The Whittington Hospital NHS
NHS Trust

ITEM: 11

MEETING: Trust Board Meeting – 18 July 2006

TITLE: Proposal to recruit to Two Consultant Posts - A Consultant Cardiologist and a Consultant Acute Physician

SUMMARY:

In September 2005 Trust Board agreed that the Trust should employ a replacement Cardiology Consultant to replace Dr Roy Davies who had retired. This post was made up of eight Programmed Activities (PAs) Cardiology and two PAs Acute Physician and contributed to the establishment of the Acute Physician role at the Whittington. The recruitment campaign to this post has been unsuccessful and the Cardiology department has been covering this vacancy with the existing Consultants working additional PAs to create the required capacity. It is proposed that the post is changed to be a full time Cardiology Consultant.

The medical school is interested in relocating 'Medicine in the Community' medical students into Acute Trusts, from September 2006, as GPs are unable to continue to provide training for them in the community It is proposed that SIFT money which follows these students, in combination with other funds becoming available are used to appoint an Acute Physician who will then be responsible for the delivery of training for these students and the delivery of the Acute Physician element of the previous combined post.

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SPONSORED BY: Kate Slemeck – Director of Operations

Financial details supplied/checked by: Susan Cunnion
(finance officer)

Recommendations contained within this paper have been checked for compliance with relevant statute and regulations/directions/policy as follows:

(Relevant law/direction etc.) Yes

(Name) Kate Slemeck

A Proposal to Recruit a Consultant Cardiologist and a Consultant Acute Physician

1. Introduction & Historical Context

In September 2005 Trust Board agreed that the Trust should employ a replacement Cardiology Consultant to replace Dr Roy Davies following his retirement. This post was made up of eight Programmed Activities (PAs) Cardiology and two PAs Acute Physician and contributed to the establishment of the Acute Physician role at the Whittington.

The Trust has been unsuccessful in recruiting to this post, and in the meantime the Cardiology department has been covering this vacancy with the existing Consultants working additional PAs to create the required capacity.

Following the unsuccessful recruitment the Cardiologists have discussed the post with external colleagues. The view is that the post is unpopular, as prospective Consultants, whilst happy to undertake Medical on-call duties, wish to specialise in Cardiology and would not wish to undertake the two PAs of the Acute Physician role. It is believed that this was a major factor in the unsuccessful recruitment to this post. It is proposed, therefore, that the post is changed back to be a full time Cardiology Consultant. This post would be well placed to provide clinical leadership and cohesiveness within the speciality.

Further to the above, the medical school has expressed an interest for the Whittington to establish a Cardiothoracic placement to undergraduates, and wishes to relocate 'Medicine in the Community' medical students into Acute Trusts, from September 2006, as GPs are unable to continue to provide training for them in the community. Following analysis of existing training and educational workloads in Cardiology and Chest medicine it is known that the Whittington will be unable to provide additional supervision without increasing Consultant teaching capacity. It is proposed that the £68,420 of SIFT funding that will follow these students is used to appoint an Acute Physician who will be responsible for the delivery of supervision and some training for these students with delivery of the two PAs of Acute Physician time incorporated previously into the original Cardiology/Acute Physician post. In addition to this the Cardiology and Chest teams will incorporate some specialty training support into their existing teaching load.

This paper will present a case for employing a full time Cardiologist and a separate case for the recruitment of a full time Acute Physician. The funding for the posts will be analysed collectively as the financing the posts are interdependent.

2. Cardiology Post

2.1 Background

Dr Davies retired in May 2005. His post has remained vacant for the last year following an unsuccessful recruitment campaign. Dr Davies' four cardiology outpatients (OP), reporting of investigations duties, two ward rounds and ongoing care of Cardiology inpatients and correspondence has been undertaken by the other cardiology Consultants and Dr Rosaire Gray, Consultant Geriatrician with a cardiology subspecialty. Dr Lok Yap, Acute Physician, is providing the General Internal Medicine (GIM) cover of Dr Davies medical on call duties, including two ward

rounds a week. Each of the consultants has increased their Direct Clinical Care (DCCs) PAs to cover for the vacant post in cardiology as follows:

