Medical Directors Update

Dr Colin Wasson, Medical Director & Dr Gill Burrows, Deputy Medical Director June 2016

NHS hospital care is facing challenging times, and we are all likely to see considerable change in our working environment. Keeping our staff well informed will be essential as we develop. In this update we have included information from the Trust Board / Executive Team meetings and regional developments, updates on other issues relating to medical staff, and on developments specific to one area of the Trust but of wider interest. We will circulate this to all of our permanent medical staff, and if it is found to be useful it could be a regular publication.

**Healthier Together**

Progress thus far has been relatively slow. Further clarity has been given with regards to the ‘Healthier Together Model’ clearly stating that all elective colorectal surgery, and all non- ambulatory emergency surgery will be done only in specialist hospitals.

East Cheshire (Macclesfield), although not part of the Greater Manchester consultation, initially showed interest (executive level and commissioners) in collaborating with the sector rationalisation of general surgery. It has proven difficult to achieve any real clarity on their commitment towards working on a single site, and at the recent sector board meeting it was agreed we must have this clarity otherwise efforts to integrate their service with the remainder of our ‘southeast sector’ will have to be put on hold.

Tameside and Stockport remain bound by the conclusions of the public consultation and while some understandable resistance to the proposals remains from their surgical representatives, the political will driving this initiative is considerable. We remain confident that progress will be made. Anticipated date for initial (but not full) movement of patients across the sector is March 2017.

**Non elective care pathway**

‘Headline’ news has been about our poor 4 hour ED performance, at times one of the worst performing trusts in the country. This is not an ‘ED problem’, rather a problem with the flow of emergency patients through (and out of) our hospital. The graph below speaks for itself.



Our poor performance in this area has certainly brought us unwanted attention, but more importantly it has had a major effect on the care that we deliver. Anyone who has passed through our Emergency Department in recent months will have seen how this manifests itself, with patients at times managed for prolonged periods on trolleys, in corridors. ED staff have been working under considerable pressure in this environment, and not surprisingly recruitment and retention is a challenge. The staff working in ED have delivered the best care possible in difficult circumstances and deserve considerable recognition for their heroic efforts. They are a brilliant team.

Whilst there are issues with how we maintain flow of patients through our emergency pathway, the ‘bed crisis’ also reflects a wider issue as placement of patients medically fit for discharge, but unable to return to their previous place of residence.

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The ‘delayed transfers of care’, are not unique to Stockport, and has been widely reported in the press as a national problem. None the less, our ED performance has stood out as worse than that seen elsewhere. The delayed transfers of care is one of several areas that we are working to try to improve.

Our current ED trajectory is slightly improved, but if there is a brief let up over the summer months, we need capitalise on it if we are to ensure that we have an improved plan before ‘winter’ (i.e. anything that is not the middle of summer!’) is upon us once again. Consideration about the size, layout and supporting services for our ED and Acute medical service is currently subject to considerable focus (see below).

**ED performance and the 10 pledges** (the 10 pledges2013 is attached as an appendix)

One of the frustrations voiced when ED is busy, is delays accessing specialty review of patients. Specialty staff argue that such referrals are often only received at 3 hours and 59 minutes, leaving little prospect of reviewing andresolving the patient’s care in a timely fashion. In reality, both issues cause us problems, and the patients can end up on a trolley in ED for prolonged periods. To better understand where the recurrent problems lie, we will be recording the time of referral, and the time of specialty review. This will allow us to track the issue and feedback based upon more than hearsay and rhetoric. The timings collected will be ‘time of referral’, and ‘time of speciality review documentation in notes’. The latter documentation is only done after the review, so it is suggested we aim for this to be done within 90 minutes of the referral (the 10 pledges was for the patient to be ‘seen’ within 60 minutes). The goal is to minimise the time patients spend on trolleys and in ED. We will feedback with the data by specialty when we have it.

