midwifery

Clinical Senate Review of North Cumbria Services Re-provision (June/July 2015 visit)

Comments on Pathway: Deteriorating Patient

Features of the Pathway	Assessment of Progress to date	What is needed
-NEWS Score and clinical criteria now trigger ''Senior Decision maker'' Input Cohorting of sickest patients on ''Enhanced Observation Unit'' (EOU) Await further input regarding the details of the pathway Patients who deteriorate on ward transferred to EOU.	- Have rejected idea that NEWS can be used on its own to trigger transfer which is sensible. - Using senior decision maker is appropriate, but unclear who this will be outside 8AM to 6PM when acute physician present. There is a consultant available in hospital until 10 pm however unclear as to how consistency will be maintained. Middle grade registrar not defined. What competencies will they have and more importantly how will they have been measured and assessed. - After 10pm would the decision to transfer be an individual decision or a team decision including the on-call consultant? - Transfer would also require agreement of the receiving hospital. Who would be communicated with and how would this communication be circulated? We are informed	- Written pathway needs to be finalised. - Define Medical Registrar competencies - What is the role of critical care outreach? - What is the advantage of transferring to CIC if a decision maker is at WCH. - The public need to understand reasons and benefits - How many patients are transferred to CIC? - Who transfers the patients? - Impact on NWAS? - Capacity modelling at CIC: There may not be an advantage if patients end up in busy ED rather than an appropriate ward bed.. - Detailed proposal for collaboration with UCLAN and impact on staff - Nursing staff ratios – what are they? - Interaction between clinical team and NWAS? - There would appear to be a need for much further communication to take place involving but not exclusively - 1) Acute Trust - 2) Senior medical staff all both sites and all involve specialities - 3)CCG - 4)GPs in the West Cumbria area - 5)Patient groups

	that present policies set this out but we heard evidence that there is inconsistency in application of these policies. - Consideration needs to be made of what would happen if there is no transfer ambulance available	- 6) NWAS - To ensure that a robust and sustainable pathway is put in place.

Clinical Senate Review of North Cumbria Services Re-provision (June/July 2015 visit)

Comments on Pathway: Deteriorating Patient

Features of the Pathway	Assessment of Progress to date	What is needed
Commendable focus on extended roles of non-medical staffing	Some progress on flow charts/algorithms – but several inconsistencies and uncertainties remain – still very much a 'Work in progress'. All the work for WCH still seems reliant on 'Medical registrar' role which is not reliable (locums ++) Senior Decision Maker – CCT holder or equivalent The trust has extensive recruitment problems which is one of the major reasons why a deteriorating patient pathway is being developed however considerable skill, knowledge and experience is required to identify patients who would benefit from the transfer process. Viewed from a patient / carer (or GP) perspective this could be seen as an anomalous situation; if there are facilities, and expert decision making	Clarity of purpose Clarity about this as a Trust issue rather than just West Cumberland. The Trust's efforts to identify novel routes for staffing are recognised, including the initiative with UCLAN. However, there is considerable risk that this initiative may not deliver the required enhancement in senior medical cover. Identify what they are going to do to replace the 'Registrar' role Need to look specifically at care of elderly – underprovided at Trust level

	input to assess, initiate treatment and stabilise acutely ill patients at WCH it is unclear what the extra benefit is of transferring these patients to CIC with the potential risks inherent in transfer.	

Clinical Senate Review of North Cumbria Services Re-provision (June/July 2015 visit)

Comments on Pathway: Ill child

Features of the Pathway	Assessment of Progress to date	What is needed
Vision (Sam's House): • Joined up services • Close to home • Delivered in partnership with children, their families and other agencies	This is a high level vision at an early stage of implementation Working relationship between GPs and primary / community care. We understand that paediatric consultants are undertaking some clinics in the community setting Engagement of parents, children and young people in the development of the vision (Sam's House) Concentration on staffing at WCH / CIC rather than overall vision detailed in Sam's House	Given that this was the first visit to Paediatrics the review team would suggest a further Senate review when more detailed work has been undertaken Closer working with partnership organisations / stakeholders to develop 'hospital – community networks' that can work through detail of proposal and build confidence / competence to enable vision to be implemented. Continuous engagement of children and their families throughout process – to gain understanding and build trust * Post visit note:- the communications and engagement plan and a related brief for targeted engagement with children and young people were provided after the visit. It is noted that initial engagement regarding Sam's House was undertaken and that further engagement is planned from September 2015. Vision central to work to build trust across stakeholders and the community at large Also- Best practice pathways to describe cross boundary working (see below)

Paediatric departments at WCH & CIC WCH SSPAU (24/7) Low dependency inpatient unit Cons Junior ?APNP SCBU (Level 1+) CIC SSPAU (24/7) Surgery (Limited) Inpatient unit SCBU (Level 1+) Cons Middle APNP/SAS	The model described is based upon our understanding – present descriptions lack clarity – e.g. on level of APNP working Staffing of 'tier 2 type rota' at CIC – hybrid suggested but will require further detail Act as independent units with some collaboration (e.g. regular meetings & a cross site clinic - CF)	Further modelling of medical (APNP) staffing at both WCH and CIC Modelling needs to ensure that staff ratios are maintained / enhanced during the transition phase. Newly qualified APNP unlikely to have competencies for middle grade role for first 1-2 years. Ensure that staff model meets requirements RCPCH Facing the Future Standards (2011 & 2015) at both sites taking into account that WCH ☐ Small ur CIC ☐ 5,000 acute admissions) Model should clarify hybrid rotas in short and long term and the expected timescales – alongside any requirement for resident consultant on call - this can then form part of future job plans WCH and CIC should become more 'integrated' and act as a single service on 2 sites (e.g. may involve WCH Consultants contributions to resident cover at CIC although would need back fill of time in WCH) Would suggest that the term 'network' is not used for the working relationships between WCH and CIC

