

**CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

**AGENDA ITEM:14  
4 December 2008**

**BOARD OF GOVERNORS**

**MEDICAL DIRECTOR'S ANNUAL REPORT**

**Report of: Dr Jag Ahluwalia**

# **Medical Director's Annual Report to the Board of Governors 2008**

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## **Medical Director's Annual Report to the Board of Governors 2008**

### **Introduction**

**Medical Director: Dr Jag Ahluwalia**

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### **Introduction**

This report serves to demonstrate the work of the Medical Directorate in assisting the Trust to reach its targets and to support the drivers that are at the forefront of the NHS.

The following report is divided into two sections. The first section includes information on the highest priorities of the Medical Directorate, Patient Safety and Infection Control. The remainder provides greater detail in relation to specific areas of responsibility.

### **Medical Directorate Structure**

The past twelve months have seen some significant changes to the Medical Directorate structure. Having completed nearly six years as Medical Director, Dr Robert Winter stepped down from the post on 31 March 2008. Dr Winter made a significant and extremely valued contribution to the Medical Directorate and to the Trust as a whole and set the scene for future developments.

Dr Jag Ahluwalia was appointed to the post of Medical Director on 1 April 2008. Following this appointment, the roles and responsibilities of the Medical Directorate Team were developed further. There are now four Associate Medical Directors in post, each with their own portfolio, which include Infection Control, Patient Safety, University Integration and NHS Professional Development. The Associate Medical Directors, alongside the Medical Directorate Team, play an integral role with helping the Trust reach its challenging objectives. The Team also now includes a Safety First Project Lead, Dr Trevor Baglin, who via the use of SDU assessments is responsible for ensuring safety is paramount across all specialties. There is further consideration given to Patient Safety later in this report.

The current structure, along with the portfolios of the Associate Medical Directors, are shown in Appendix 1 and Appendix 2.

### **Clinical and Service Delivery Unit Directors**

The current Clinical and Service Delivery Unit structure is given in Appendix 3. The roles of the Clinical and SDU Director remain pivotal in the running of the clinical service. Dr Jane MacDougall, the highly effective and respected Clinical Director for Women's Services stepped down from the role on 30 September 2008, after 5 years in post. Mr Gerald Hackett succeeded Jane from 1 October 2008. The work of Clinical Directors and SDU Directors is becoming increasingly time-consuming. However, the solid relationship between the Trust and clinicians is strengthened through these roles and the support and efforts of these individuals should be noted.

As the Board will be aware, comprehensive discussions have recently taken place in relation to the structure of the clinical directorates. Whilst still in the final stages of discussion, the new structure will serve to ensure greater equity and increased strategic responsibility for those managing clinical areas. All Clinical Directors have contributed to these discussions and selection of Divisional Directors will be taking place this month.

## Clinical Staff

Between 1 April 2007 and 31 March 2008, 33 new consultant appointments were made, the need arising from increasing clinical activity or the ongoing objective of service improvement. Between 1 April and 31 October 2008, 16 new consultant appointments were made. The details of these appointments can be found in Appendix 4, tables 1 and 2. These reports show consultants who hold their contracts at Addenbrooke's as well as those that hold their contracts elsewhere and undertake clinical sessions at the Trust. These appointments help to ensure that Addenbrooke's remains a first class Hospital. The total number of Medical Staff at the Trust is 1090, the breakdown by grade can be found in Appendix 5.

## Consultant Appraisal

100% eligible consultants completed an annual appraisal in 2007/08. Last year, several new key performance indicators were included in the appraisal process. These included the necessity to complete mandatory training, resuscitation training and possessing and accessing an [addenbrookes.nhs.uk](http://addenbrookes.nhs.uk) or [nhs.net](http://nhs.net) e-mail address for abnormal results reporting. The 2008 appraisal round, which was launched in September, will further highlight the necessity to ensure that all consultants comply with these important indicators.

Key changes are being introduced by the GMC and an annual appraisal will be one of the elements to support revalidation based on the module derived from *Good Medical Practice*. The exact requirements of revalidation remain unclear, however, multi-source feedback from colleagues and patients will be important components.

Multi-source feedback (360 degree appraisal) was piloted during the 2007/08 appraisal round and various options have been explored in order to identify the most appropriate system for the Trust. Early indications show that 360 degree appraisal was well received and those participating in the pilot found the process extremely useful. We plan to roll out 360 degree appraisal to the consultant body in the spring of 2009, following directly on from the 2009/10 job planning round.

## Job Planning

All NHS consultants and clinical academics are required to have a current annual job plan. The average number of Programmed Activities (PA) for full time NHS and Honorary Consultants in the 2008/09 round is 11.29. In the 2007/08 job planning round, the average number of Programmed Activities was 11.28.

Discussions are currently taking place to determine how the process can be made fairer and more equitable in 2009/10. There are several factors which will be considered:

- Job Planning 'Tariff'
- Job Planning Timescales
- Complying with deadlines
- Patient and Consultant Reported Outcome Measures
- Additional Academic PA Top Up

A meeting will be taking place later this month with Clinical Directors and the Medical Directorate Team, in order to take this forward.

## Key Performance Indicators

The Medical Directorate has continued to highlight the importance of compliance with mandatory training, resuscitation training, corporate induction and local induction over the

last year. All Clinical Directors and SDU Directors are aware of the safety requirements of completing this and are cascading the message to their colleagues. Adequate recording and reporting of figures is paramount and we are currently working to clean the data held on record for medical staff.

Medical Staff currently complete mandatory refresher training by reviewing a set of slides, which include all relevant and important areas of note specifically for clinicians. This new format of completion is more convenient and less time consuming and has been extremely well received.

In addition, this year all grades of medical staff who are new to the Trust (including consultants) are required to the Corporate Induction programme organised by the Medical Staffing Department. Again, this is specific to the needs of clinicians and this change has also been very well received by colleagues.

### **Leadership Development**

From 2009, the Trust will look into alternative ways of delivering leadership development training to clinicians. Discussions will be taking place with BMM (British Association of Medical Managers) later this month, in order to develop an appropriate programme. The need for a revised programme has been further highlighted by the impending directorate restructure.

