Newcastle’s Specialist Continence Service wins Award

The award recognises the outstanding efforts of the entire, multi-disciplinary team whose readmissions project is reducing hospital admissions from Care and Residential Homes due to avoidable UTIs and CAUTIs. Congratulations to the team.

Finalists in the Nursing Standard Nurse Awards

Two of our leading nursing teams have also been shortlisted for the 25th Anniversary Nursing Standard Awards. They are:

- The Respiratory Cognitive Behavioural Therapy (CBT) Team led by Karen Heslop, Nurse Consultant, for the Innovations in Respiratory Award, and
- The Upper GI Cancer Nursing Team led by Claire Sedgwick, Upper GI Cancer Nurse Specialist, for the Innovations in your Specialty Award

As well as the team nominations, both Karen and Claire have been shortlisted for the coveted Nurse of the Year Award. We wish them all the very best of luck at the Awards ceremony in May 2014.

Newcastle Study reinforces message - prompt treatment saves lives

Leading Cardiologists at the Freeman Hospital’s Cardiothoracic Centre have recently published results of a definitive study in the European Heart Journal which shows that survival following a heart attack is no different for patients living in rural areas to those residing near a hospital. The most important message is for patients to call 999 as soon as they think they are having a heart attack. See the news section on our website for more information and the full report.

Staff endorse the services they provide

Results of the recent national NHS Staff Survey have shown that our staff are more likely to recommend their place of work to family and friends for care and treatment than any other Trust in the North East. The positive response rate to the Survey’s key finding “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation” was 87% - by far the highest response for any acute Trust across the region – being a clear endorsement from our own staff that the Newcastle Hospitals’ are a provider of the highest quality patient care.

Also inside...

- Vertical integration
- Newcastle Occupational Health Service - a refresh for all
- ‘Better Together...’ Heart Failure readmissions project
- Direct Access Pacing
- New Walk-In Service in Lemington

Plus...

- Home Parenteral Nutrition (HPN) service
- Improving care for our Elders
- Bringing patients back into the world of sound
- Newcastle Leading in Kidney Scarring Prevention

We hope you find our newsletters helpful and if there are any hot topics you would like us to cover in future editions, or indeed if you would like to contribute, please contact us at gpmatters@nuth.nhs.uk

Healthcare at its very best - with a personal touch
Vertical Integration

Defined by the Oxford Dictionary as “The combination in one firm of two or more stages of production normally operated by separate firms”. Strangely, it is not “The takeover of small independent companies by a larger hostile organisation”.

I suspect that most of us working in the NHS have been frustrated by the fragmentation which has been created by ongoing structural change to the healthcare architecture over the years.

Separate organisations, within what is still a “National Health Service”, create problems at the interface. Jobsworths, who do not want to be helpful, can now say “it’s not in the contract” while those who have the patients’ welfare at heart still have problems with the “Who ya gonna call?” question.

I well remember sterile discussions as to how, for example, coeliac disease could best be managed. Clinicians could easily agree a model but commissioning it, when input was needed from secondary care, a separate community service and GPs, seemed to defeat the best of minds.

No boundary between competing organisations is seamless, so there is a chance for patients to fall between the cracks. We also have to fund an army so that different parts of the NHS can bill and invoice each other and fret about the outcomes.

Patients don’t care, and should not have to, about which is the lead organisation in managing their care. They expect a unified joined up system to carry them along the pathway. Surely this clinical need should dictate the organisational structure behind it?

I suggest that a health and social care family, which is a closely knit alliance, would best provide this. It would need to respect the skills and aspirations of its members, the leadership would have to be a multi-disciplinary team and the aim would be to deliver for patients, not the greater glory of any organisation.

Almost any clinical imperative, especially if aimed at reducing admissions, can be better solved jointly.

- Finding all the AF or CHF or COPD in the city, investigating it and monitoring the results?
- Managing fracture risk?
- Earlier discharge?
- Alternatives to admission?
- Management plans on discharge?
- Co-ordination with PAMS?

GPs can start by working more closely together as GP Federations and keeping the door always open for opportunities of partnership working. Hospital trusts need to change too. Opportunities to reach into the community must be matched by the transfer of resources into the community to meet clinical needs. We are mutually co dependent and it’s time to recognise this. Where is the threat?