One of the ‘10 pledges’ states; ***‘If there is a delay in a patient being reviewed and the patient has been seen by a middle grade and/or Consultant in ED and it is felt that a transfer to the relevant ward is appropriate, the patient will be transferred without review by the inpatient specialty. In such situations a formal clinical handover at senior level (ST and above) is required to ensure that patient safety is not compromised.’*** There has been considerable resistance to this process, driven by the experience that once admitted under the wrong specialty, due to bed pressures it then becomes almost impossible to transfer the patient to the correct specilaty. To combat this, it is proposed that ***if a ‘ward transfer without specialty review’ has been undertaken as per this protocol, and the subsequent speciality review concludes that they have been admitted under the wrong specilaty*** (and the receiving specialty agrees with the conclusion)***, the patient should be allocated the next avilable bed in the correct specialty, irrespective of the ED wait at the time.*** We will continue to monitor how this works, and welcome any feedback.

An elderly patient recently presented to ED after a fall. She had sustained a considerable injury to her hip and pelvis with an expanding pelvic / retroperitoneal haematoma, but no hip fracture. There was a considerable dispute between ED, T&O, General Surgery and Medicine about who should provide on-going care. The patient was not a candidate for surgery, nor was surgical intervention indicated, but the physicians felt the bleeding may require surgical or vascular input. Her condition subsequently deteriorated fairly quickly. The ‘ten pledges’ is fairly clear on how such disputes should be managed;

***‘ED Consultants have the authority to admit patients to the most appropriate specialty in their view. In the case of disagreement between specialties, ED consultants will communicate their decision to the relevant consultants.’***

In reality, any of the three specialties in this case could have managed this patient (palliative measures in a ward environment and in a proper bed). All refused, and gave valid reasons. This case illustrates why we need an ‘independent arbiter’ is required in such cases, and to this end, after balanced discussion, ultimately the ED consultant should make the final decision and expect to be supported. This patient died in ED on a trolley with the dispute unresolved. She should have received better care.

The ‘ten pledges’ were introduced in 2013, and set out to establish a code of practice that would ensure the emergency flow of patients is efficient and effective. This has been more important than ever during our recent capacity challenges. As ever we welcome any debate on any shortcomings of the pledges, as they can always be improved upon.

**D Block ‘surgical unit’ extension.**

The building work on the D block extension is making good progress, and it is anticipated that it will open on time in October. Top floor will be the day case and short stay surgical facility, along with the Surgical Assessment Unit. First floor will be four new operating theatres to replace our day case unit (1 theatre), address a current considerable shortfall in capacity (1 theatre), and prepare for any expansion resultant from Healthier Together (1-2 theatres). The ground floor will provide a large in-patient ward.

The existing plans were for the new ground floor ward beds to be for surgical patients. In the light of the problems with acute care flow in ED / medicine, this has now been reconsidered. Our inability to cope with the demand for emergency medical care (as outlined above), will continue unless affirmative action is taken. Without it we will continue to see poor patient experience, cancellation of elective surgery, and initiatives such as healthier together have absolutely no prospect of developing. In this context, it is now proposed that emergency flow of medical admission be improved by developing a single ‘emergency floor’ for ED and acute medicine, which encompasses the current ED footprint, and the ground floor of the D block extension. This will consolidate resources into a smaller area, make efficient use of our acute medical consultants, and enable the development of a minor injuries unit to displace some of the activity out of the congested main ED.

Without the use of the ground floor beds, plans to transfer all of our surgical wards to the D block extension have had to be reviewed. Two of the existing surgical wards (probably C6 and B3) will need to be retained for surgical patients. While this is a disappointment to surgery, plans for surgical expansion, and the prospect of another winter of cancelled elective cases justify the decision. Details are to be finalised.

While moving our acute medical wards into immediate proximity to ED will help, there is a need for far broader changes in how we manage our acute medical admissions if we are to see the kind of changes to flow that we need. We need to capitalise on any ‘quiet months’ to ensure we are in a fit state to face re-escalation in demand later in the year.