Pathway for acute referrals to WCH SSPAU from primary care and ED and transfer to CIC	Patients admitted from ED or primary care ☐ SSPAU day/early evening (16 hour) Current model appears to also suggest that overnight admissions will also be admitted to a 24/7 SSPAU at WCH? NWAS do not have provision for additional transfers ED ☐ CIC Local concerns for families	Staffing model required needs to be considered. Our understanding of the proposed staffing structure suggests that WCH would not meet standards required for admission of children to the SSPAU overnight – in particular, Facing the Future Standard 2 (RCPCH 2015) which states that 'every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.' <u>Post Review note:</u> The Trust has indicated that the RCPCH standards are met; the Consultant on call could come in if there was an admission. In the light of the very differing levels of competencies of the resident paediatric staff, the review team would like to understand further the circumstances when the Consultant would be resident. WCH/CIC and NWAS to work through agreed model for transfer of these patients – consider resource implications Need to consider transport plans for families (e.g. financial support) and potential accommodation for them at CIC

Provision of HDU care at WCH and CIC. Management of critically ill children prior to transfer (e.g. to tertiary care)	Overview document states that HDU provision required at WCH and CIC. We were, further, given to understand that high flow is provided on paediatric wards at WCH for the occasional infant with bronchiolitis. CPAP has been provided for these infants on SCBU at WCH – not certain if this is the case at CIC also. * Post visit note:- Confirmed that high flow and CPAP are used on both units. Pathway for critically ill child admitted to ED at WCH not clarified – nor ability of staff to maintain skills to manage these serious but	This needs to be clarified taking into account Facing the Future and Paediatric Intensive Care Society Standards This needs to be clearly defined as part of the pathway work – e.g. short term until transfer out of patient arranged and with on-site consultant. We would be concerned if any longer term provision were made as part of a designated paediatric assessment unit. Provision of this, and other HDU care, at CIC needs to be consistent with requirements in Facing the Future (RPCH 2015) and Paediatric Intensive Care Society Standards. <u>Post Review note:</u> The Trust has described that there is no intention for long-term HDU care on either site. There is recognition that for some children transfer to a tertiary unit may require intubation and ventilation (escalation from HDU to ITU care) to ensure safer transfer. If a child's condition is stable and improving NCUH clinicians consider it appropriate for a child to remain in North Cumbria – otherwise such children are

	rare patients Outline model only alongside accommodation (WCH / CIC)	transferred to the tertiary unit and there is no intention that there will be any alteration in current transfer practice. Provision of CPAP on SCBU is addressed below. This needs to be considered in future model of care – and include staffing levels (including grade) / training and education (including simulation based training) / governance (review programme with retrieval team of patients moved). This work should be undertaken with the regional Paediatric Critical Care Operational Delivery Network
Best practice pathways	There has been some work in this area (e.g bronchiolitis / asthma) although we were not shown details of the pathways It was suggested that certain low dependency patients could be care for at WCH as in-patients	Additional work on pathway details (e.g trigger points) and how pathways meet best practice within proposed SSPAUs (workforce planning) particularly at WCH. . Also – acceptable upper limit of stay on SSPAU (e.g. for asthmatic) With the assumed staffing model, would suggest that, at WCH, any patients kept overnight need to have been assessed by senior clinicians as requiring only nursing care – e.g. there should be no expectation of medical input * Additional work is required to define a small number of, mainly elective, longer term, low acuity patients that require hospitalisation currently not included in plan.

Development of integrated nursing team	Limited evidence shared with us of progress to date– presume that this is part of the on-going work	This to be worked through as part of the overall development
APNP programme	Planned development of APNPs x4/year Acknowledged that most would come from present paediatric nursing pool (total approx. 33 trained wte across both sites) Paediatric nurse recruitment has not been an issue at either site Previous APNPs have left to join work in the community Plan for APNPs to work on both junior and tier 2 rota	Would suggest that there is an assurance that nursing staff recruitment and skill mix retained during development Close partnership working with community / GPs to ensure success of the APNP programme across the whole healthcare community. Continued programme of training to replace loss from acute to community service. Once qualified, these APNPs will take time to reach competencies required for a middle grade rota (see notes under Standard 2 of Facing the Future, 2015). Note that APNPs may only serve the purpose of contributing to middle grade rota for acute paediatrics. Robustness of this solution to middle grade cover at CIC depends upon whether plan to provide >Level 1 care and the development of the ANNP role

SCBU provision at CIC and WCH – provision of advanced airway support both now and with future model of care (although not directly within our remit any service change on the paediatric wards will have a direct effect on SCBU provision – medical staffing model)	At present both units describe themselves as Level "1+" (not defined in BAPM standards but we understood this related to provision of some element of level 2 – HDU - care including CPAP at both sites) Acknowledges that maternity service provision will also have an effect on this	Our understanding of the current and future proposed medical staffing model for WCH suggests that it would not support any type of HDU care for neonates on SCBU within BAPM standards for middle grade support. HDU including CPAP should not be provided other than pending transfer – either for newborns or older infants requiring HDU care. Currently our understanding is that this is also the position with respect to current staffing at CIC; We would question the provision of Level 1+ care as a model – it is outside of BAPM Standards (2010). CIC (alongside WCH) should work closely with the Regional Neonatal Operational Delivery Network to model provision of neonatal services both during and as a consequence of paediatric service reconfiguration within their hospitals. If the decision is to provide Level 2 care at CIC, a robust 3 tier rota would be required. The 'tier 2' aspect of this is likely to require a hybrid model in at least the short / medium term - a combination of middle grade (ST4 competency), ANNPs and resident consultants. This could be supported by APNPs or 2nd on call to cover emergencies in paediatrics. Current provision and transitional arrangements should be risk assessed against BAPM standards and in collaboration with the regional neonatal network

Accommodation	The team were shown around the new build for paediatrics (including ED / SSPAU / SCBU / Outpatients) at WCH and the Paediatric Ward / Outpatients at CIC Plan outlined to add 'child friendly ' decorations The accommodation was felt to meet the requirements of the future model of care	No further action at present