### **Advisory Appointment Committee Process**

Earlier in the year, it was agreed that the recruitment process for consultants should be reviewed in order to address some concerns and observations raised by some panel members. A variety of options have been considered within the Medical Directorate and more widely with Clinical Directors. In September 2008, it was agreed that the following changes would be implemented:

- Summary case of need to be circulated to panel members ahead of the AAC.
- External representatives to retain a seat on the panel. The appropriate Royal College will be approached in the first instance, however, if they do not respond in a timely manner an alternative external representative will be approached. Suggested names should be given when the post is originally proposed. Divisional Directors / SDU Directors will be expected to provide a list of suitable independent experts to advise the AAC process, when the post is first submitted for manpower approval.
- Panel to have the flexibility to request as many references as required.
- Panel composition and interview format to remain.
- If the candidate is not on the specialist register or in receipt of Article 14, locum contracts can be issued in the interim.
- 'Cooling off' period may be necessary, if there isn't a clear preferred candidate. The AAC Panel Chair should consider whether the decision to appoint can be made on the day of interview. Pressure to appoint on the day to be resisted.
- Pre-interview visits with the Medical Director to cease, in order to ensure that no candidate is unfairly disadvantaged due to diary restraints.

These revisions to the process are currently being implemented.

### **Clinical Excellence**

At the time of writing this report, the Trust has learned that 15 Addenbrooke's consultants were successful with achieving National Clinical Excellence Awards in the 2008 round. In addition, 86 Local Awards were distributed to 60 consultants in 2008. This demonstrates

the high level of esteem in which our clinicians are held by their peers both locally and nationally.

### **Medical Director's Office Website**

The new Medical Director's Office intranet site has now been published on the Connect intranet. This site can be accessed at: <http://connect/index.cfm?articleid=12754> or externally at: [www.medschl.cam.ac.uk/NHS/](http://www.medschl.cam.ac.uk/NHS/).

### **Clinical Priorities**

A significant period of consultation has been completed by the Medical Director and the Head of Planning (Mr Lawrence Ashelford), involving meeting with all Clinical Directors to determine a clinical strategy. These priorities will form the basis of the Trust's Clinical Strategy and Investment Plans over the next three years. The full clinical strategies document is available from the Medical Director's Office.

The Medical Director's Office, the Clinical Directors and relevant Executive Directors, together with the Office of the Regius Professor of Physic, the Director of R&D and the Director of Postgraduate Medical Education have been involved in providing clinical guidance and prioritisation with respect to the South Campus Programme. These discussions have allowed Clinical Directors to hear details of all elements of the South Campus Programme. A significant consensus was reached with respect to the clinical priorities of the Trust in relation to the building programme, with these conclusions helping to inform the Board's deliberations.

### **Future Developments**

In the future, we hope to pursue several new streams of work in order to improve communications and strengthen the services we provide.

The Consultant Staff Council, supported by the Office of the Medical Director, is beginning to develop a mentoring system to ensure that both new and established consultants are supported during difficult or challenging times. Mentors are currently being identified in order to take this forward.

Historically, communication channels with junior medical staff have been in need of attention. In the coming months, we will be exploring the possibility of appointing 'Chief Resident' junior doctors in each specialty. Such roles would ensure a more democratic and proactive route through which to engage junior doctors with Trust issues.

In order to reduce unnecessary e-mail traffic, in 2009 we will be looking into the publication of a 'Medical Director's Office Newsletter', summarising key items. It is hoped that a first draft of this will be available in the spring of next year.

### **Summary**

In summary, 2008 has so far been a year of significant change for the Medical Directorate. Several issues, in particular the directorate restructure, will continue to have a significant impact on the work that we do. As clinical and management integration remains a top priority, we look forward to the positive changes that this will bring.

Lastly, I would particularly like to extend my thanks to the entire Medical Directorate for their support and hard work during the past year.

**PATIENT SAFETY**

**Associate Medical Director  
(Patient Safety):  
Dr Sue Robinson  
Head of Risk and Patient Safety:  
Mr Glenn Pascoe**

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**Introduction**

There has been increasing recognition that the safety of patients is paramount and therefore must be the Trust's highest priority, at a corporate, team and individual level. This has led to a paradigm shift in our approach to safety and the introduction of the following under the "Safety First" programme.

**Establishment of a Patient Safety Executive**

The Patient Safety Executive was agreed by the Board earlier this year and is now established as a forum for ensuring action is taken regarding matters of patient safety. The Patient Safety Executive reports to the Medical Director. As a consequence of the creation of the Executive, the Claims, Complaints and Incidents Committee has been disbanded as its functions have been incorporated into those of this Executive. The terms of reference of the Patient Safety Executive can be found in Appendix 6.

**Establishment of a Patient Safety Counsel**

Work on setting up the Counsel is in progress and a final draft membership and terms of reference have been prepared for agreement by the Chief Executive and it is intended that the Counsel will first meet early in 2009 and quarterly thereafter. The Counsel will include members from the Governors and from organisations external to the Trust. The role of the Counsel is:

1. To provide a source of advice to the Patient Safety Executive and the Trust on matters of patient safety.
2. To provide a reflective forum for the Patient Safety Executive and the Trust on matters of patient safety
3. To provide a forum in which proposals made to improve patient safety can be subjected to a "test of reasonableness."
4. To advise on and inform the Trust's Patient safety Strategy.

**Creating the role of Associate Medical Director for Patient Safety**

Dr Sue Robinson was appointed as the Associate Medical Director with a specific responsibility for Patient Safety in August and will provide valuable expertise and support to the whole Safety First Programme. As a consequence of this new Associate Medical Director post, the existing roles of Lead and Associate Lead for Clinical Governance have now been ceased. The areas of responsibility covered by the previous Lead and Associate Lead Clinicians for Clinical Governance will be undertaken by the Associate Medical Director with a specific responsibility for Patient Safety (Dr Sue Robinson), the Head of Risk and Patient Safety (Mr Glenn Pascoe) and the Associate Medical Director with a responsibility for professional development (Mr Richard Miller). All of these individuals report to the Medical Director.

I would like to put on record the enormous contributions made by Dr Trevor Baglin and Dr John Klinck in their respective roles as Lead for Clinical Governance and Associate Lead for Clinical Governance.

## Pilot implementation of Clinical Area Safety Assessments

Clinical Area Safety Assessments (CASA's) are designed to assess the level to which SDUs have systems and processes in place to ensure patient safety. The assessments are complemented and supported by a set of *triggers*, which act as warning indicators. Included within the CASA process is the seeking of patient and staff views regarding safety by way of a simple questionnaire.