Table 1 – Additional PAs Commitments

Consultant	Job plan PA's	Additional PAs	New: FU ratios	Other commitments
Dr Patterson	8 Whittington, 2 UCL (recharged by Trust)	2	1:1.5	Vice Dean and Campus Director - 2 additional PA's paid directly by UCL
Dr Hardman	10.5	1	1:3	Training and education of local GP's, GP cardiology helpline, R&D
Dr Brull	7 Whittington, 4 National Heart Hospital	2	1:1.5	On call 1:4 @ National Heart Hospital
Dr Rosaire Grey	8 Whittington, 4 UCL	1	1:2	Consultant Geriatrician
Dr Lok Yap	10 Whittington	2	N/A	Acute Physician, Clinical Pharmacologist and Medical Education at UCLH
Total additional DCC PAs		8		

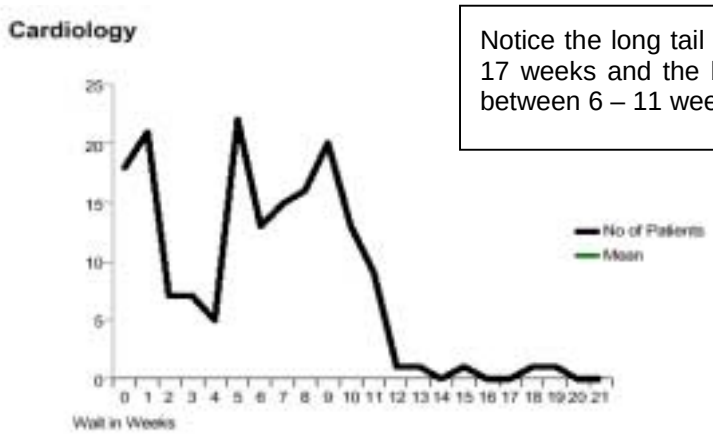
These cover arrangements are not sustainable in the long term, recruitment to the vacant post would return all Consultants to previous levels of PAs in job plans prior to Dr Davies' retirement.

2.2 Activity analysis

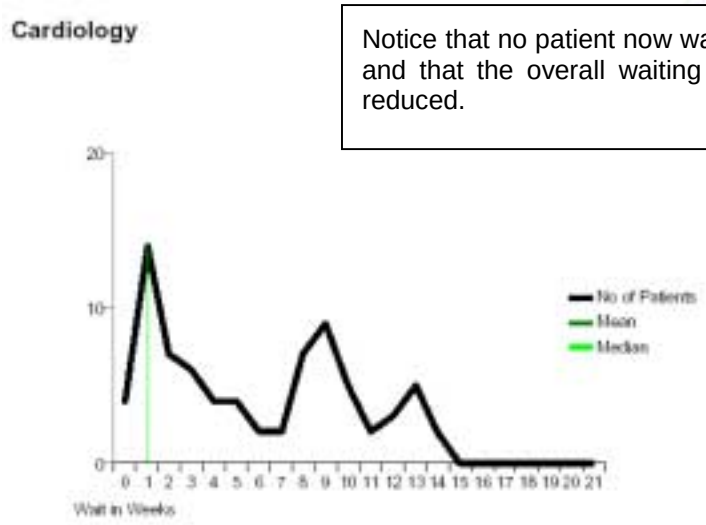
An activity analysis has been undertaken to demonstrate the need to recruit a replacement Cardiologist.

The increased demand for cardiology services has led to a requirement to increase clinic activity to maintain OP waiting below the 13-week OP target. The graphs below indicate the success of the Cardiology department in working efficiently, indicating the activity in 2004/05 and 2006 to move from achieving the 17 week OP target to achieving and maintaining the 13 week OP target:

The following graph outlines the number of patients by wait in weeks for an OP appointment at September 2005.