**The ‘Toft’ report into 7 never events**

Seven patients attended the trust for their healthcare needs between 31st December 2012 and 22nd July 2015, and suffered serious untoward incidents (SUI) later classed as ‘Never Events’. Following growing concerns about the frequency of these events, an external review of these ‘never events’ was commissioned by the trust from Professor Toft, a renowned national expert on patient safety. His report, completed in April 2016 provides an independent opinion on the systems, culture and robustness of the investigations carried out at the trust. The seven incident investigations reviewed were;

1. **Retained swab after pacemaker insertion**
2. **Wrong lens implanted**
3. **Retained swab after abdominal surgery**
4. **Retained fragment of metal following urethral procedure**
5. **Biopsy of wrong lung.**
6. **Retained swab after spinal surgery**
7. **Wrong sided local anaesthetic injection**

Of these seven ‘serious incidents’, only one would certainly have been avoided had national guidelines been followed. The remaining incidents were serious, but staff did follow existing process, and the errors that occurred resulted largely from human factors, rather than failure to follow established protocols. Professor Toft argues that only one of these incidents was truly a ‘never event’.

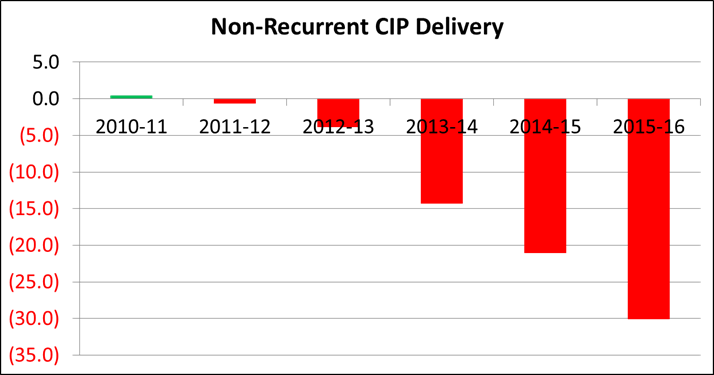
The report concludes

‘It is clear therefore that the types of SUI’s/*Never Events* experienced by the Trust during the period covered in this External Review are similar in nature to those which have occurred at numerous other NHS England Trusts. Moreover the published data shows that the number of ‘*Never Events*’ which have been reported by the Trust is significantly lower than other NHS Trusts. Hence, the Trust does not appear to be reporting an atypical or outlier pattern of such events when compared to the other Trusts in NHS England.

In addition, from the reports of the investigations into the SUI’s discussed above and the additional enquiries that have been made there appears to be no discernible pattern of behaviour which suggests that the Trust has a systemic problem with patient safety. Each of the ‘*Never Events*’ which took place did so due to a unique set of circumstances prevailing at the time. They also appear to have taken place at random over the period covered by this External Review.’

While this report offers considerable reassurance, there remain considerable lessons to be learned, not least in the way we approach our investigation of such serious incidents in the future. 33 suggested actions will be followed. The full report will be formally presented to the trust board of directors next month and will be circulated. It does make for interesting reading.

**Finance**

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Those of you who attended the ‘start of the year’ evening meeting for doctors will remember Feroz Patel, our finance director summarising our current financial position. There is little good news. While the two bar charts included above may mean more to some than others, the trajectory is clear to everyone. Having consistently made a small profit over recent years, and building up a cash reserve (savings), last year we made a loss of £12.9 million. This year, the projected loss is £34 million. **This equates to us losing money at the rate of £65 per minute, day and night, 7 days a week.** Our cash reserves are rapidly depleting, and at our current trajectory money will run out later this year.

Money ‘running out’ will manifest as loss of control of our future as external agencies take over control of our services. The measures to resume financial security are likely to feel fairly draconian, and certainly not ‘business as usual’.