CASA's have four possible outcomes in terms of accreditation:

- Unconditional – no concerns
- Conditional level 1 – minor concerns (monitored by Safety First Programme Lead)
- Conditional level 2 – concerns (monitored by Patient Safety Executive)
- Suspension of service – major concerns (Director / PSE immediate action)

Two pilot CASA's have been completed in Diabetes and Gynaecology. Both pilot assessments were rated as "Conditional Level 1", meaning that there were no significant lapses in process or systems, however improvement areas were identified and action plans drawn-up

A full evaluation of the two pilots has been undertaken and the following lessons identified. There was agreement that the CASA's had been beneficial and are worthy of continuation.

Two further CASA pilots are currently underway in Plastics and DME using a revised CASA template. The substantive programme will be ready to roll-out from January 2009, subject to the funding being provided, which has been identified in the Medical Directorate business plan.

## The National Patient Safety First Campaign

The National Patient Safety Agency launched a national *Patient Safety First Campaign* in September 2008. The Trust joined the campaign.

The campaign *cause* is: ***To make the safety of patients everyone's highest priority***

The Campaign *aims* to achieve: ***No avoidable death, and no avoidable harm***

Members are required to make a commitment that:

- Safety is their highest priority
- Ensure Board engagement regarding safety
- Implement at least one of the campaigns key clinical interventions, which are:
  1. Leadership for safety
  2. Care of deteriorating patients
  3. Critical Care
  4. Perioperative Care
  5. Reduction of harm through high risk medication
- Implement the use of the Global Trigger Tool to audit case notes

## Patient Safety Walkabouts

Patient Safety Walkabouts commenced in October 2008. These take place on a weekly basis by a small team (2-3 people) from the Patient Safety Executive.

The visits are seen as an opportunity for a two way discussion between the PSE and ward staff and provide an opportunity for ward staff to provide their thoughts regarding patient safety and influence the Trusts future strategy regarding patient safety.

The feedback from the first visits undertaken has been positive and beneficial, however it must be recognised that the walkabouts will identify issues that need resolving and resourcing at an operational and possibly Trust wide level.

### **Communicating key operational patient safety requirements via Patient Safety Directives**

As part of our approach to addressing the top 10 patient safety themes we will be introducing a series of patient safety standard. These will be communicated via the issue of Patient Safety Directives. The first one issued in October 2008 required that

- A check to be completed by 11:00 each day for all inpatients that there is the correct patient allocation to primary consultant.
- Daily medical review of all inpatients (evidenced in the patient's medical record)
- Consultant review twice weekly as a minimum (evidenced in the patient's medical record)

### **Future plans**

- Create a culture of *Board to Ward* responsibility – truly making each patients safety everyone's highest priority
- Developing the Trusts Safety First programme and participating in the national Patient Safety First campaign, through for example the use of the Global Trigger Tool.
- Developing the Strategy to ensure continuous improvement in patient safety
- Availability of accurate and relevant safety information that can be used to facilitate and monitor improvement in patient safety

### **Summary**

This year the foundations to secure improvements in patient safety at Addenbrooke's have been laid. It is a journey that will never end if we are to seek continuous improvement. There is a challenge for the Trust in changing our culture to one that makes patient safety an absolute priority. To do there is a need to work with the Board, engage clinicians and empower all staff no matter what their role so that safety is always prioritised.

To successfully achieve this, there is a need to properly resource the Safety First programme as set out in the Medical Director's Business Plan.

## INFECTION CONTROL

**Associate Medical Director  
(Infection Control): Dr Basil  
Matta  
Assistant Director of Nursing:  
Mrs Angela Thompson**

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### Introduction

Since January 2008, the Medical Director has been the Trust designated Director of Infection Prevention and Control (DIPC). Prior to this the position was held by the Chief Nurse. Dr Basil Matta acts as Associate Medical Director with responsibility for Health Care Acquired Infections (HCAI). Each service delivery unit (SDU) within the Trust has a designated medical consultant lead and senior clinical nurse lead for infection control, with clear roles and responsibilities relating to infection control. The Trust Control of Infection Committee is chaired by Professor A. Lever (Honorary Consultant in Infectious Diseases).

The Trust's **Infection Control Annual report for 2007/08**, which can be found via the following link: [http://connect/media/pdf/m/e/Infection\\_Control\\_Annual\\_Report\\_2007-08.pdf](http://connect/media/pdf/m/e/Infection_Control_Annual_Report_2007-08.pdf), showed how the Trust exceeded its target reductions in both methicillin-resistant *Staphylococcus aureus* (MRSA) blood stream infection and *Clostridium difficile* infection.

### Performance 2007/08

- The number of MRSA blood stream infections in the Trust in the year 2007/08 was 41, compared to 81 in 2006/07, a reduction of 49%.
- The number of cases of *Clostridium difficile* infection in 2007/08 was 21% lower than in 2006/07. The reduction in patients aged 65 years or older was 17%, which exceeded the local target of a 12.5% reduction in this age group agreed with Cambridgeshire PCT.

### Performance - April 2008-September 2008

- A target of no more than 33 MRSA bacteraemia infections has been agreed for the period 2008/09. The position to September 2008 is 18 cases vs a target of 17
- A target of no more than 300 cases of *Clostridium difficile* has been agreed for the period 2008/09. The position to September 2008 is 151 cases vs a target of 150

In July, the Trust were issued with a Performance Notice from the PCT for non-compliance with the *Clostridium difficile* target trajectory. As a consequence the Trust are required to report on a monthly basis to Monitor. The Trust has implemented a Remedial Action Plan and have committed to an increase in HCAI funding of £1.178m.

### Key Infection Control Priorities for 2008/09:

The Trust HCAI priorities and audit time-table are detailed in the Trust Strategic Infection Control Action Plan, which is updated on a monthly basis, key aspects include:

### Isolation

Ward K3 (28 bedded facility) operating as the *Clostridium difficile* isolation ward (opened January 2008). There is an operational policy in place with clear criteria for referral to the isolation ward. Compliance with the policy is monitored and reported monthly within the infection control performance report. There are daily multi-disciplinary review meetings of patients/staffing in Operations Centre. An increase in the Infectious Disease medical staffing establishment has been approved by the Medical Manpower Committee (1 Infection Control Doctor, 1 STR3 and 3 SHO).

The opening of Ward N2 with 22 single room isolation facilities, is proposed for January 2009; this ward will become the *Clostridium difficile* isolation facility.

### **MRSA Screening**

The Trust increased screening for MRSA colonisation significantly during 2007/08. In line with national initiatives, all elective admissions in high risk specialities were screened before admission to hospital. During the last year screening was extended to include all emergency admissions as well as elective patients admitted to the Trust as in-patients. Screening for emergency admissions is performed in the Emergency Department before patients are admitted to the ward. Compliance with elective screening is reported monthly to the DH. The Trust is currently working towards compliance with screening all elective day cases meeting the criteria detailed within the national guidance.