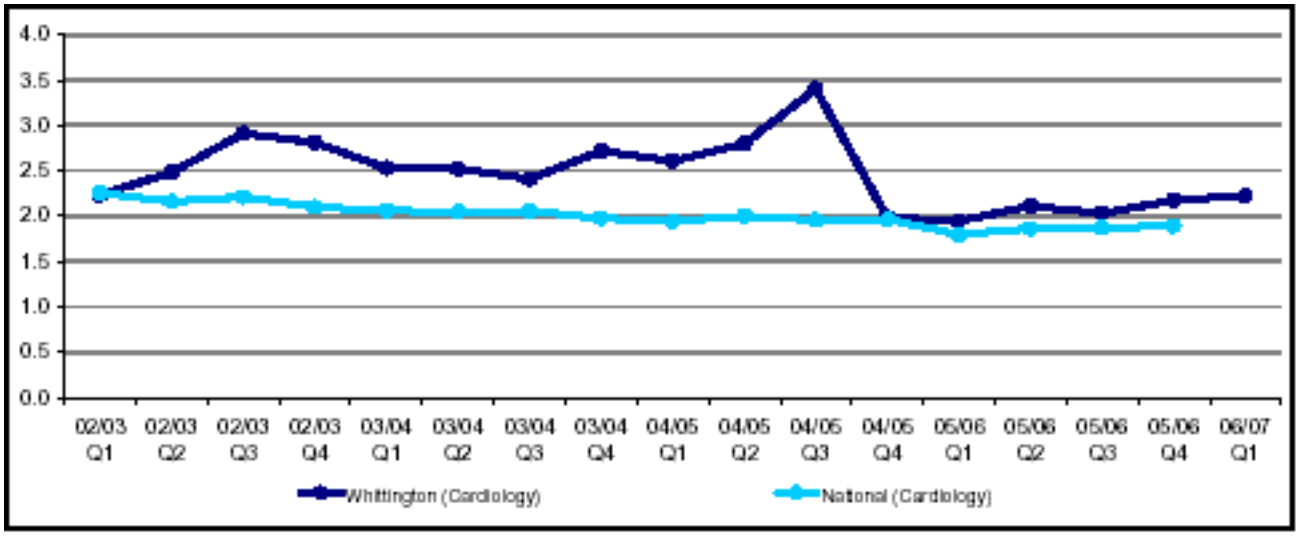
The 13-week OP target became a standard requirement in December 2005. The graph below outlines the outpatient waiting times as of May 2006 demonstrates the improvement waiting time position.



This increase in activity has been achieved by reducing New to Follow up OP attendance ratios with increased discharge of patients who previously had numerous follow ups. Table 1 above, indicates the ratio by Consultant and the associated graph below demonstrates this, plotting the Whittington's position in relation to the national picture.

320 Cardiology

Outpatient Appointments: Subsequent to First Appointment Ratio



The number of out patient (OP) referrals to our Cardiology service is increasing. Table 2 below demonstrates activity performance against the SLA from 1 April 2006 to 31 May 2006:

Table 2 – Activity performance 2006/7 Actual versus Target

Outpatient Activity

	Annual Plan		Target to May 2006		Actual Activity to May 2006		Variance		
Specialty	First Attend	Follow Up	First Attend	Follow Up	First Attend	Follow Up	First Attend	Follow Up	Total variance
Cardiology	1,675	4,551	279	759	739	705	460	-54	406

Additionally Emergency in-patient activity is increasing with in year growth outlined in Table 3 below:

Table 3 – Emergency Inpatient Activity

Emergency Inpatient Activity

	Annual Plan	Target to May 2006	Actual Activity to May 2006	Variance
Specialty	Non Elective	Non Elective	Non Elective	Non Elective
Cardiology	108	18	29	11

2.3 Other Supporting Factors

2.3.1 Delivering Trust Strategy

A key component of the Trusts strategic plan is to improve health outcomes for people with long-term conditions (LTC). Patients with cardiovascular disease, which is categorised as a LTC, are the Trusts second largest medical in-patient group. Recruitment to this post will ensure the cardiology service is in a position to deliver against the Trust strategy

2.3.2 National targets – local issues

There is a national target to reduce by 40%, deaths caused by coronary heart disease by 2010. The demography of the local community is an important factor when considering the replacement of this post. Islington and Haringey Boroughs have a high level of social deprivation and ethnic diversity with associated high levels of cardiovascular disease and cardiovascular mortality. The prevalence of diabetes is high and rising in both boroughs, which effectively predicts the likely increase in future burden of cardiovascular disease.