Dr Mike Scott, Lead GP at Newburn Surgery and GP Clinical Advisor for the Newcastle Hospitals can be contacted at mike.scott2@nhs.net

Newcastle Occupational Health Service - a refresh for all

The Newcastle Hospitals has provided an in-house Occupational Health and Wellbeing Service for over five years. The service supports the employees of the Newcastle Hospitals as well as several significant key organisations such as the University of Northumbria and Newcastle University’s Medical and Dental School.

Dr Elizabeth Murphy, a senior Consultant Occupational Physician, was appointed to the service last Summer. She says: “Returning to Newcastle from an established Consultant post in Aberdeen has been an exciting and challenging move. However as I trained in Medicine in Newcastle and completed early training in Respiratory Medicine and higher training in Occupational Medicine in the region, it is a delight to bring some of my experience to the Occupational Health Service here.”

Closer working with General Practice is growing and the service is increasingly receiving requests for advice and assessment from Primary Care, as well as the screening of those joining the local performers’ list for health clearance. NewcastleOHS would wish to continue to support GPs requiring quality occupational health advice and support.

As an appointed member of the GMC Medical Practitioners Tribunal Service, Dr Elizabeth Murphy has particular expertise in supporting individuals and organisations with complex fitness to practice issues. Dr Murphy says: “Seeking early advice and support for any healthcare worker who may be unwell or having performance issues is vital in maximizing the potential for rehabilitation and remediation, whilst minimizing the risks for patients.”

NewcastleOHS can provide ad hoc item per service advice and assessment and can be contacted via Newcastle.ohs@nhs.net.

More information of the NewcastleOHS services is available at www.newcastle-hospitals.org.uk/NewcastleOHS.
Heart failure readmissions project

Chronic heart failure is a serious condition which impacts on patients’ quality of life, increases mortality and can result in emergency admissions to hospital. For those with left ventricular systolic dysfunction (LVSD) there are a number of evidence based treatments which lead to substantial symptomatic improvement, reduce admission to hospital and improve prognosis.

Identifying patients with LVSD before they develop symptoms of heart failure also allows treatments to retard the progression to symptomatic heart failure to be optimised. Ensuring the right patients have the right combination of treatments and monitoring can be a challenge and the Newcastle Hospitals’ Cardiology Team have been working in partnership with GP practices to identify and optimise management in patients with chronic heart failure. Those already identified on Practice registers are having their management optimised and we are testing out the methodology to case-find those with LVSD who are not yet symptomatic.

The searches in the 5 pilot Practices are now complete and the ECGs and echocardiograms to test out the case finding methodology completed. Patients with known heart failure and those identified with LVSD as part of the case finding have been seen in 2 Practices, and community clinics for those from the remaining 3 Practices are on-going. We are currently evaluating the outcome of this initial pilot and will be looking to roll out what we find to be clinically effective to other Practices once that is agreed.

Unfortunately chronic heart failure is often not a stable condition and patients require regular review of their management, as well as when their symptoms change. This may not always be directly due to their heart failure and we have audited patients being admitted to hospital with other conditions such as chest infections and urinary tract infections. In many of these patients their heart failure drugs have to be reduced whilst they recover and following discharge these drugs need to be re-titrated and heart failure treatment re-optimised. As part of the project we want to work in partnership with primary care to agree how on-going management can be most effectively provided. Practice teams have very helpfully provided feedback in response to a survey about how they feel about managing heart failure. We now are planning some educational events in June and July at different community venues, and will be in touch with practices about those soon.

Dr Jane S Skinner, Clinical Director for Community Services and Consultant Community Cardiologist can be contacted at jane.skinner@nuth.nhs.uk

Direct Access Pacing

If a GP sees a patient with heart block who would benefit from permanent pacing, and has an ECG confirming the diagnosis, the patient may now be referred directly to the Coronary Care Unit (CCU) at the Freeman Hospital, rather than the Royal Victoria Infirmary (RVI).

We have audited urgent permanent pacing in Freeman Hospital over a three year period, and establishing that over 60% of patients could have been identified at first presentation as needing a permanent pacemaker. If these patients had been admitted directly to Freeman Hospital rather than the RVI, three bed days per patient could have been saved. The major reason patients were not considered suitable for direct admission was that the diagnosis of bradycardia was not obvious at presentation. Other reasons included significant trauma at the time of collapse, which would be much more appropriately managed in the RVI’s Emergency Department (ED), active infection (which is a relative contraindication to pacing) and complex co morbidity. Statistical analysis showed that a heart rate of < 50 beats per minute, and high grade AV block (second or third degree) identified patients suitable for direct admission with an accuracy of > 80%.