### **Antibiotic Prescribing**

Changes were made from 1 June 2008 to the Trust's '**Antibiotic Therapy: Abbreviated Guide to Antibiotic Therapy in Adult Patients Guideline**'. Ceftriaxone and ciprofloxacin have been replaced with intravenous or oral co-amoxiclav. Intravenous piperacillin-tazobactam is to be used in severely ill septicaemic patients before they are switched to oral coamoxiclav. **Treatment of *Clostridium difficile*-associated diarrhoea:** Oral vancomycin is to be used instead of oral metronidazole in severe cases of *C difficile* infection. The key priority for the Trust is to ensure judicious prescribing and to reduce the total antibiotic load. Compliance with the policy is audited by a dedicated antibiotic pharmacist. These changes further increased the Trust's compliance within SHA recommendations.

### **HPV/Deep Cleaning**

The Trust's deep cleaning programme and rolling programme of refurbishment works is currently on target. The 12 wards identified as having the highest numbers of *C difficile* toxin positive patients have been prioritised for enhanced cleaning and deep cleaning including the use of hydrogen peroxide vapour (HPV). The deep cleaning frequency for each ward will be two months on a rolling programme. An evaluation of the effectiveness of HPV is underway with a view to the purchase of equipment for long-term use by Trust staff as part of the environmental cleaning programme.

An equipment washer has been installed and there has been a rolling programme of equipment cleaning in place since June 2008 with tracking system in place for audit purposes.

A Ward Manager training programme commenced in July 2008 as part of the ward manager leadership programme. This focuses on roles and responsibilities with regard to environmental decontamination, equipment cleaning and monitoring of the ward environment.

### **Saving Lives: reducing infection delivering safe care**

The Take Five audit tools were reviewed to reflect the High Impact Interventions contained within the Department of Health 'Saving Lives: reducing infection, delivering clean and safe care (October 2007). The audit programme was re-launched In June 2008 as '**Saving Lives' reducing infection delivering safe care**'. An audit tool for MRSA decolonisation was incorporated within the audit programme for 2008-09. A breakdown of individual ward results is included within the monthly Nursing Key Performance Indicators.

## External reviews

The Trust's arrangements for the control of infection were subject to external review by a team from the Strategic Health Authority. The Team visited on the 30-31 January 2008 and again on the 23 September 2008. The overall assessment following the visit in September was positive with the SHA team recognizing that the Trust had good systems in place and a real commitment to reducing HCAs. The SHA raised two areas of concern, the first was the level of input from the Infectious Diseases doctors for patients on the *C difficile* ward; further funding has been agreed for 1 additional Consultant, 1 STR3 and 3 SHOs. The second concern related to the root cause analysis process and the tool used for reviewing *C difficile* cases; it has been agreed with the PCT that The Trust will continue to adhere to the national guidance which is to undertake RCA on all *C difficile* deaths from Part 1 on the death certificate, colectomies, outbreaks/clusters. A joint meeting with the PCT is to be held in December to review the October RCAs. The Trust have also initiated an audit of all *C difficile* deaths on part 1 of the death certificate and colectomies from 1 April – 31 October 2008 and the Trust are now reporting these as Sudden Untoward Incidents to the SHA.

The Healthcare Commission also assessed compliance with the *Code of Practice* (Duties 2, 4 and 8) during an unannounced inspection on the 11-12 September 2008. The Trust was assessed as fully compliant with Duty 2 and 8 however the HCC identified a material failing of Duty 4, sub-duty (f) of the Hygiene Code relating to the effective arrangements for the appropriate decontamination of instruments and other equipment. The HCC made recommendations for improvements in relation to Duty 4f and these were actioned immediately by the Trust and the HCC provided with the appropriate evidence, eg risk assessments. The HCC will be revisiting the Trust in January 2009 to review the actions implemented.

## Self Assessment of Compliance with the Code of Practice

The Trust uses the DH balanced scorecard for self-assessing compliance against the current 11 duties of the Code of Practice. Compliance is reviewed quarterly. The Trust is currently reporting partial compliance with:

Duty 3(a) failure to fully comply with national MRSA screening guidance produced in 2008 for elective medical/surgical day cases

Duty 4(c) satellite decontamination units

Duty 11(a) new national guidance produced in 2008 for the screening and immunisation of staff.

Action plans are in place to address areas of non-compliance and funding has been agreed to ensure the Trust is fully compliant by 31 March 2009. The appropriate Directorate leads are responsible for ensuring the actions contained within the balanced scorecard are taken forward. From January 2009 the Trust will be required to register with the Care Quality Commission in relation to HCAI.

**MEDICAL STAFFING**

**Assistant Director of  
Organisational Development:  
Miss Alison Risker**

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**Specialty Recruitment - 2008**

Round 1 of the 2008 national recruitment programme ended on 16 May 2008. A large number of vacancies were passed back to the Trust for recruitment, many of which were advertised a further 2-3 times. Most posts were filled prior to August changeover; however, recruitment was required up until the day before changeover. A small number of gaps remained, predominantly in the surgical specialties due to the ongoing national shortage of junior doctors and locums. The effect of this was two-fold, the fact that short-notice gaps for sickness absence are very difficult and / or expensive to fill, and secondly, a number of new rotas planned for introduction in August were postponed, most notably in ENT, Radiology, Renal Medicine and Trauma & Orthopaedics. Work is ongoing with the departments with rotas which are non-compliant with European Working Time Directive 2009, to develop alternative plans ahead of the August 2009 deadline.

The actual changeover in August 2008 was the biggest in the history of the Trust (in excess of 300 new starters). The Corporate Induction programme run by the Medical Staffing Department now includes registrars and consultants.

Many junior doctors in medicine resigned from their current posts and left before the end of their rotations. This resulted in a vacancy rate of 25% which had a significant impact on the remaining staff in post. This situation was exacerbated by the national locum shortage. The rota was micro-managed on a daily basis.

Modernising Medical Careers continues to be extremely problematic, with too many appointments needing to be made in too short a period of time.

**Specialty Recruitment - 2009**

The Recruitment process for 2009 is an interim measure pending the establishment of Medical Education England in 2010. There is no confidence that the process in 2009 will be improved in anyway on that in 2008. It is anticipated that the workload of the Medical Staffing Department from May – August 2009 will again be unacceptably high.