*If not case does not fulfil PICS standard no.67

**RCPCH 2011

Standard Documents considered:

- Facing the future: Standards for paediatric services, 2011, Royal College of Paediatrics and Child Health
- Facing the future: Standards for acute general paediatric services, 2015, Royal College of Paediatrics and Child Health
- Standards for care of the critically ill child(4th edition), 2010, Paediatric Intensive care Society
- High dependency care for children, Time to move on, 2014, Royal College of Paediatrics and Child Health
- Service standards for hospitals providing neonatal care (3rd Edition), 2010, British Association of Perinatal Medicine
- Toolkit for high-quality neonatal services, 2009, Department of Health
- Service specification: Neonatal care services, 2012, NHS Commissioning Board

Comments on Pathway: Stroke

Features of the Pathway	Assessment of Progress to date	What is needed
Paramedic triage currently with FAST	- FAST is used - Pre-alerts are in place	- Better communication with receiving base – Phone call - Clinician to clinician - NWAS consultation about transfers, numbers and potential changes 'en-route-communication consider ROSIER or other tool - Pre-hospital screening - Transfers to and from CIC with sufficient capacity to manage - ROSIER or other could improve accuracy of diagnosis potentially reduce Mimics transferred
Consultant led pathway meeting national specifications for a HASU including 7 days consultant review Single site HASU based at CIC	- Mapped the need for 5 Consultants Business case currently only gives number of confirmed strokes	- Focus on recruitment - Consider working in conjunction with Northumbria or other NE providers including CPFT (Neurology). - May need to consider having 6 Consultants if the service is to provide enough cover for both sites. These could be joint Neurology posts - Consider the Nurse Consultant role to support the service Assumptions regarding mimic strokes need to be made explicit in the business case including impact on bed capacity and costings. NWAS costings

		Refurbishment costs for CIC - Storage - Rehabilitation space - Equipment - Item from National Clinical Director(NCD) review
Out of hours telemedicine to support thrombolysis decision	- Already in place to support thrombolysis in conjunction with NW	- Explore potential for collaboration with Northumbria in relation to OOH thrombolysis should acquisition proceed. - *Post visit note: Thrombolysis is currently with Cumbria and Lancashire Network; discussions with Northumbria already indicate likely collaboration within NHFT.
Early Supported Discharge Teams. (ESDT)	Early engagement with CPFT When finalising the business case should include the impact of the ESDT. Good Integrated services in part of the region and an ESDT service in another	Equity across the region as there are currently a number of service models in place which include some ESDT Modelling of Rehabilitation Needs and ESDT - Numbers of patients - Capacity in Community hospitals - Manchester/Cheshire, London and also rural areas.

Clinical Senate Review of North Cumbria Services Re-provision (June/July 2015 visit)

Pathway: Nursing

Features of the Pathway	Assessment of Progress to date	What is needed
All of the pathways have implications for the nursing workforce; many have suggested that nurses could be trained as advanced practitioners. This approach is appropriate, however, needs to be considered as a whole as well as per pathway.	Nurse training and recruitment has been identified as key to the overall strategy for service delivery by both NCUH and CPFT Education programme for rural practitioners. Adult Nursing Strategy is in place and there is confidence in being able to recruit to nurse training and subsequently to support Advanced Nursing posts assuming the resource is available.	A comprehensive accredited training programme for Advanced Nurse Practitioners. Nursing workforce analysis to ascertain the numbers of post holders who would have the relevant skills to step up to these posts. Recruitment and training to ensure there are enough staff in place to backfill for the ANP posts and to sustain the current numbers of nurses needed. Continue to consider integrated models of work utilising the nurse role however this needs to be costed – we did not see the strategy nor a the estimated timescale and finances for this but aware this has been considered. Whilst utilising nurses is an appropriate and innovative solution the post holders will need the correct level of supervision. This could cause capacity problems for the limited numbers of medics.
The Deteriorating Patient Pathway	Already recruited Emergency Practitioners with some success.	Need more clarity of nurse staff ratios

Paediatrics/ Child Health Pathway	There is confidence in being able to recruit to Maternity and Child Health Nursing posts.	See Child Health Pathway
Stroke plan to have a HASU at CIC site requires an intensity of staffing by registered nurses.	Some consideration has been given to the numbers of Nurses and AHPs needed in the business case. Current cohort of staff are skilled (STAT trained) and could be trained to take on extra duties. Training could include a previously agreed University of Cumbria accredited Stroke Nurse module (not currently commissioned). Stroke could be attractive for nurse career progression. Already talking with nurses in training to attract them to work in Stroke.	Workforce figures need demonstrate explicit consideration of mimics. Advanced Nurse Post or Nurse Consultant post could be considered if the recruitment of Consultant Medical posts is unlikely. The Nurse could be utilised for example in early assessment and turn around.

Overall Review

The review team heard of the progress that has been maintained in implementation of the changes in pathways since the November visit. Particular note was made of the early July implementation date for the planned changes to the respiratory pathway. Pathways for Stroke and the Deteriorating Patient were considered during the November visit and were the subject of the current visit with Paediatrics added as a third pathway.

Considerable progress has been made in the development of a business case for the creation of a Hyper Acute Stroke Unit at CIC. This model is fully supported by the Senate review team; the National Clinical Director for Stroke services also endorses this plan. Further detail is needed, however, refining the business case specifically to state explicit assumptions regarding activity for patients where symptoms mimic a stroke and the implications for bed capacity and ambulance transfers, review the number of consultants needed for a HASU and further develop a joint rehabilitation plan with CPFT. The direction of travel is still fully supported by the review team.