The Department of Health's Public Service Agreement for long-term conditions encompasses services for people living with coronary heart disease and especially heart failure. It will prove difficult to support this initiative without recruitment to this post

2.3.3 The impact of PCT demand management on the service

Discussions with Primary Care Trust (PCT) commissioners indicate that their intention is to provide more ongoing care of patients with cardiac disease in the community. The Whittington is currently hosting the supervision and role development of community heart failure nurse specialists and community matrons and assisting our two main PCTs with their development of community based Anticoagulation services. PCTs anticipate that this work will reduce demand in Cardiology in the longer term.

Dr Suzanna Hardman is currently piloting telephone consultation to local GPs and community specialist nurses and has two PAs allocated to this role, with the aim of attendance avoidance to out-patients and ED and reduction in length of stay by supporting community staff in the care of discharged patients. Islington PCT is interested in commissioning Dr Hardman's time and funding these two PAs through the SLA negotiations. It is anticipated that this may be a solution to the Trust's need to reduce costs as the reduction in income from demand management begins.

2.3.4 Consultant Retirement

Although this paper indicates that there is currently growth in Cardiology services, PCT incentive schemes and practice based commissioning is in its infancy and is expected, as outlined above, to reduce both OP and in-patient activity. Dr Patterson has indicated that he will be retiring in September 2007. Careful analysis of the planned reduction in activity by both Islington and Haringey PCTs through demand management suggests that the Trust will not need to replace Dr Patterson with a full time post, if indeed at all. It is less clear however to what level there will be a need to replace Dr Patterson PAs and at this time it is suggested that a 0.5 wte Consultant will suffice. This will be reviewed carefully nearer the time of his retirement.

3. Acute Physician Post

3.1 Background

The Specialist Training Authority has approved acute Medicine as a sub-specialty of General Internal Medicine (GIM) in 2003. The specialty has come about through the realisation of a need for senior medical presence in Medical Assessment Units (MAU).

Professor George Alberti, DoH Emergency Care Tsar, recommended the development of the Acute Physician role to support achieving the Emergency Department 4-hour target and reduce emergency beds days, following his visit to the Whittington in 2004.

The Whittington has employed Dr Lok Yap as 0.4 Acute Physician. This will increase by 0.2 wte of Acute Physician time with the replacement of Dr Robin Vicary, Consultant Gastroenterologist, with a combined Gastroenterology/Acute Physician role when he retires in September 2006. This new post would take the Trust to the employment of 10 PAs of Direct Clinical Care Acute Physician time.

There is an intention for an increase of 6.24wte medical students to a Cardiothoracic placement from September 2006 at the Whittington, which has strong support from the SIFT Coordinator, Medical Schools Finance, following the recent medical school visit. Each student will come with funding of £11,000 that will total £68,640. This funding is recurrent for as long as students are allocated to the Whittington. Following analysis of existing training and educational workloads in Cardiology and Chest medicine it is known that the Whittington will be unable to provide additional supervision without increasing Consultant teaching capacity. It is proposed that the £68,420 of SIFT funding that will follow these students is used to appoint an Acute Physician who will be responsible for the delivery of supervision and some training for these students. The post will comprise of 4PAs allocated to Acute Physician role and 6PAs to teaching and supporting activities. The teaching will be both classroom based and direct patient care supervised practice. In addition to this the Cardiology and Chest teams will incorporate some specialty training support into their existing teaching load.

3.2 The case for recruiting an Acute Physician

The role of consultant physicians involved in the acute medical take has the following advantages:

3.2.1 Senior management of medical emergencies and clinical decision making

When the current MAU transfers into the new Mary Seacole ward in the PFI in early 2007, it will be used as an environment for assessment, investigation and management.

Patients referred to the medical take team will be fast-tracked there from the Emergency Department (ED). During their Acute Physician allocated sessions the post holder will based in the ED & MAU, to ensure that all acutely unwell patients will have consultant led assessment and decision making within the hour of their arrival.

3.2.2 Maintenance of direct discharges.

From the work undertaken by Dr Lok Yap it is clear that early senior decision-making by a Consultant Physician has meant that a number of patients who would previously have been admitted are now being redirected to out-patient follow-up, thereby avoiding admission. By working closely with the community matrons and our ED Matron, patients are quickly linked into suitable community follow-up.