**2008 Casework**

During the period 1 April 2008 – 31 October 2008, casework was completed for 5 consultants, 7 junior doctors and in relation to 6 rota / banding payments.

**Future workstreams**

Future work will include:

- 2009 recruitment will once again present a massive undertaking for the Medical Staffing department.
- 100% compliance with EWTD 2009 compliance is required by 1 August 2009.
- Work will be taking place on implementing the new Staff Grade and Associate Specialist contract.
- Revision of the Leadership Development programme and its further evaluation.

**POSTGRADUATE MEDICAL EDUCATION****Director of Postgraduate Medical  
Education: Dr Arun Gupta**

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**Introduction**

The Postgraduate Medical Education Centre (PGMC) continues to be integral in keeping the Trust informed of the changes to Postgraduate Medical Education and ensuring that the directives issued by the East of England Deanery are implemented in a manner which fits with the Trusts' overall plan.

**Specialist Training**

The new training structure for doctors entering Specialist Training is now established, with the Specialist Training Programmes developed under the auspices of the Royal Colleges and the Postgraduate Medical Education and Training Board (PMETB). Recruitment to most of the speciality training posts has been led by Deaneries at local level. Recruitment was generally well conducted this year, with representation from Addenbrooke's consultants on selection panels. In 2008, some specialties were recruited to at Deanery level and others at national level. A national IT system is currently in use for General Practice and will be piloted by Core Medical Training in 2009.

**Foundation Programme**

The training programme for Foundation Years 1 and 2 is now firmly established, working well and has attracted high calibre applicants. The new Academic foundation programme for which further Central funding was given is also highly regarded. There are now separate teaching sessions for FY1s and FY2s, which are well attended ensuring the training for F1 and F2 is excellent. The mandatory ALS, ALERT, clinical skills and simulator sessions which are all part of the curriculum are highly rated courses. ALS and ALERT training for FY1s continues to be funded by the Trust.

**Study Leave**

Study Leave continues to be administered through the Postgraduate Medical Centre, with the 2008/2009 budget set at £300 per trainee.

**Provision of courses**

The postgraduate medical centre continues to organise a broad spectrum of courses for medical and an increasing number for non medical staff. New courses started in 2008 which deserve highlighting include the Emergency Ultrasound courses, The Fothergill Society Meeting, Facial Trauma Plating Course and the Vascular Access Conference. The primary care programmes for dental and GP education continue to deliver high quality well attended meetings.

**Support for trainees and trainers**

Performance based assessments are now embedded and are required to be completed by the trainees, with e.portfolios being a fundamental part of the recording of their assessments. The PGMC facilitates this by ensuring that the required number of assessments are completed and that the educational supervisors are satisfied that the trainee is of adequate competence. Training Seminars for assessors and educational supervisors have continued throughout the year.

The Postgraduate Centre continues to run a number of meetings for educational supervisors, consultants and trainees alike to keep abreast of current changes in medical education.

### **Simulation Centre**

The demand for the simulation centre has continually increased throughout the year. All final year students from the Clinical School are now going through the Centre and compulsory simulator training of Foundation 2 doctors is now established, with training for the Foundation 1 doctors starting in the Autumn of 2008. The critical care nurses continue to develop and run internal teaching programmes, and are planning to increase the number of courses being delivered in the centre. The primary care teams have run a number of teaching sessions using the simulators in 2008.

### **Postgraduate Centre**

Dr Arun Gupta as Director of Postgraduate Medical Education with Dr Pamela Todd as Associate Director and Miss Helen Fernandes the Foundation years 1 and 2 Programme Director, continue to have close relationships with Professor Huw Jones the Regional Postgraduate Dean, and the East of England SHA Multi-professional Deanery staff. Mary Archibald continues as centre manager. There is increasing demand on administration with the rolling out of the e-portfolios.

**The PGMC and simulation Centre website** includes details of available courses and information on study leave, together with FY1 education programme ([www.addenbrokes-pgmc.org.uk](http://www.addenbrokes-pgmc.org.uk)).

**RESEARCH & DEVELOPMENT****Director of Research &  
Development: Dr John Bradley**

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**Introduction**

The Research & Development department has continued to support in excess of 1000 active research projects within the Trust, whilst providing oversight of the challenges presented by the new national health research strategy 'Best Research for Best Health'.

The NIHR Cambridge Biomedical Research Centre is now established, and is supporting research in key strategic themes of:

- Cancer
- Cardiovascular disease
- Diabetes, obesity, and metabolic disorders
- Imaging
- Improving outcomes in transplantation
- Infection and immunity
- Medical genetics'
- Musculoskeletal disorders
- Neurosciences
- Women's Health

In addition, seven fellowships in translational medical research have been awarded and will provide training for the next generation of clinical scientists. Two of these have been established in partnership with GSK. Capital awards exceeding £7m have allowed the Trust to proceed with key projects, including the installation of PET/CT in partnership with Merck, development of a core research laboratory within Biochemistry and upgrades to WBIC and facilities for stem cell preparation.

Cambridge University Hospitals NHS Foundation Trust has become host to the West Anglian Comprehensive Local Research Network, which has been established to support clinical research.

The importance of patient and public involvement in research has been recognised by the establishment of a Patient Panel to provide advice on all aspects of research, and a highly successful public event that provided an overview of research on the Addenbrooke's campus.

The speed of implementation of recent changes in NHS R&D as required considerable resource and effort, which will need to be sustained to ensure that the Trust meets its aim of becoming the leading Biomedical Campus in Europe.

## **SIFT MONITORING & REVIEW**

**Clinical Sub-Dean:  
Dr John Firth**

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Cambridge University Hospitals Foundation Trust continues to deliver about 50% of the teaching provided by the Cambridge Clinical School. All students are now working on the 'new' three-year course, which progresses from very structured teaching in the first few months to clinical apprenticeship in the final year, with the aim of producing doctors able to work effectively on the wards of Addenbrookes and other hospitals on qualification.

Established medical schools are subject to routine QABME (Quality Assurance of Basic Medical Education) monitoring visits from the General Medical Council every five years. In 2007/8 the Cambridge medical school was visited, with the Clinical School receiving a very favourable report.

Funding for teaching clinical students (total >£15M/year) is managed by the Trust's SIFT management team, which meets with representatives of the Clinical School on a four-monthly basis, other issues arising during the course of the year being dealt with outside the formal committee when necessary. This funding is devolved within individual departmental budgets, each Directorate being responsible for ensuring that appropriate teaching is provided, the amount and quality of which is assessed and managed in response to systematic feedback obtained from the students and from external review (such as the QABME process).