In an effort to avoid this scenario, plans are in place to reduce the ‘loss’ by approximately half.

Close 40 beds £4.7 million

Improve theatre utilisation £2.2 million

Improve procurement £2 million

Reduce inappropriate tests and delays £1.6 million

Reduce agency costs £4 million

Reduce avoidable cancelled ops £1.7 million

Reduce the size of the estate £1.8 million

The bed closures may seem counter intuitive, given the experience of recent months, but this does assume reducing demand as the ‘Stockport Together’ collaborative work starts to bite.

Needless to say, it is in all of our interests to get behind these initiatives. There are challenging times ahead, and if we fail to maintain our financial viability as an organisation, we will lose much of the influence on our future that we currently hold. Nationally, all but seven hospital trusts are showing a deficit, so others are in a similar boat. Our actions need to ensure that our financial position remains stronger than our peers. If we work together we can keep our heads above water and maintain a successful future for our hospital.

**KPMG**

In the light of our financial challenge, we have successfully bid to NHS Improvement (formerly Monitor and the TDA) to be one of a number of trusts to get external support with the development of a Financial Improvement Program (further refinement of the savings outlined above). The financial consultants KPMG currently have a team of 22 staff on site reviewing our finances and strategic plans. After a three week appraisal period, they will be presenting a proposed financial improvement plan. Whilst I suspect that some of the proposals that are included will feel unpalatable, if we fail to address our current financial trajectory, the future imposed upon us will be considerably worse. Once the KPMG report has been published we have requested an evening meeting with our consultants to share the proposals – a good attendance will send a clear message – please come if you possibly can.

**Evening meeting for Consultants : Update on the Financial Improvement Plan.**

Tuesday 12th July 17:30 – 19:30 Details to follow.

**Job planning**

Medical job planning has been a variable feast across the trust. Some areas have historically done this well, such as Radiology, Pathology, Anaesthetics and ICU. Others, such as some medical specialties have made a great deal of progress over the last two years. Many of the surgical specialties have made little progress if any in the past five years, and job plans remain poorly defined.

There are four key stages / standards for effective job planning;

1. The job plan is on Allocate
2. The PA’s on Allocate match with the payroll PA’s
3. The consultant and the CD / AMD / Director agree the job plan
4. The job plan is annually reviewed.

While all consultants have a job plan on Allocate, for many this conflicts with payroll, and for others there is PA disagreement between the consultants and their managers. Few teams are managing to complete all four steps.

SAS doctors also need to be job planned, indeed as a rule their job planning was put on hold while consultant job plans were completed. We have agreed that the four job planning standards will apply to the SAS doctors too.

Whilst I am confident that the work being undertaken largely equates well to the work being paid for, we have a collective joint responsibility to make a better job of job planning. The current status quo cannot continue. Meeting the four standards of job planning needs to be a joint responsibility between the consultant, the clinical director and the business manager. Oversight of this process will be from Colin Wasson as Medical Director and Jayne Shaw as director of workforce. A well organised job plan protects doctors from being abused, and gives the trust assurance that its salary payments are being used to optimal effect. Sorting out our job plans is in all our interests.

I would endorse any consultants and SAS doctors who have not had a job plan review, to enquire of their clinical directors and business managers about their strategy for achieving the required standards. Local arrangements will be made at a departmental level. For those departments struggling to make progress, support and assistance will be provided however there is much to be said for maintaining departmental control of job planning, and I strongly recommend each department ensures its internal process to resolve this is robust.

Consultants with a particular interest in job planning and keen to take on a role as a trouble-shooter, please get in touch, as I think that such a role could be a great asset.