When tested in a year-long prospective study, taking suitable patients directly from ED or the Emergency Assessment Suite (EAS), we saw that 53% of urgent presentations to the RVI, who subsequently received a pacemaker, could be identified either in the ED or EAS as suitable for pacing. 64% of these patients were transferred to the Freeman Hospital for pacing the same day or the next, saving about four bed days per patient.

We are now undertaking a study with the North East Ambulance Service (NEAS) so that patients they see with bradycardia can be assessed by an experienced CCU nurse at the Freeman, using the acute myocardial infarction system – a telemetered ECG and a phone call. Appropriate patients can then be admitted directly to the Freeman’s CCU for pacing, without having to go via the RVI. This has been working well since we started in February, but some of the patients are still referred by their GP to the RVI’s EAS. These patients can now be referred directly to Freeman’s CCU.

The patient should have a heart rate of <50 bpm, with AV block. It is important that the patient is afebrile (pacemaker implantation is contraindicated when there is acute infection), and does not have either trauma that would be better treated in the ED, or comorbidity that would significantly delay discharge.

Does your patient need a pacemaker? Is there:

• Unexplained fall / collapse, syncope or dizziness? AND
• Heart rate < 50 bpm, with evidence of AV block?

If YES (and there are no exclusions – see below), then please refer the patient direct to Freeman Hospital. To discuss urgent transfer of the patient for pacing:

• fax the ECG to Freeman’s CCU Fax: 0191 2231139 AND
• contact Freeman CCU’s Coordinator on: 0191 2448596

Exclusions: Direct referral via this route is inappropriate if the patient:

• has evidence of active infection
• has trauma / comorbidity requiring specific management
• has a clear, reversible cause for bradycardia but please consider discussion with the Cardiology SpR on call.
Home Parenteral Nutrition (HPN) service

Over the past 14 years the Freeman Hospital has established a regional Home Parenteral Nutrition (HPN) service. HPN allows patients who would normally require a prolonged hospital stay or multiple admissions for IV nutrition to stay in their own home. The team now looks after 62 patients around the region from the Borders, across North Cumbria and down to North Yorkshire - this has grown from only 16 patients in 2010. Our HPN team provides a life-saving service for many patients suffering from chronic intestinal failure who need specialist nutritional support to prevent malnutrition and dehydration.

Patient groups include those who have:
- had a significant section of their bowel removed surgically for conditions affecting the intestine such as Crohn’s Disease;
- suffered an acute abdominal catastrophe, such as bowel ischaemia, resulting in patients having stomas and or fistulae which can leave the intestine unable to function without specialist support. PN may be required for 6 to 12 months as a “bridge to recovery”, allowing the abdomen to recover prior to further definitive surgery;
- slow, progressive cancer causing intestinal obstruction and so compromise a patient’s nutritional intake. Our HPN service offers these patients an improved quality of life whilst keeping them at home.

The team consists of Gastroenterologist Dr Nick Thompson, recently joined by colleague Dr Chris Mountford; Intestinal Failure Surgeons Prof Derek Manas and Mr Fantin Bergin; Nutrition Nurse Specialists Hayley Leyland and Hannah Cook and Dieticians Barbara Davidson and Lisa Gemmell. The team also benefits from dedicated Pathology and Pharmacy support.

As the service has expanded so has the quality of care we can offer. One of the most serious complications of HPN is an infection of the long-term intravenous catheter, often a Hickman line. The rate of infection in our patients has reduced from 0.8 infections per 1,000 patient days on HPN before 2011 to 0.31 infections in 2013 and this year the “rolling” infection rate is 0.17. Reducing infections saves patient harm and also reduces the need for expensive hospital admissions. Our rate of line infection compares favourably with the Royal Hope Hospital in Salford, which is one of two nationally funded Intestinal Failure centres, which reported an infection rate in 2013 of 0.39/1,000 patient days.

In tandem with the HPN service the Intestinal Failure Surgical Service expands. This surgery is highly complex, often to restore gut continuity and may require joint operating with Mani Ragbir, Consultant Plastic Surgeon. In the last year 16 patients have undergone this specialised surgery.