In 2008/09 key issues will be

- (1) To continue to refine the 'new' clinical course where feedback indicates that improvements are required
- (2) To work on the development of a new database and Virtual Learning Environment for the Clinical School to make management of the course more efficient and allow development of new methods of learning
- (3) To continue to work to encourage, develop and sustain the teaching capabilities of medical and other staff working for the Trust.

# MEDICAL DIRECTORATE

**EXECUTIVE ADMINISTRATIVE TEAM:**  
Miss Katie Prentice

**ASSISTANT DIRECTOR OF ORGANISATIONAL DEVELOPMENT**  
Miss Alison Risker

**ASSOCIATE MEDICAL DIRECTOR (University)**  
**Professor Andrew Bradley**  
Honorary Consultant Surgeon

**MEDICAL DIRECTOR**  
**Dr Jag Ahluwalia**  
Consultant Neonatologist

**ASSOCIATE MEDICAL DIRECTOR (NHS)**  
**Mr Richard Miller**  
Consultant Surgeon

**ASSOCIATE MEDICAL DIRECTOR (Infection Control)**  
**Dr Basil Matta**  
Consultant Anaesthetist

**ASSOCIATE MEDICAL DIRECTOR (Patient Safety)**  
**Dr Sue Robinson**  
Consultant in Emergency Medicine

**Safety First Project Lead**  
**Dr Trevor Baglin**  
Consultant Haematologist

**Caldicott Guardian**  
**Dr John Klinck**  
Consultant Anaesthetist

**Clinical Audit**  
**Dr Paul Roe**  
Consultant Anaesthetist

**Director of Postgraduate Medical Education**  
**Dr Arun Gupta**  
Consultant Anaesthetist

**Associate**  
**Dr Pamela Todd**  
Consultant Dermatologist

**Director of Research & Development**  
**Dr John Bradley**  
Consultant Physician

**Associate Clinical Sub Dean**  
**Dr John Firth**  
Consultant Physician

## CLINICAL DIRECTORS – (13)

(Medicine/Specialist Medicine/DME/Surgery/Specialist Surgery/Transplantation/Perioperative Care/Neurosciences/Oncology/Children's/Pathology/Radiology/Women's)

On matters of Discipline & Conduct, Clinical Audit, Clinical Governance, Research & Development, and Education and Training

**Associate Medical Directors**  
**Roles and Responsibilities**

<b>Associate Medical Director (Infection Control)</b>	<b>Associate Medical Director (University)</b>	<b>Associate Medical Director (NHS Professional Development)</b>	<b>Associate Medical Director (Patient Safety)</b>
Dr Basil Matta	Professor Andrew Bradley	Mr Richard Miller	Dr Sue Robinson
<u>Term 1:</u> 1 August 2006 – 31 July 2009	<u>Term 1:</u> 1 January 2005 – 31 December 2008	<u>Term 1:</u> 1 June 2008 – 31 May 2011	<u>Term 1:</u> Dates 1 September 2008 – 31 August 2009
<ul style="list-style-type: none"> <li>➤ Infection control and prevention.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Trust / University Integration.</li> <li>➤ Research integration with the University.</li> <li>➤ Clinical Excellence Awards</li> <li>➤ Support for new consultants</li> <li>➤ Consultant Induction.</li> <li>➤ Consultants Welcome &amp; Introduction to Addenbrooke's.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Job Planning.</li> <li>➤ Research PAs.</li> <li>➤ Appraisal and Revalidation.</li> <li>➤ 360 Degree Appraisal.</li> <li>➤ Clinical Information Technology.</li> <li>➤ Consultant Communications.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Patient safety lead.</li> <li>➤ New clinical governance agenda.</li> <li>➤ Junior Doctors Handbook.</li> <li>➤ Revised Induction programme for SpRs / ST3s and above.</li> <li>➤ NHSLA Risk Management Standards.</li> <li>➤ Key Performance Indicators.</li> <li>➤ Chair of Patient Safety Executive Meeting.</li> </ul>
<ul style="list-style-type: none"> <li>➤ Attendance at Medical Directorate Meetings.</li> <li>➤ Chairing meetings on behalf of Medical Director as and when required.</li> <li>➤ Assisting with concerns in relation to medical staff as and when required.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Attendance at Medical Directorate Meetings.</li> <li>➤ Chairing meetings on behalf of Medical Director as and when required.</li> <li>➤ Assisting with concerns in relation to medical staff as and when required.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Attendance at Medical Directorate Meetings.</li> <li>➤ Chairing meetings on behalf of Medical Director as and when required.</li> <li>➤ Assisting with concerns in relation to medical staff as and when required.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Attendance at Medical Directorate Meetings.</li> <li>➤ Chairing meetings on behalf of Medical Director as and when required.</li> <li>➤ Assisting with concerns in relation to medical staff as and when required.</li> </ul>

**CLINICAL DIRECTORATES AND  
SERVICE DELIVERY UNITS**

As at: 1 November 2008

<b>CLINICAL DIRECTORATE</b>	<b>SERVICE DELIVERY UNIT</b>	<b>SDU DIRECTOR</b>
<b>CHILDREN'S</b>  Clinical Director: <b>Dr Denise Williams</b>	<b>General &amp; Acute Paediatrics</b> <b>Paediatric Intensive Care</b> <b>Paediatric Neurology / Child Development Centre</b> <b>Paediatric Oncology</b> <b>Paediatric Surgery</b>	Dr Peter Heinz Dr Samir Latifi Dr Alasdair Parker  Dr James Nicholson Mr Adil Aslam
<b>MEDICINE 1</b>  Clinical Director: <b>Dr Alex Gimson</b>	<b>Acute Medicine</b> <b>Allergy &amp; Immunology / Respiratory</b>  <b>Cardiology &amp; Clinical Pharmacology</b> <b>Endocrinology &amp; Diabetes</b> <b>Gastroenterology, Hepatology &amp; Endoscopy</b> <b>Renal Medicine</b>  <i>Infectious Disease Medicine</i>	Dr Stephen Haydock <i>Dr Alex Gimson temporarily</i>  Dr Michael O'Sullivan Professor Krish Chatterjee Dr Miles Parkes  Dr John Firth  <i>Dr Effrossyni Gkrania-Klotsas</i>
<b>MEDICINE - SPECIALIST</b>  Clinical Director: <b>Dr Chris Sonnex</b>	<b>Dermatology</b> <b>Disablement Services</b> <b>Gauchers Disease Service</b> <b>Genito-Urinary Medicine</b> <b>Medical Haematology</b> <b>Metabolic Bone Disease</b> <b>Rehabilitation</b> <b>Rheumatology</b>  <i>Occupational Health Medicine</i> <i>Blood Transfusion</i>	Dr Jane Sterling Dr Stephen Kirker Professor Tim Cox Dr Chris Carne Dr Trevor Baglin Dr Juliet Compston Dr John Jenner Dr Adrian Crisp
<b>MEDICINE FOR THE ELDERLY</b>  Clinical Director: <b>Dr Claire Nicholl</b>	<i>Stroke Medicine</i>	Dr Eoin O'Brien
<b>NEUROSCIENCES</b>  Clinical Director: <b>Professor John Pickard</b>	<b>Neurology</b> <b>Neurosurgery</b> <b>Neuro Intensive Care</b>	Dr Chris Allen Mr Peter Kirkpatrick Dr Rowan Burnstein
<b>ONCOLOGY</b>  Clinical Director: <b>Dr David Gilligan</b>	<b>Haemato-Oncology</b>	Dr Jenny Craig