**Consultant SPA time.**

Integral, to good job planning but with its own parallel issues, is our management of SPA time. We have seen the majority of neighbouring trusts in Manchester take a more punitive stance over SPA time, with many offering a standard of 1 or 1.5 SPA in their standard consultant contract, and only staff with major roles receiving more than this. At Stepping Hill we have historically adopted a more liberal approach, with full time consultants receiving a ‘core’ SPA of 1.5 PA’s, but the vast majority also receiving an additional 1 additional ‘SPA’ in recognition of additional roles. Previous attempts to identify and quantify these additional roles have largely failed. This has gone unchallenged.

We have talked extensively in this newsletter about the difficulties that we face as a trust. The need for consultant engagement has never been greater. In practical terms if we are to navigate through the choppy waters ahead, we ‘need’ consultants’ SPA time to be fully brought to bear on these issues. All consultants carry some additional roles, but these range from a heroic additional commitment in some, through a balanced commitment in many, and a very limited commitment in a minority. Overall the SPA work done is almost certainly proportionate to the total SPA time paid for, but while the salary is largely evenly distributed the additional work is not. A minority who make a limited commitment ‘over and above’ DCC work and core SPA commitments generate a considerable sense of resentment in others, and serve as a massive dis-incentive to engagement for those willing to get involved.

When faced with the austerity in which we now operate we can no longer afford the luxury of paying for work without scrutinising the return on that investment. While we do not aspire to reduce the overall spend on SPA time, we do need greater accountability for what is delivered. In reviewing SPA work, our goal is not to save money, but to mobilise this resource and allocate it in such a way as to ensure the considerable (medical leadership / development / governance and training) needs of the trust are met. It may well make more sense for some roles to attract 3 or 3.5 SPA’s while it is accepted that others may choose to retain only ‘core’ spa, or convert SPA time to DCC time.

Just a few ***examples of the roles*** that need to be further developed are;

Departmental leads for NCEPOD / NICE / National audit reports

Mortality and cardiac arrest reviews

Governance leads

Infection control and Sepsis leads.

CQUIN clinical leads

Stockport Together and Healthier Together Clinical leadership

All SPA time needs to be ***explicitly included in the job plan***, not simply included as ‘additional hours flexibly worked’. Where the work is flexibly moved from week to week, dependent upon demand it should be clearly documented when SPA work is ‘usually done’ even when this is in the evening or at the weekend. (ie 2.5 SPA should be explained by 10 hours of non DCC time in which the SPA work is usually done). While considerable flexibility is accepted as to where and when SPA work is undertaken, it is expected that all SPA work be undertaken on site. Where off site SPA is required, this should never be more than 50% of the allocated time.

All consultants who undertake private practice will be required to ‘offer’ 11 PA’s of time to the trust, even if only core SPA is retained.

In parallel to the job planning reviews outlined above, we plan to introduce a process to review the roles and commitments being undertaken in SPA time, and where and when it is done. The details of this process are currently being developed, and will be circulated when finalised. This is not about catching anyone out, or cutting back on salary payments. If you are concerned that your ‘portfolio’ is a bit thin at the moment, speak to your CD, or get in touch directly. The goal of SPA review is not to catch anyone out, rather to co-ordinate our efforts and ensure we are in a strong position to cope with the challenges ahead.

Making this trust a success hugely depends upon engagement of the medical staff, and their leadership of our clinical teams as we adapt our service in a rapidly changing landscape. Once again, it is in all our interests to make this work, and we hope you will support these efforts.

**New Junior Doctor Contract**

We have been advised by NHS Employers that all work on the implementation of the new contract should be suspended until the outcome of the ballot is known in July; but that the appointment of the Guardian of Safe Working Hours is to continue. Hopefully you should all have received an invitation to apply for this (closing date 3rd June).