For the Deteriorating Patient pathway, greater clarity on the purpose and ownership of the pathway is needed. There does not appear to be a consistent agreement with the intention of introducing the pathway and this is not helped by the current lack of confidence in securing the Senior Decision Maker role at WCH. Further discussion is also needed with NWAS about numbers of potential transfers. The facilities at WCH are very impressive and there is potential to explore innovative joint clinical posts with CPFT and Primary Care to ensure patients can be safely assessed and treated at WCH. If acutely ill medical patients can be assessed and treatment initiated in such an excellent facility, there needs to be a very clear case made as to which patients will benefit from transfer to CIC.

Given that the above pathways have now been visited twice, the review team would be willing to further review them without necessarily entailing a visit. Full documentation would, however, be needed eg. job plans, rotas, operational policies and protocols, financial plans and communication plans.

For Paediatrics, this was the first visit and it is hoped that the comments in the pathways section of this report are helpful. The impact of the decision regarding Obstetrics is not to be underestimated and the review team would welcome the Programme Director for the Success Regime considering this as a priority.

(*To get a better understanding of the challenges posed by geography the review team travelled between CIC and WCH by mini bus on 1st July 2015)*

All of these observations and suggestions need to be seen in the light or the emerging themes:

1. Communication and engagement
2. Recruitment
3. Organisational issues/success regime
4. Pace

5. Culture

If themes can be satisfactorily addressed, then there should be an opportunity to take this forward in a positive and constructive way.

Emerging Themes and Suggestions

The prime focus of the Terms of Reference for this review was the state of readiness for the three clinical pathways to be implemented safely. It was also envisaged that there would be some general themes to emerge over the course of the visit with opportunities to share learning and make suggestions regarding the implementation phase of any changes. This section pulls together those themes and identifies some suggestions which partners in North Cumbria may wish to consider. The Themes are grouped around

a. Communication and Engagement
b. Recruitment
c. Organisational issues/Success Regime
d. Pace
e. Culture

1. **Communication and Engagement**

Clinical

Within NCUH there appears to be a degree of successful buy in from most, but not all, senior clinicians. The task to continue this process of gaining buy in is not being underestimated; there is an internal assessment that since our last visit there has been improved engagement with staff (particularly at WCH) but with a recognition that there is still some way to go.

The feedback from GP colleagues was quite negative and made a clear distinction between engagement of the CCG and engagement of local GPs. There was a strong willingness on their part to become closely involved in planning and running services; there was clear recognition that the changes to the Cardiac pathway were an improvement to be welcomed but they had clear reservations regarding the other pathways. An approach to them as potential ambassadors will need to be far more proactive.

Public

Of more concern are the comments and observations regarding engagement with the public and colleagues in primary care, including General Practitioners (GPs). In spite of the considerable attention that has been given to this by management at NCUH, with numerous roadshows supported by Healthwatch, there still appears to be considerable mistrust of the direction of travel in developing pathways which are perceived to be an ongoing process of steadily removing services from WCH. Trust management is seeing its task as ‘de-risking’ services at WCH with an inherent improvement in quality and patient safety. Whilst the review team fully supports the emphasis on quality and patient safety, it may need a much more positive description of the vision for services at

WCH; reference was made several times to the positive way in which the 2008 Strategy – Care Closer to Home – was received.

The mistrust of the local community in NCUH management is acknowledged by all parties to be deep seated in spite of the considerable efforts to be transparent and patient focussed.

Suggestions

Further work is needed on telling the positive story on what WCH will offer for its local population with extensive use of case studies and examples highlighting the numbers of patients who will be able to be treated at WCH or in the community rather than just the numbers who will transfer.

Genuine engagement with local GPs might be a way forward given their popularity ratings and role within the local community as ambassadors for health services. A few local champions may go a long way towards convincing the public that change is needed, but the local champions need to be engaged very quickly.

Consideration might usefully be given to a much more positive vision for the future of WCH; the facilities in the new hospital are very impressive with well thought through departmental adjacencies and an extensive range of diagnostic modalities.

1. Recruitment – The Review Team does not underestimate the difficult task of recruiting into posts currently occupied by Locums and after Communication and Engagement, successful recruitment was seen as the key to delivering a vision of services remaining at WCH. Medical recruitment is an issue for NCUH and for Primary Care. Efforts to increase/improve the focus on academic and research posts are to be applauded as a way of raising profile and making service posts more attractive. There was a sense of prioritising several key posts for early attention with an overall target of 50% of current vacancies being filled over the next 12 months. It is understood that a sensitivity analysis of which posts in which specialties is being maintained; this is welcomed and supported as a means of persuading all concerned of the urgency of the recruitment task.

It might also be appropriate to design quickly a joint recruitment campaign between primary and secondary care as both sectors are describing similar recruitment problems. The review team heard during the last visit (November 2014) of early plans to have innovative joint posts on the Emergency Floor in the new part of WCH and we understand this worked well at a time of crisis in December 2014, but is less well thought through outside the crisis period. *Post visit note:- It is understood that an event is taking place in September 2015 to explore this. It was also noted for the second time that there were issues with the Human Resources department at Northumbria Healthcare NHS Foundation Trust

regarding recruitment processes during the crisis when NCUH and CPFT were working closely together to solve the crisis.

Suggestions – a cross sector approach to medical recruitment should be strongly considered, prioritising senior decision making posts in the first instance, and linking into planned academic and research arrangements.

2. Organisational issues/Success Regime – Those reviewers who were involved in both visits felt that the whole system did not feel as collective as previously. The understandable urgency of handling demand pressures over the winter/spring period alongside the contracting round may well help explain this. All involved seemed to welcome the impending Success Regime and the new Director this regime would bring with a renewed focus on solving issues across Cumbria heath community rather than as individual organisations. There also appears to be a recognition that the Success Regime will require some difficult decisions to be made especially regarding financial challenges.

Suggestions – An offer is made for the incoming leadership of the Success Regime to meet with the Senate Chair, Vice Chair and Associate Director at an early opportunity to discuss the outcome of the two review visits to North Cumbria. An encouragement is given to all organisations to consider how the boundaries of the organisations can be removed where appropriate at all times rather than just at times of crisis. The incoming leadership of the Success Regime to consider examining whether a tariff based system of payment has the right incentives for such a financially challenged economy.