If you would like to find out more the HPN programme, please contact Dr Nick Thompson at nick.thompson@nuth.nhs.uk or christopher.mountford@nuth.nhs.uk
Caring for frail, older patients is a key issue facing urgent care in the UK today. The rising proportion of older patients as a percentage of total urgent care needs, alongside an exponential rise of frail older people at the extremes of old age requiring urgent care, are well documented.

In tandem, a dramatic increase in the complexity of co-morbid conditions and social needs, with a concomitant rise in the number of elders residing in residential and nursing home care, predispose towards a higher need for urgent care.

In recent years, primary and secondary healthcare and adult social services in Newcastle have introduced a number of successful initiatives to help improve care for our older patients:

- The Care Homes Project
- A Consultant Physician ‘Helpline’ on the Royal Victoria Infirmary (RVI) Assessment Suite (AS) for GPs seeking immediate general medical advice: 0191 282 1524
- Specialist Nurses in the Emergency Department at the RVI to speed up assessment and early discharge of older patients
- Reconfiguration of community health and social care teams into the new CRRT

New initiatives will continue to ensure smooth, rapid and safe assessment and transitional care for frail, older patients. Yet despite such progressive approaches, these patients continue to represent a disproportionate number of medical admissions, with high rates to the Emergency Department (ED) and onwards to the AS and Medical Wards.

This year’s Winter Planning increased medical capacity across our hospitals to ensure adequate accommodation of the inevitable emergency caseload – often consisting of patients with long-term conditions who have multiple, clinical management planning needs. This has involved a number of non-medical wards and so to ensure that patients receive the best possible care, a new 7 day a week, RE-HIT Service (Roving Elders’ Hospitalist Interface Team) has been introduced.

This multi-disciplinary, roving team proactively case-finds frail older patients in ED, AS and all wards admitting these patients across our hospitals. They triage the patients for a Comprehensive Geriatric Assessment (CGA) – an evidence-based approach involving multi-disciplinary assessment and management with resultant benefits in quality of care, reductions in length of stay and reduced readmission rates. This process supports early discharge via CRRT, primary care colleagues, and Day Hospitals, and facilitates ongoing specialist input as required. Early analysis shows a reduction in length of stay in patients managed using this approach, taking multidisciplinary care needs to individual patients regardless of where they are in the hospital.

Another area of work with a positive impact during the winter months has been the redesignation of some medical bed capacity, for the care of older people. Two Consultant Physicians specialising in the elderly care are based there and liaise with colleagues in the AS and ED as well as the High Dependency and Intensive Care Units, and Surgical Wards. Early identification of these patients enables rapid access to an old age acute care specialist – ideally in the first 24 hours - to set up the right management plan.

The Trust embraces the patient centred principles of good care and post discharge management as outlined by the national Emergency Care Intensive Support Team (ECIST). We have a dedicated Discharge Co-ordinator who supports colleagues on the Wards with day-to-day decision making, particularly with complex discharge issues, and collaborating with multi-disciplinary teams including Social Workers to improve and promote safe and timely discharge.

For the future we are also considering the principle of ‘Discharge to assess’. This means discharging the patient as soon as the acute episode is complete, and planning post-acute care in the person’s own home or other usual place of residence. Here the Community Health and Social Care Teams can provide the comprehensive assessment and reablement need during post-acute care to determine and manage long-term care needs. More on this in a future Edition of GP Matters.

By working “Better together” we can collectively conceive overarching solutions incorporating community services, primary care, social services and our acute provision to ensure continuous improvements to how we care for our frail, older patients.

Dr Steve Parry, Clinical Director and Consultant Physician can be contacted at steve.parry@nuth.nhs.uk

GPs can seek immediate general medical advice using the Consultant Physician ‘Helpline’ on the RVI’s Assessment Suite on ☎: 0191 282 1524
Bringing patients back into the world of sound

Hearing loss affects around 10% of the population to some degree, and is one of the most common conditions presenting in medical practice today. Gradual, sudden or congenital loss of hearing can have a detrimental impact on normal speech, intellectual and social development, as well general wellbeing. Here in Newcastle, our Bone Anchored Hearing Aid (BAHA) Centre – the largest in Europe - is dedicated to helping those with hearing loss return to the world of sound.