<b>CLINICAL DIRECTORATE</b>	<b>SERVICE DELIVERY UNIT</b>	<b>SDU DIRECTOR</b>
<b>PATHOLOGY</b>  Clinical Director: <b>Dr Jo Whittaker</b>	<b>Clinical Biochemistry &amp; Immunology</b> <b>Clinical Microbiology &amp; Virology</b>  <b>Haematology</b> <b>Histopathology &amp; Cytology</b> <b>Medical Genetics / Cytogenetics</b>  Tissue Typing	Professor Steve O'Rahilly Dr Mark Farrington  Dr Wendy Erber Dr John Grant Dr Jo Whittaker / Lead Clinician: Dr Geoff Woods
<b>PERI-OPERATIVE CARE</b>  Clinical Director: <b>Dr Basil Matta</b>	<b>Anaesthesia</b> <b>Day Surgery</b> <b>Intensive Care</b> <b>Neuro Critical Care Unit</b>	Dr James Bamber Dr Ian Munday Dr Kevin Gunning Dr Rowan Burnstein
<b>RADIOLOGY</b>  Clinical Director: <b>Dr Philip Bearcroft</b>	<b>Radiology</b> <b>Nuclear Medicine</b>  Breast Imaging	Dr Philip Bearcroft Dr Kottekkattu Balan ( <i>Dr Jane Dutton from 1 December 2008</i> )  Lead Clinician: Dr Sue Barter
<b>SURGERY 1</b>  Clinical Director: <b>Mr Richard Miller</b>	<b>Accident &amp; Emergency</b> <b>General Surgery</b> Breast Cardiothoracic Surgery Colorectal Vascular Upper GI  <b>Orthopaedics &amp; Trauma</b> <b>Urology</b>	Dr Sue Robinson Mr Kevin Varty      Mr Julian Owen Professor David Neal
<b>SPECIALIST SURGERY</b>  Clinical Director: <b>Mr David Adlam</b>	<b>ENT</b> <b>Ophthalmology</b>  <b>Oral &amp; Maxillofacial Surgery</b> <b>Plastic Surgery</b>	Mr Patrick Axon <i>Mr David Adlam temporarily</i>  Miss Rowena Rimes Mr Michael Irwin
<b>TRANSPLANTATION</b>  Clinical Director: <b>Professor Andrew Bradley</b>	<b>Transplantation Surgery</b>	Professor Andrew Bradley
<b>WOMEN'S SERVICES</b>  Clinical Director: <b>Mr Gerald Hackett</b>	<b>Neonatal Intensive Care</b> <b>Gynaecology</b> <b>Obstetrics</b>	Dr Wilf Kelsall Mr Mahmood Shafi Miss Charlotte Patient

# Medical Director's Annual Report to the Board of Governors

## Appendix 4 Table 1

### NHS Consultant Appointments for year 01/04/2007 - 31/03/2008

#### Category: N1 and N2

*N1 Contract held by Addenbrooke's*

*N2 Contract held by another Trust, with Programmed Activities here under a Service Level Agreement or a Joint appointment with another Trust*

<b>Start Date</b>	<b>Specialty</b>	<b>Consultant</b>	<b>New or Replacement</b>	<b>Category</b>	<b>Lead Trust</b>
01/04/2007	Obstetrics & Gynaecology	Dr H H Missfelder Lobos	N	N1	Addenbrookes'
01/04/2007	Endocrinology & Diabetes	Dr D Simmons	R	N1	Addenbrooke's
23/04/2007	Neurosurgery	Dr M R Garnett	R	N1	Addenbrooke's
01/05/2007	Clinical Genetics	Dr S Mehta	N	N1	Addenbrooke's
11/06/2007	Trauma & Orthopaedics	Mr J R Crawford	N	N1	Addenbrooke's
01/07/2007	Oncology/Clinical	Dr G Horan	N	N1	Addenbrooke's
30/07/2007	General Surgery/Colorectal	Mr R J Davies	N	N1	Addenbrooke's
01/08/2007	Anaesthesia	Dr P G Bradley	R	N1	Addenbrooke's
03/09/2007	Urology	Mr O J Wiseman	R	N1	Addenbrooke's
17/09/2007	Radiology	Dr J A Hughes	N	N1	Addenbrooke's
01/10/2007	Radiology	Dr S J Barter	N	N1	Addenbrooke's
01/10/2007	Respiratory Medicine	Dr P Sivasothy	N	N1	Papworth
01/10/2007	Renal Medicine	Dr S S Gunda	R	N1	Addenbrooke's
01/10/2007	Obstetrics & Gynaecology	Dr C Prasannan-Nair	R	N1	Addenbrooke's
08/10/2007	Rheumatology	Dr N G N Shenker	R	N1	Addenbrooke's
01/11/2007	Radiology	Dr M G Wallis		N1	Addenbrooke's
19/11/2007	Anaesthesia	Dr D A J Frear	N	N1	Addenbrooke's
10/12/2007	Radiology	Dr J L Babar	N	N1	Addenbrooke's
10/12/2007	Geriatric Medicine	Dr R W S Biram	N	N1	Addenbrooke's
01/01/2008	Anaesthesia	Dr M E Jones	N	N1	Addenbrooke's
01/01/2008	Renal Medicine	Dr A N Chaudhry	N	N1	Addenbrooke's
01/01/2008	Paediatrics/NICU	Dr N K Yeane	N	N1	Addenbrooke's
02/01/2008	Chemical Pathology	Dr A J Park		N2	West Suffolk
02/01/2008	Anaesthesia	Dr P M Rolfe	N	N1	Addenbrooke's