3. **Pace –** It was noted that several features impact on the pace at which implementation of the three pathways can be delivered

a. The new hospital in Whitehaven is due to open in September

b. Plans for Maternity services have to be agreed by March 2016 with very clear implications for Paediatric pathways; our assumption in commenting on the proposed Paediatric pathways is that full Obstetric services will remain at WCH

c. Plans to recruit into key medical posts suggest that 50% of current vacancies will need to be filled substantively by next summer.

The pace of these timelines suggest that a firm project plan could sensibly be developed by the whole economy with the incoming Director of the Success Regime holding the system to account for delivery.

Suggestion – a detailed project plan be designed at an early opportunity.

4. Culture – The review team became even more aware on this visit that there is a very distinct culture in Cumbria, most particularly in West Cumbria and they picked up a sense that this was not universally understood or appreciated. Inevitably when it comes to culture there is not a great deal of concrete evidence to point to but there is a clear sense when talking to people of being ‘done to’

rather than working up solutions that fit for the people of Cumbria. It is a very difficult balance to achieve but the review team would encourage all key stakeholders to be mindful of the unique features which influence the culture in Cumbria and find ways to reflect the differences which might be needed in pathway design.

Conclusion – After much deliberation the review team came to the conclusion that it is not possible to simply implement acknowledged models of care developed for other parts of the country. Rather, highly innovative approaches are needed to reflect geography, new role models perhaps combining primary and secondary care responsibilities, and even the potential development of single funded pathways across organisational boundaries.

Appendix 1:Terms of Reference

CLINICAL SENATE REVIEW TERMS OF REFERENCE

Title
High Risk Pathways for medicine (Stoke and Deteriorating patient) and Child Health/Paediatrics in North Cumbria University Hospitals NHS Trust
Sponsoring Organisation
NHS Cumbria Clinical Commissioning Group
Clinical Senate
Northern
NHS England regional or area team
NHS Cumbria, Northumberland, Tyne and Wear Area Team

Terms of reference agreed by:
(Name)
on behalf (name) Clinical Senate and
(Name)
on behalf of sponsoring organisation (name)
Date:

Clinical review team members

Andrew Cant (Chair) – Clinical Senate Chair and Consultant in Paediatric Immunology and Infection , Newcastle upon Tyne Hospitals Foundation Trust
Alison Featherstone – Network Manager (CVD and Cancer), Northern England Strategic Clinical Networks
Andrew Simpson – Consultant in Accident & Emergency Medicine, North Tees & Hartlepool NHS Trust
Chris Plummer – Consultant Cardiologist, Newcastle upon Tyne Hospitals Foundation Trust
Jeff Perring - Consultant Intensivist , Associate Medical Director ,Sheffield Children's NHS Foundation Trust
Jon Scott – Stroke Consultant, South Tyneside NHS Foundation Trust
Paul Fell – Consultant Paramedic, North East NHS Ambulance Service Trust
Robin Mitchell – Clinical Director, Northern England Strategic Clinical Networks
Rollo Clifford - Consultant Paediatrician ,Dorset County Hospital and RCP representative
Roy McLachlan – Associate Director, Northern England Strategic Clinical Networks and Senate, NHS England
Suresh Joseph – Consultant Psychiatrist, Northumberland Tyne and Wear NHS FT and Clinical Senate Vice Chair

Aims and objectives of the clinical review

To review CCG proposals for high risk pathways for in North Cumbria University Hospitals NHS Trust medicine (Stroke and Deteriorating Patient and Child Health/Paediatrics to advise on aspects of implementation.

Scope of the review

To include part 1 review of the Deteriorating patient and Paediatric/Child Health and part 2 review of the acute Stroke pathways. To be given an overview of the progress in implementation of Cardiac, Respiratory and GI Bleed pathways.

Timeline

The review visit will take place on 1st and 2nd July 2015.

Reporting arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report. Clinical senate council will submit the report to the sponsoring organisation. Part 2 clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

Information collated by the sponsoring organisation to be presented to the senate review team before the actual visit: including demographic data, organisational information, site maps, patient flows and any other information that the sponsoring organisation thinks will help the reviewers understand the issues surrounding the services under review.

Reviewers will meet in Cumbria the evening of 30th June to discuss the information received and plan for the following 2 days

Day 1 (1st July 2015)

Reviewers will visit both hospital sites to meet a range of clinical Directors, Clinical colleagues and GPs.

Day 2 (2nd July 2015)

Reviewers will meet with CCG leads, Trust Executives, Heathwatch, Patient Groups, OSC representatives and NWAS. Later afternoon reviewers will set aside for discussion.

Report

A draft clinical senate assurance report will be circulated within 10 working days from the visit to the review team and the sponsoring organisation for factual accuracy. Comments/ correction must be received within [10] working days.
The final report will be submitted to the sponsoring organisation by Mid-August 2015.

Communication and media handling

The arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation. The sponsoring organisation identified communication lead (Rachel Chapman?), to advise on publication of the report and organise press releases/conferences, meetings with patent groups, public, staff and boards, health and wellbeing boards and Health overview and scrutiny committees as deemed appropriate.

Resources

The Northern clinical senate will provide administrative support to the review team , including setting up the meetings and other duties as appropriate.
The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance

The clinical review team is part of the Northern Clinical Senate accountability and governance structure.
The Northern clinical senate is a non statutory advisory body and will submit the report to the sponsoring organisation.
The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

i. Provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions). The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. Respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. Submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical senate council and the sponsoring organisation will

i. Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate council will

i. Appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. Endorse the terms of reference, timetable and methodology for the review
iii. Consider the review recommendations and report (and may wish to make further recommendations)
iv. Provide suitable support to the team and
v. Submit the final report to the sponsoring organisation

Clinical review team will

i. Undertake its review in line the methodology agreed in the terms of reference
ii. Follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. Submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. Keep accurate notes of meetings.