There are a number of different reasons for hearing loss:

• congenital hearing loss, present at birth;
• unilateral hearing loss following a traumatic injury such as an assault or car accidents, or side effects following surgical removal of acoustic or glomus tumours;
• sound not reaching the nerve cells of the inner ear, eg. due to microtia or the effects of chronic ear disease; (patients with hearing loss due to chronic ear disease such as recurrent infection, where the drum and/or the small bones in the middle ear have become damaged, are often unable to tolerate a conventional hearing aid in the ear canal due to either continuous or intermittent draining.)

The solution for these patients could be a bone conduction hearing device - a BAHA - bypassing the middle ear and stimulating the inner ear directly through the skull. BAHAs are also suitable for people with certain medical conditions such as Down Syndrome, a common feature of the condition being narrow ear canals and middle ear malformation leading to impaired hearing, and Treacher-Collins, dependent upon the severity of the condition.

Mr Johnson, Consultant ENT Surgeon and Director of Newcastle BAHA Centre explains: “Bone conduction hearing systems allow us to help patients who are clinically unsuitable for other treatments, eg. traditional hearing aids. By using a small implant, we simply bypass problem areas and that means we can restore hearing that’s seriously deteriorated, or give someone the joy of being able to hear for the first time”.

The surgical procedure involved is simple with minimal discomfort and pain for the patient. Most importantly, there is no risk of further hearing loss due to the surgery. For infants and young children, the surgery would not take place until aged 4 or 5 years. However, prior to surgery, a sound processor can be worn on a head band or soft band which the infant wears to hold the BAHA against the skull and this is very well tolerated.

Mr Johnson adds: “We’ve treated more than 1,200 patients here in Newcastle to date. They come from all over the UK and further afield. Regardless of where they live, we want to make it as easy as possible for patients to use our service, so if necessary we can conduct surgery the day after a first consultation. We are particularly keen to see people with long-term, chronically discharging ears who so often find themselves with no further avenue of treatment after the conventional treatment approaches. These cases are often ideal for consideration of BAHA. If successful, they can completely transform people’s lives.”

Mr Johnson would be delighted to discuss any individuals cases and can be contacted on ☏: 0191 213 7627 or at ian.johnson@nuth.nhs.uk

New Walk-in Service in Lemington

When it comes to providing quality healthcare for minor ailments and injury, Walk-in Centres are a great alternative to hospitals. They offer local people access to modern health services in the heart of their community.

The Newcastle Hospitals run both the Westgate Walk-in, in Newcastle’s west end, and Molineux Street in Byker, each seeing up to 80 people a day for minor injuries such as cuts, burns, sprains and minor ailments.

In early March a new Walk-in service commenced, based at the Lemington Resource Centre in Lemington. The service is led by Nurse Practitioners who have extended clinical skills to provide diagnosis and treatment. Most staff are independent prescribers and can therefore treat the majority of conditions that come in to the centre. Nurse Practitioners also have access to Emergency Department Consultants for second opinions should they need it.

Mr Johnson would be delighted to discuss any individuals cases and can be contacted on ☏: 0191 213 7627 or at ian.johnson@nuth.nhs.uk
UTIs are the most common bacterial infection under the age of 2 and for most children treatment is straightforward with no serious consequences. However, for a few, UTIs are associated with serious long-term complications such as renal scarring (chronic pyelonephritis), hypertension and renal impairment. Accurate diagnosis of UTI in young children is important as UTI may be a marker for urinary tract abnormalities and prompt treatment can affect outcome.

The Great North Childrens Hospitals’ Paediatric Nephrology Service have historically worked in close collaboration with GP colleagues across Newcastle and its environs with the aim of increasing vigilance around suspected symptoms of UTIs.

A recent publication by the GNCH team compares two audits of children under 8 years, presenting with UTIs in Newcastle, one from 1992–1995 the second from 2004–2011. The audits show that children with a first UTI in the 2000s compared to those in the 1990s, were referred younger, were half as likely to have a renal scar and were about 12 times more likely to have vesicoureteric reflux without scarring. Furthermore treating children’s urinary tract infections in 3 days or less, more than halves the risk of them acquiring kidney scars.

The team is keen to reduce investigations and imaging of children and has just published a further audit on children with UTIs within Newcastle who were referred and imaged according to the Newcastle guidelines during 2008. They compared their management with that which would have taken place by following the NICE CG54 Childhood UTI Guidelines introduced in 2007. This included monitoring cases through 2011 to identify those with recurrent UTIs. The results showed that fewer children would have been imaged by NICE than Newcastle (150 vs 427), but the sensitivity of the NICE guideline was lower, at 44% for detecting scarring, 10% for identifying vesicoureteric reflux without scarring. Furthermore, treating children’s urinary tract infections in 3 days or less, more than halves the risk of them acquiring kidney scars.