<i>Start Date</i>	<i>Specialty</i>	<i>Consultant</i>	<i>New or Replacement</i>	<i>Category</i>	<i>Lead Trust</i>
			<i>Post</i>		
07/01/2008	Plastic Surgery	Mr P H Gillespie	N	N1	Addenbrooke's
14/01/2008	Anaesthesia	Dr H D B Alawattegama	N	N1	Addenbrooke's
14/01/2008	Cardiology	Dr MRD Belham	N	N1	Addenbrooke's
14/01/2008	Paediatrics	Dr R B Heuschkel	N	N1	Addenbrooke's
01/02/2008	Geriatric Medicine	Dr E Dolan	N	N1	Addenbrooke's
01/02/2008	Trauma & Orthopaedics	Mr V Khanduja	N	N1	Addenbrooke's
01/03/2008	Haematology	Dr G A Follows	R	N1	Addenbrooke's
01/03/2008	Anaesthesia	Dr V V Kakhandki	N	N1	Addenbrooke's
27/03/2008	General Medicine/Infectious	Dr E Gkrania-Klotsas	N	N1	Addenbrooke's

**Medical Director's Annual Report  
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**Appendix 4 Table 2**

**NHS Consultant Appointments for year 01/04/2008 - to 31/10/2008**

**Category: N1 and N2**

*N1 Contract held by*

*N2 Contract held by another Trust, with Programmed Activities here under  
a Service Level Agreement or a Joint appointment with another Trust*

<b>Start Date</b>	<b>Specialty</b>	<b>Consultant</b>	<b>New or Replacement Post</b>	<b>Category</b>	<b>Lead Trust</b>
01/04/2008	Neuroradiology	Dr D J Scoffings	N	N1	Addenbrooke's H
01/04/2008	Respiratory Medicine	Dr J P Fuld	N	N1	Addenbrooke's
01/05/2008	Neurosurgery	Mr S Thomson	N	N1	Addenbrooke's
01/05/2008	Cardiology	Dr P J Pugh	N	N1	Addenbrooke's
01/06/2008	Plastic Surgery	Mr A J Durrani	R	N1	Addenbrooke's
01/07/2008	Medical Microbiology	Dr S H Aliyu	N	N1	Addenbrooke's
14/07/2008	Radiology	Dr S S Upponi	N	N1	Addenbrooke's
01/08/2008	Oncology/Clinical	Dr L T Hughes-Davies		N1	Addenbrooke's
04/08/2008	Histopathology	Dr S J E Pursglove	R	N1	Addenbrooke's
04/08/2008	Renal Medicine	Dr S Ojha	N	N1	Addenbrooke's
18/08/2008	Histopathology	Dr E Provenzano	R	N1	Addenbrooke's
01/09/2008	Clinical Pharmacology	Dr F A Mir	N	N1	Addenbrooke's
01/09/2008	Paediatrics	Dr G M Pierre	N	N1	Addenbrooke's
01/09/2008	Neurosurgery	Mr S J Price	N	N1	Addenbrooke's
01/10/2008	Histopathology	Dr V Phillips	R	N1	Addenbrooke's
13/10/2008	Obstetrics & Gynaecology	Mr P Bose	N	N1	Addenbrooke's

**Medical Director's Annual Report  
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**Appendix 5**

**MEDICAL STAFF as at 1 November 2008**

<b>NHS Staff</b>	<b>No. in Post</b>
<b>Consultants</b> - Contract held: employed by Addenbrooke's (including Split Contract holders)	312
<b>Consultants</b> - Contract held: employed by another Trust, with sessions here under Service Level Agreement	32
<b>Consultants</b> - Locum	24
<b>Other Grades:</b> Associate Specialist	15
Staff Grade	4
Clinical Assistant	16
<b>Trainee Grades:</b> Specialist Registrar / ST3	206
Specialty Registrar (to include FTSTAs)	193
Foundation House Officer 1	46
Foundation House Officer 2	40
Flexible Trainee	13
<b>Clinical Fellows:</b>	65
<b>Total</b>	<b>966</b>

<b>Honorary Medical Staff</b>	<b>No. in Post</b>
Honorary Consultants	124
Clinical Lecturers (equates to Honorary Specialist Registrar)	Unknown
Honorary Clinical Fellows	Unknown
Honorary Specialist Registrars	Unknown
Honorary Senior House Officers	Unknown
<b>Total</b>	<b>124</b>

<b>GRAND TOTAL</b>	<b>1090 +</b> Junior Honorary posts and Clinical Lecturers
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### Cambridge University Hospitals NHS Foundation Trust

#### Patient Safety Counsel

#### Draft Terms of Reference

##### 1. Purpose

- 1.1. The Patient Safety Counsel will act as an advisory and reference group for the Patient Executive and provide support and "wise counsel" regarding matters of patient safety.

##### 2. Membership

- 2.1. Membership will be as follows:

- Associate medical Director - Patient Safety (Sue Robinson)
- Chief Executive (Gareth Goodier)
- Director of Nursing and Organisational Development (Karen Castille)
- Educational Representative (TBC)
- Governor representatives x 2 (Georgina Pharaoh and Eric Revell)
- Head of Risk and Patient Safety (Glenn Pascoe)
- Medical Director (*initial Chair*) (Jag Ahluwalia)
- National Safety First Lead (Stephen Ramsden, invited, TBC)
- Non Executive Director
- Senior Consultants x 4 (TBC)
- Senior PAM (TBC)
- SCN (TBC)
- SDM or Operations Manager (TBC)
- SPR (Simon Lewis?)
- Representative from another University Teaching Hospital (Rob Evans GOSH, confirmed)
- Solicitor (TBC)
- University Engineering Dept representative (Professor John Clarkson, TBC)

- 2.2. Other appropriate staff can be co-opted as and when required as members to provide specific advice.

##### 3. Frequency of Meetings

- 3.1. Meetings will normally be held quarterly and no less often than three times in a year.

##### 4. Duties and responsibilities

- 4.1. To provide a source of advice to the Patient Safety Executive and the Trust on matters of patient safety.
- 4.2. To provide a reflective forum for the Patient Safety Executive and the Trust on matters of patient safety
- 4.3. To provide a forum in which proposals made to improve patient safety can be subjected to a "test of reasonableness."
- 4.4. To advise on and inform the Trust's Patient Safety Strategy.