Clinical review team members will undertake to

i. Commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology).
ii. Contribute fully to the process and review report
iii. Ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. Comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix 2:Time Table for visit

Tuesday 30/06/2015			
Time	Venue	Programme	Comments
17:15	Castle Inn Best Western, Bassenthwaite, Keswick, Cumbria CA12 4RG	Senate Review Team Pre-Meet	
17:30		Briefing with CCG colleagues	David Rogers, David Stout, Kirsty Roberton
18:30		Meeting with GPs	Meeting Dr. L Rhodes, Dr. H Horton and Dr. J Fidalgo
19:30		Dinner	

Time Table for visit

Wednesday 01/07/2015			
Time	Venue	Programme	Comments
07:15		Breakfast	
07:45		Travel to WCH	
08:30		Arrive at WCH	Meet Lisa Robinson in Reception
08:45	Management Suite	Update from Trust colleagues	Debbie Freake, Director of Strategy and Julian Auckland-Lewis, Interim Director of Service Transformation
09:30	Meeting Room 1 TBA	Group 1 - Stroke	Dr Olu Orugun (Consultant) and Rachel Glover(Specialist Nurse)
	Meeting Room 2 TBA	Group 2 - Paediatrics/child Health	Tour of paediatrics WCH – Les Morgan, Director of West Cumberland Hospital Redevelopment & Jason Gane, Paediatric Consultant
	Meeting Room 3 TBA	Group 3 - Deteriorating Patient Group	Charles Brett ,James Hetton and Claire Summers (A&E Consultants at WCH)
11:00		Tour of the Emergency Department	Les Morgan – Director of West Cumberland Hospital Re-development and Jo Cox, Consultant
12:00		Travel to CIC	
13:30	Chair office, pillar building	Arrive at CIC and Lunch	
14:00 – 14.30 – tour of stroke unit and paediatrics	Video Conferencing Room, Education Centre, CIC	Group 1 - Stroke Paul Davies will provide tour of Stroke Unit at CIC between 2pm and 2.30pm	Paul Davies (Consultant, Stroke) , Lisa Pearce (Stroke Specialist Nurse) , Gemma Richardson (CT Section Lead Radiographer) (Stroke team at CIC)
	Classroom 1, Education Centre, CIC	Group 2 - Paediatrics/child Health Paul Whitehead will provide tour of Paediatrics at CIC between 2pm and 2.30pm	Jonathan Cardwell (Business Director), Paul Whitehead (Consultant) , Sara Jones (General Manager) , Mahfud Ben-Hamida (Clinical Director) , Eleanor Hodgson (CCG), Neela Shabde (CCG), Marl Alban (GP), Wendy Rankin (CPFT)

		Group 3 - Deteriorating Patient Group	Split to accompany Stroke and Paed groups
16:30	Video Conferencing Room, Education Centre, CIC	Trust Executives	Gail Naylor, Director of Nursing and Midwifery Jeremy Rushmer, Medical Director
17:30		Return to hotel	
18:30	Hotel	Plenary	
19:30		Dinner	

Time Table for visit

Thursday 02/07/2015			
Time	Venue	Programme	Comments
07:00	Castle Inn Best Western	Breakfast	
		Itinerary for Group 3, Deteriorating Patient Group	
08:00	Teleconference with Ann Farrar, Chief Executive		
	CIC	Group 3 – Deteriorating Patient Group travelling to CIC	Mike Hodgson, (Consultant Anaesthetist) , Stephanie Preston(Deputy BU Director) , Denise Burke, (Business Unit Director) , Kath Martin,(General Manager) , Diane Murchison (Matron, Critical Care)
09:00	Stephanie Preston's Office, Pillar Building, CIC	Group 3 Deteriorating Patient Group meeting colleagues	
10:30		Group 3 travelling to Castle Inn to join the rest of the panel for sessions	
		Itinerary for Group 1, Group 2 and rest of the panel	
08:00	Castle Inn Best Western	Session 1 (Review Panel only)	Review meeting
09:00		Session 2	David Lewis and Salli Pilcher CPFT
10:00		Break	
10:15		Session 3	Mrs. Carol Woodman and Mr. Mahesh Dhebar (White Haven Action Group)
11:15		Session 4	Coun Neil Hughes, chair of health scrutiny and David Blacklock, chief executive of Healthwatch
12:15		Session 5	Teleconference - Bob Williams (NWAS) and team
13:15		Lunch	
14:15		Session 6	Deteriorating Patient – Jim Shawcross, consultant physician Paul Plant, Clinical Director

15:00		Discussion and Report Writing	
16:30		Finish	

Appendix 3:Review Panel members

Prof. Andrew Cant. Clinical Senate Chair

After training in internal medicine, infectious diseases, paediatrics and neonatology at St George's and Guy's Hospitals in London, Professor Cant held a Medical Research Council Fellowship in immunology before completing his training in paediatric immunology and infectious diseases at the Hospital for Sick Children, Great Ormond Street, London and L'Hopital Necker, Paris. Professor Cant was appointed as a Consultant Paediatrician in Newcastle in 1990, to set up 1 of 2 national referral centres for the treatment of children with severe immunological disorders, and a regional paediatric infectious diseases service In 1997 Professor Cant became Clinical Director for Children's Services within the Royal Victoria Infirmary. He has led the development of the £100 million 244 bedded Great North Children's Hospital (GNCH) which opened in 2009 and was fully completed in late 2010.