**Stockport Together**

The work to move towards Integrated Care across Health and Social Care in Stockport is continuing. There are 3 initiatives involving the Trust:

* Consultant Connect. This is ‘live’ in Diabetes & Endocrinology; Haematology; Paediatrics and DMOP. It offers an opportunity for GPs to speak directly to Consultants about individual patients; to optimise management and prevent unnecessary referrals and admissions.
* 100 day improvement programmes. Together with NHS England, Stockport Together is looking at 3 areas to encourage teams to work differently; particularly looking at referrals into secondary care; shared decision making and current OP practises. The 3 clinical areas involved are Gastroenterology; Cardiology and Respiratory Medicine and T&O. Teams from these areas have been invited to workshops to start this work.
* Outcome Based Commissioning. There is now a commitment to move away from ‘payment by process’ (eg a payment system based on work done, such as OP clinic appointment; surgical procedure etc); to ‘payment by outcome’. This requires appropriate outcomes to be developed, and this is being done by 4 Expert Reference Groups which relate to 4 key segments of the population: Healthy; People with chronic disease/disability; People with Frailty and People at the End of Life. This offers a new opportunity to influence the way Healthcare is funded; and Dr David Waterman and Dr Krishnamoorthy are leading 2 of these groups.

**‘Block contract’ for outpatients agreed with CCG**

The opportunity to be paid for outpatient and non-elective activity by block contract rather than item of service brings with it great opportunities to modernise our pathways without fear of financial penalty.  In the past our ability to deliver care in a modern and innovative way has been hampered by funding models which could potentially penalise innovation – for example poor (or no) tariff for telephone or virtual clinics.  This gives us the chance to develop pathways which deliver care in a modern, patient centred way.

**Appraisal**

Dr Ian Mecrow has agreed to continue as Appraisal Lead; and we are identifying improvements which we need to make to the appraisal system:

* PreP. If you didn’t attend the training session for PreP; please complete the e-learning; you should have received a link when you were sent your password. Any problems, please contact Laura Cregan or Karen Jackson
* Out of specialty appraisal. We will be implementing this over the next 12 months, but need to ensure that the relevant College requirements are included. We will be asking specialties to supply this information, to be included in the appraisal form.
* Quality Assurance. We will be setting up a more robust system for ensuring that the quality of appraisals is high; with feedback to appraisers
* Appraisal Support Group. Ian will continue to lead these. We have had feedback about preferred times for these meetings (during core hours or in the evenings); if appraisers have ideas about how to improve attendance at these meetings, please contact Ian
* Trust data. We are aware that the flow of data from the Trust (especially about SIs, complaints, Datix reports etc) to appraisees and appraisers is poor. We are trying to develop a system to ensure that information is more accurate; recognising that the appraisee has a responsibility to reflect on these incidents and discuss them with their appraiser

**GMC educational register**

For those of you who have not yet picked up upon the impending changes to consultant training registration, **please take note and ACT!**  The GMC will be deciding which consultants can be recognised as trainers, recognising that to train requires selection, induction, training, and appraisal. To be a trainer, consultants must undergo an educational appraisal, or have their educational role specifically appraised during their clinical appraisal. All must undertake a piece of educational CPD each year.

By the 22nd July this year, the trust will need to submit a list of all consultants who meet these criteria and are suitable to train. HENW have said that Clinical/Educational Supervisors not registered or only provisionally registered must have their trainee(s) withdrawn after that date.

For those who have limited educational CPD, and have not yet undertaken one of the GMC trainer sessions, I strongly suggest you contact the post graduate centre, or speak to David Baxter and register for a session ASAP.

From this year on the following proposal to monitor training status is suggested;

1. Medical Education to contact consultants 6 weeks prior to their appraisal to ask for the name of their appraiser and their evidence for Domain 7 (educational CPD) so that the DME can review it to ensure its compliancy with health education north west (HENW) requirements for trainer standards
2. Assuming Domain 7 is appropriate, Medical Education will upload evidence to file and update the Trainer database accordingly
3. Medical Education will contact the Consultant prior to their appraisal to notify them that the evidence sent is satisfactory for Educational CPD Domain 7

**This applies to all consultants**, not just those wishing to be educational leads, educational supervisors or named clinical supervisors. Any consultant who works with trainees, either during daytime work or out of hours, will need to be a registered trainer with the GMC. This should not be underestimated, as I suspect getting registered if not achieved initially will be considerably harder than registering from the outset. If you have further questions or doubts contact David Baxter, who can advise you accordingly. The names of all recognised trainers will be published on the GMC website in autumn 2016.