3.2.3 Reduction in emergency bed days

By December 2008 the Trust will be expected to achieve the national target of a reduction in emergency beds days of 5% based on 2003/04 out turn.

Dr Yap plans for the acute physicians to set up emergency outpatient clinics accessed directly from the ED, which will facilitate rapid review of patients who would normally have been admitted to hospital, so avoiding admissions.

Additionally appointment to this post would fulfil the Whittington's aim to have five days a week Acute Physician cover so reducing the day time on call commitments of Specialty Consultants. The Divisional Board of Medicine is currently reviewing the roles of specialty Consultants in the management of GIM patients and using this opportunity to establish specialty emergency out patient clinics that can be accessed by both ED patients and Ward patients with the aim of avoiding admissions and facilitating earlier patient discharge from the wards. Both would result in reducing emergency beds days.

3.2.4 Education of junior medical staff and students in management of acutely ill patients

Through more direct education and supervision of junior doctors whilst on take, knowledge, skills and experience will improve, investigatory and admitting behaviours are expected to change.

The Whittington has a successful Management and Clinician partnership approach to develop this role and has attracted interest from candidates who are feeling constrained in their current role as Acute Physician in other organisations. This suggests that should the Trust develop a post that is primarily an Acute Physician post there would be a field of suitable applicants.

4. Proposal

It is proposed that a full time Cardiologist post is recruited to in addition to a full time Acute Physician.

5. Financial Analysis

The Cardiology budget has a fully budgeted 1.0 wte vacancy, which would fund the Cardiology post. (Appendix 1 outlines the financial detail for funding for the 1.0 wte Acute Physician post).

A summary of this analysis is as follows:

- An additional 6.24wte medical students will be allocated to a Whittington Cardiothoracic placement from September 2006. Each student will come with funding of £11,000 that will total £68,640

- Recent job plan changes to Dr Suzanna Hardman has resulted in a 1 PA (£11,044), with an additional stopping of on-call supplement (£991), reduction in costs which will be allocated to the Acute Physician post
- During the last year our Clinical Haematology Consultants have been establishing a service for Sickle cell and Thalassaemia patients at UCLH, which they deliver at UCLH. We have negotiated payment for 2 PAs (£24,412) of Clinical Haematology time with UCLH. The Clinical Haematology team are managing both in-patient and outpatient activity within existing capacity and do not require additional capacity to incorporate the UCLH work. The clinical haematology budget was under spent by £188,552 in 2005/06. We intend therefore to allocate the £26,853 to part fund the Acute Physician post.
- The cost of 1.0 wte Acute physician is £93,390. Collectively the schemes outlined above total £105,116. This offers a surplus of £11,264.
- Should the PCTs demand management plans succeed, Dr Patterson's retirement next year will give the Trust the opportunity to reduce costs by a minimum of £37,503

6. Conclusion and Recommendation

The Board is asked to support the recruitment to these two posts, which will support Trust strategy to:

- Maximise the Trusts success in recruiting a Cardiology Consultant to replace Dr Davies.
- Provide consistent cardiology care and management of both acute in-patients and out patients within a funded establishment of cardiology consultants
- Return the existing Consultants to their old job plan Pas
- Ensure the Trust sustains the 13-week outpatient target and other NSF targets.
- Through cardiology specialist management of patients with Long Term Conditions and in line with 'Our Health, Our Care, Our Say', assist in the transfer of care to the community setting and ensure the reduction of emergency bed days by 5% by 2008.
- This post may be well placed to provide clinical leadership within the speciality and cohesiveness.
- Meet the recommendations made by Professor Sir George Alberti that the Whittington establishes Acute Physician posts for the development of Acute Care Services
- Reduce emergency bed days by 5% by 2008 through admission management in the MAU and ED
- Reduce medical delays in the ED to maximise the Trusts opportunity to sustain ED 4-hour target performance

- Deliver excellent training and supervision to medical students undertaking their cardiothoracic placement and maximise SIFT income to assist with service developments

- Provide the Trust with the opportunity to position itself to gain further postgraduate training funding through facilitation of the training of a ‘new breed’ of doctors accredited as ‘Acute Physicians’ with a second speciality.

- Offer good value for money from the realignment of job plans to service strategy and the eventual saving made by the retirement of Dr Patterson