In 2006 Professor Cant led a national review of UK children's specialist services on behalf of the RCPCH and the Children's Commission for England, entitled, "Modelling the Future". This survey highlighted current provision, defined need, proposed standards for networks From 2006 to 2009 Professor Cant was President of the European Society for Paediatric Infectious Diseases (ESPID). Professor Cant was Chair of the Medical Advisory Panel of the UK Primary Immunodeficiency Association from 1998 to 2007; In 2005 he oversaw the national consensus document 'Diagnosis and management of C1 inhibitor deficiency' In 2006 he led joint clinician/patient review/accreditation of primary immunodeficiency centres in the UK, setting and monitoring standards.

From 2007 Professor Cant chaired the 'Children's Clinical Network' (initially the children's work stream of 'Our Vision, Our Future') for the North East of England. Professor Cant is very much enjoying his new role as Chair of the Clinical Senate and is fully committed to lead the Senate's work, serving the Clinical Commissioning Group, Clinical Networks and wider community, in giving clear strategic clinical advice, operational development, and to oversee coherent and effective senate arrangements in the North East, in a way that facilitates in achieving the best possible outcomes for patients and benefits to the health of the population as a whole.

Dr. Chris Plummer, Consultant Cardiologist

Dr Plummer trained in Bristol and Oxford Universities and undertook his post-graduate medical education in the Northern Deanery. He works as a consultant cardiologist in the Freeman Hospital where he is clinical lead for implantable cardiac rhythm devices. His other clinical and research interests include the cardiovascular effects of cancer treatments including the early detection of toxicity with biomarkers and protective strategies for adults and children. He is also heavily involved in all

aspects of medical education from medical student interviews and exam setting to working as training programme director for cardiology.

Dr Jon Scott BMedSci BM BS FRCP MD

Dr Scott graduated from the University of Nottingham in 1992 and after postgraduate training in various hospitals around the North East was appointed as a Consultant in Elderly Care/General Medicine with a Specialist Interest in Stroke Medicine at South Tyneside Hospital in 2003.

In addition to leading on Trust stroke and TIA services, Dr Scott is one of 4 Consultant Acute Physicians within the Trust working on the Emergency Assessment Unit and shares responsibility for elderly care in-patient services.

Dr Scott was appointed as one of 2 clinical advisors for stroke to the Northern Cardiovascular Network between July 2008 and April 2012. From an educational point of view, Dr Scott served as Foundation Programme Tutor for the Trust between 2006 and 2013 before being appointed to the role of Foundation School Director for Health Education North East.He maintains an active interest in teaching as a Clinical Lecturer for the Wear Base Unit of the University of Newcastle and in research, supervising recruitment into a number of stroke trials. Dr Scott was appointed to the Northern Clinical Senate in 2013.

Dr. Robin Mitchell, Clinical Director, Strategic Clinical Networks

Dr Robin Mitchell graduated in medicine from the University of Edinburgh in 1980. He undertook training in Anaesthesia and Intensive Care in Edinburgh and Leicester. In 1989 he was appointed as Consultant Anaesthetist in Durham, and subsequently undertook the roles of College Tutor and Clinical Director. He maintained a wide range of clinical interests including obstetric anaesthesia and intensive care medicine. He was a member of the project team for the development of the new North Durham Hospital, and was chair of the Durham and Tees Clinical Advisory Group for maternity and children's services in 2012-13. Dr Mitchell was Director of Medical Services for North Durham Acute Hospitals Trust from 1996 to 2000, and Executive Medical Director for County Durham and Darlington NHS Foundation Trust from 2010 to 2013. In 2013 he took up the role of Clinical Director for Northern England Strategic Clinical Networks. He has a keen interest in patient safety and service design.

Mr. Paul Fell, Consultant Paramedic

Paul was appointed as the Consultant Paramedic in November 2013, prior to this appointment Paul was the Head of Clinical Care and Patient Safety for the Trust, Paul specialises in education and training as well as Research and Development for the Trust and has a specific interest in advanced pre-hospital care.

Dr. Andy Simpson, MBBS, FRCS(Ed), FCEM, DCH, Dip Clin Ed.

Qualified in 1988 Consultant in Emergency Medicine since 1999 initially in Hartlepool then Jointly with University Hospital of North Tees until Hartlepool A&E closed in 2011. Clinical Director of Emergency Care for North Tees and Hartlepool NHS

Foundation Trust since 2006. Specific interests are Paediatric Emergency Medicine and Medical Education

Mr. Roy McLachlan, Associate Director, Strategic Clinical Networks and Senate

Roy joined the NECN in February 2009 on secondment from Northumberland, Tyne and Wear NHS Trust where he was Chief Operating Officer. Prior to that he was Chief Executive of a number of NHS statutory bodies - NHS Trusts, a Health Authority and a Primary Care Trust. He has spent most of his managerial career working in the North East but started working in Scotland on the graduate scheme having completed an M.A. in French at St. Andrews University. He subsequently became one of the first NHS managers in the North East to undertake an M.B.A. Roy has been the Associate Director of the SCN since April 2013.

Dr Rollo Clifford FRCPCH, DM

Dr Clifford is a Consultant Paediatrician at the Dorset County Hospital with a special interest in respiratory medicine including the local cystic fibrosis clinic; he also provides a service for severe food allergy and has contributed to Dorset community policies and procedures on this. He has been local investigator for a number of national trials and is a member and past chair of the South and West Committee for Research and Audit in CF.

Rollo was Clinical Director for 5 years, during which he led his department in the first sustainable paediatric resident consultant scheme. He was his trust lead for Clinical Audit for a further 3 years; subsequently he has been a member of RCPCH Council as Officer for Continuing Professional Development 2008 – 2013.

Dr Jeff Perring, Consultant Paediatric Intensivist

Jeff qualified from the University of Liverpool in 1988 and specialised in Anaesthesia before moving into Paediatric Intensive Care, becoming a Consultant Intensivist at Sheffield Children's NHS Foundation Trust in September 2002. He was Director of the Paediatric Critical Care Unit from 2007 until 2015 when he became Associate Medical Director for the Trust. During this time he was medical lead for the setting up of Embrace, the Yorkshire and Humber Infant and Children's Transport Service which began in 2009 and now undertakes in excess of 2,000 transfers annually.