**Consultant study leave.**

Anthony McCluskey as LNC chair has asked for clarity about how the consultant study leave budget is managed.

The annual consultant study leave budget equates to approximately £850 per consultant per year (inclusive of fees, travel, accommodation and meals). After discussion with the LNC, we do not currently apply this as an individual budget cap to each consultant, recognising that some consultants have greater development needs than others, and access to local meetings, or commercial sponsorship for meetings is variable between specialties.

All requests under £500 are CD approved. All requests over £500 are reviewed by the medical director / deputy medical director and associate medical directors at a weekly meeting. Our goal is to ensure that the budget that we have is distributed fairly, reasonably evenly, and is put to optimal use. We have no other ‘hidden agenda’. To make the most of the available funds, as a rough rule of thumb we will only fund travel (UK or overseas) to a maximum of £250, accommodation to £80 a night and food £20 a day. ‘Expensive’ courses, with a total cost above the annual ‘budget’ average per person are only likely to be approved on alternate years. Staff who demonstrate little evidence of effort to attend local meetings / training opportunities, are less likely to see their costly courses with significant travel expenses supported. If consultants have exceptional circumstances to justify exceptional funding, we will try to judge each case on its merits.

We recognise that this approach is disappointing to some, who would like to attend expensive courses, or travel to distant overseas meetings, but the alternative is to approve all requests early in the year, until the annual budget runs out, and then refuse all other requests until the next financial year. This would be neither fair nor sensible use of these limited resources. If anyone has an alternative proposal for how to manage study leave, we are open to suggestions.

**Antibiotic guidelines.**

There are extreme concerns nationally about the rise in antibiotic resistance. There have been national CQUIN targets set for 2016/17 specifically to

* Reduce overall antibiotic prescribing
* Ensure review of iv antibiotics at 72hrs at the latest with a view to switching to orals
* Reduce the use of meropenem and tazocin

Our trust empirical antibiotic guidelines have been extensively revised to remove tazocin as the first line antibiotic to comply with the above, but also because currently both national and local data suggest more Gram-negative isolates are sensitive to gentamicin than tazocin.

The new guidelines have been introduced gradually over the past few weeks and are now going to be fully implemented, with removal of the previous guidelines.

Department of health antibiotic guidance “Start Smart then Focus” advises antibiotic review at 48-72 hrs after initial empirical treatment. An iv to oral checklist to assist in decision making and appropriate de-escalation. (included as an appendix to this document).

The new guidelines are available on the Stockport Antibiotic App which is available on android and apple devices under the name “Tap on the Bugs”. The App can also be accessed through the intranet via “My Applications” ---“More” ---“Antibiotic Guidelines”.

**Key themes**;

Document review of ALL antibiotics daily to ensure shortest course possible given (NB reasons for continuation MUST be documented on a daily basis)

If microbiology results detect a specific pathogen change antibiotics to narrowest spectrum pathogen directed antibiotics.

Gentamicin should be dosed using ideal body weight. This is a great drug, but does require careful use. Attached in the appendices is an excellent algorithm for its use, available on the microsite. We have had one serious incident this week, where this was not followed, so it is worth taking the time to read it.