Jeff is Vice Chair of the Yorkshire and Humber Clinical Senate, joint lead for the Yorkshire and Humber Paediatric Critical Care Operational Delivery Network (ODN) and the regional representative on the Paediatric Critical Care Clinical Reference Group (CRG). Since 2013 he has chaired the steering committee of the National Transport Medicine Programme in Ireland. In 2007 Jeff completed an MA in Healthcare Ethics and Law, an area in which he continues to have a close interest.

Dr Suresh A. Joseph MBBS MMedSc FRCPsych.Vice Chair, Northern Clinical Senate

Dr. Joseph is a psychiatrist who in addition to his clinical role has contributed in the areas of professional and clinical leadership, service redesign and development, and postgraduate training, having held senior positions in NHS management and in the Royal College of Psychiatrists. He was Executive Medical Director of Northumberland, Tyne and Wear NHS Foundation Trust, one of the largest mental health and disability healthcare organisations in the UK, between 2007 and 2014. He led on clinical and quality governance and safety of services, service development and innovation, and the development of the medical workforce. Prior to this he contributed at regional and national levels as Hon. Secretary of the Faculty, RCPsych., Convenor for psychiatric training schemes in Scotland, Programme Director and Postgraduate Tutor for Psychiatry in the Northern Deanery.

He has wide experience of service development and redesign, having led large-scale change projects in Newcastle and Sunderland. He initiated a comprehensive review of service models for his Trust leading to an ongoing service transformation programme. He is trained in change methodology in the North East Transformation System, in association with Virginia Mason Hospital in Seattle, and in the NHS Institute's Large Scale Change programme.

Through his experience as Medical Director and Responsible Officer of a large NHS Trust, he has expertise in establishing and operating medical professional development and regulatory systems, carrying out complex investigations into serious incidents and concerns about professional practice.

He is a medical member of the First Tier Tribunal (Mental Health). He has supported NHS Trusts in improving systems for the Mental Health Act and provides mentoring for clinical leaders.

Alison Featherstone, Clinical Network Manager, CVD and Cancer

Alison Featherstone is the Clinical Network Manager for Cancer and Cardiovascular disease. She is also the Network Lead for patient and public involvement and covers a programme of work around end of life care. Alison qualified as a nurse in 1986 and spent most of her 30 years within the NHS working as a cancer and palliative care nurse. She has a BA (Hons) in Cancer and Palliative care and an MSC in integrated Service Improvement. Alison has worked in a number of organisations in nursing management and leadership roles. She is also a lecturer at Newcastle University (Medical School).

Appendix 4:Glossary of Acronyms

A&E	Accidents and Emergency
ACS	Acute coronary syndrome
AHP	Allied Health Professional
ANNP	Advanced Neonatal Nurse Practioner
APNP	Advanced Paediatric Nurse Practitioner
BAPM	British Association for Paediatric Medicine?
BCIS	British Cardiovascular Intervention Society
BU	Business Unit
CCG	Clinical Commissioning Group
CCT	Certificate of Completion of Training
CE	Chief Executive
CEO	Chief Executive Officer
CIC	Cumberland Infirmary ,Carlisle
CPAP	Continuous Positive Airway Pressure
CPFT	Cumbria Partnership Foundation Trust
CQC	Care Quality Commission
DTN	Door To Needle
ECG	Echo Cardiogram
ED	Emergency Department
EOU	Enhanced Observation Unit
ESDT	Early Supported Discharge Teams
FAST	Face Arms Speech Time
GI Bleed	Gastrointestinal Bleed
GP	General Practitioner
GP	General Practioner
GRACE	Global Registry in Acute Coronary Events
HASU	Hyper Acute Stroke Unit
HDU	High Dependency Unit
HR<40	Heart Rate
LV	Left Ventricular
MI	Myocardial Infarction
MINAP	Myocardial Ischaemia National Audit Project
NCOR	National Institute for Cardiovascular Outcomes Research
NCUHT	North Cumbria University Hospital Trust
NE	North East
NEWS	National Early Warning Score
NICE	National Institute for Health and Care Excellence
NICOR	National Institute for Cardiovascular Outcomes Research
NSTEMI	non-ST-segment elevation myocardial infarction
NWAS	North West Ambulance Service
OOH	Out of Hospital
OOH	Out Of Hours
OSC	Overseas Scrutiny Committee
PCI	Primary Cardiac Intervention
PCI	Percutaneous Coronary Intervention
PIC	Primary Coronary Intervention
PICS	Paediatric Intensive Care Society
PPCI	Primary Percutaneous Coronary Intervention (Primary Angena)
RCPCH	Royal college of Paediatrics and Child Health

ROSIER	Recognition of Stroke in the Emergency Room (Stroke Assessment Tool)
SBAR	Situation-Background-Assessment-Recommendation
SCBU	Special Care Baby Unit
SSNAP	Sentinel Stroke National Audit Programme
SSPAU	Short Stay Paediatric Assessment Unit
STEMI	ST segment elevation myocardial infarction
TDA	Trust Development Authority
TIA	Transient ischaemic attack
TIMI	Thrombolysis in Myocardial Infarction
UCLAN	University of Central Lancashire
UGI	Upper Gastrointestinal
UHNC	University Hospital North Cumbria
UK	United Kingdom
WCH	West Cumberland Hospital

Appendix 5: Contact Details

Northern Clinical Senate Office
Waterfront 4
Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY
Tel: 0113 825 3039
Email: england.northernclinicalsenate@nhs.net
Web: www. nesenate.nhs.uk
Senate Chair : Prof. Andrew Cant (Contact: gale.roberts@nuth.nhs.uk)
Associate Director for Networks & Senate: Roy McLachlan (contact: roy.mclachlan@nhs.net)
Senate PA: Seema Srihari (Contact: seemasrihari@nhs.net)