Maximum duration of IV antibiotics 72 hours

Maximum total duration of antibiotics (IV plus oral) 7 days

Deviance from these guidelines MUST be discussed with a microbiologist or antibiotic pharmacist

Severe or deep infections may need longer courses of antibiotics

**Surgical prophylaxis.**

Concerns have been raised about a trend in some clinicians back to routine prophylactic antibiotics after surgery, particularly in ENT, dental and urology. There is strong evidence against this practice. The ‘start smart then focus’ guidelines for surgery clearly and explicitly recommend that antibiotics be limited to surgery with a prosthesis, contaminated surgery, or clean contaminated surgery. Antibiotic should be a single dose of antibiotic within 60 minutes before knife to skin (further doses in prolonged surgery or massive blood loss). **Post op antibiotics are only appropriate for dirty surgery or infected wounds** (unless directed by a microbiology approved protocol or specific microbiology advice).

**NCEPOD ‘just say sepsis’ – introduction of the sepsis screening tool to ward care.**

The main recommendation of the latest NCEPOD report ‘just say sepsis’ was that ‘all hospitals should have a formal protocol for the early identification and immediate management of patients with sepsis. While we have had use of ‘the sepsis six’ protocol (oxygen, blood cultures, iv antibiotics, iv fluids, lactate, urine output check) for the past five years, uptake has been great in some places, but variable in others. There is a strong evidence base to support this care bundle. Current national guidelines promote sepsis screening tools that further formalise this process, with documentation of when key requirements are completed. Details are available on the ‘uk sepsis trust’ internet site.

Our ED are already largely complaint with these guidelines, following a considerable amount of work by them, further supported by the ED advantis electronic interface. We now plan to introduce the inpatient sepsis screening tool for patients who develop a septic episode on the ward. This tool sets ‘sepsis six’ targets for these patients. It is currently being piloted by Dr Kayan (thanks) on M4 and E2. A trust sepsis group is being formed (please volunteer if interested) and will have its first meeting next month with a view to rolling out the protocol across all wards in July. This is a national CQUIN, uptake will be audited, and results shared.

**Head injury management in ward patients.**

In 2014 NICE produced some very clear guidance on the management of head injuries.

Of particular note in the NICE guidance is the requirement that patients on clopidogrel, and those on novel anticoagulants should be treated as for those on warfarin. The threshold for CT brain should be low.

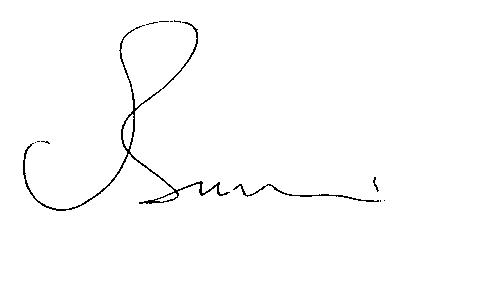
In a recent case, in spite of being anticoagulated, and sustaining a significant head injury, a scan was not done in a timely fashion, and the developing large subdural was not identified until too advanced for intervention. Our emergency department have a clear protocol that summarises the NICE guidance available on their intranet site. This protocol should also be followed for patients who have a head injury on the ward (such as after a fall).

**In summary**

We appreciate that times are challenging, and that in this newsletter we have included a great deal that may cause some anxiety. It is important to remember that we are not alone. Similar anxieties are playing out in hospitals across the country. Stepping Hill has been appointed a ‘specialist hospital’, and has a great reputation for excellent care. We have a lot to be proud of. As consultants we have a huge influence on the services we manage, and the staff that we lead. Our staff will take their lead from us. Many of them are every bit as anxious about the future as we are. If we can show our staff the leadership that they require, co-ordinate our efforts effectively, we can maintain and develop our reputation, and grow our position in the region. This will give us great prospects for the future. The balance between success and failure is a fine one, and it will take all our focus to make sure the balance is tipped in our favour.

That is all for now, feedback is welcome.

Thanks.

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**Dr Colin Wasson, Medical Director Gill Burrows, Deputy Medical Director**

Appendix 1 10 pledges

Appendix 2 Gentamicin protocol

Appendix 3 antibiotic guidelines

Appendix 4 start smart then focus guidelines

Appendix 5 IV to oral switch assessment