The team is keen to be invited to visit local GP practices and colleagues across Newcastle and its environs with the aim of increasing vigilance around suspected symptoms of UTIs. In the future, they aim to conduct a prospective audit of diagnosis and management here in Newcastle, and are keen to work closely with primary care and with clinicians across the region to improve the quality of care for children affected by UTIs. Also, we are very pleased to demonstrate that active and early management of UTI reduces scarring rates" and notes “this would not have been detected if the NICE guidelines for investigating childhood UTI had been implemented locally.”

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New Appointments

Colin Wilson and Stephen McNally have both recently taken up Consultant Surgeon posts, specialising in pancreatic and liver transplantation and HPB surgery.

Colin studied at Newcastle University Medical School before undertaking training across the Northern Region. He took up his post in February this year.

Stephen studied at the University of Aberdeen, subsequently training in abdominal transplantation and hepato-pancreato-biliary surgery at the Royal Infirmary of Edinburgh. During this time he undertook a five year Clinician Scientist fellowship, researching strategies to improve perioperative liver function. He took up his post in February this year.

These new Consultant roles will enable continued expansion of Newcastle’s Transplant Services at the UK’s very first Institute dedicated solely to Transplantation, whilst enhancing the quality of patient care and strengthening our academic and research profile, both on a national and international footing.

Whilst specialising in Transplantation both Colin and Stephen will provide additional expertise for patients requiring surgical interventional for a range of hepatopancreato-biliary (HPB) related conditions such as biliary colic, cholecystitis, pancreatitis, liver cysts, tumours and sarcomas, as well as more general conditions such as hernias, abdominal conditions and “lumps and bumps”.

Whilst based at the Freeman Hospital both Colin and Stephen will be providing outreach specialist hepatobiliary surgery clinics across the region. Colin’s clinics will run alongside the current “Outreach” service and are already available in Middlesbrough and Stephen will be running regular clinics across in Carlisle in the very near future.

Mr James McCaslin, Consultant Vascular and Endovascular Surgeon was appointed in early April.

Having studied at Newcastle University and carried out all medical training across the Northern Region, James embarked on a year’s fellowship in Perth, Australia to further enhance his endovascular skills.

James is delighted to join the Northern Vascular Service in Newcastle. He hopes to continue to develop the Endovascular Surgical Service working closely with both surgical and interventional radiology colleagues providing exceptional care for patients with aneurysms and peripheral arterial disease. He will also work alongside Mr Tim Lees, Consultant Vascular Surgeon and Clinical Lead for Vascular Surgery, running the combined venous clinic, along with a specialist arterio-venous malformation (AVM) MDT.

Dr Christopher Mountford, Consultant Gastroenterologist joined us in March and specialises in luminal gastroenterology with a particular interest in nutritional support including intestinal failure and home parenteral nutrition.

Having studied at Newcastle University and carried out his postgraduate training across the North East, Christopher completed a Masters degree in Nutritional Medicine and gained valuable experience from a secondment to the National Intestinal Failure Centre in Salford. Clinical time is divided between general gastroenterology and endoscopy work and input to the specialist regional intestinal failure and nutritional support service based at the Freeman Hospital. He runs general gastroenterology clinics on both RVI and Freeman sites and will be offering evening sessions every Wednesday to help improve access to endoscopy for patients.

Christopher looks forward to working with our excellent Intestinal Failure Team including Dr Nick Thompson, Consultant Gastroenterologist, and Consultant Surgeons, Professor Derek Manas and Mr Fintan Bergen.

News Flash

Doctors Shortlisted for BMJ Awards

The Freeman Hospital’s homegrown UK Endovascular Trainees (UKETS) group have been shortlisted as finalists in this year’s prestigious BMJ Healthcare Awards in the Education Team category.

UKETS is an enthusiastic, cross-speciality collaboration of doctors who have developed an innovative approach using simulators to provide training support in endovascular procedures for trainees interested, or currently training, in radiology, cardiology and vascular surgery. They have produced a wide range of training films on YouTube showing how to use the equipment safely and without supervision, so that trainees can ‘virtually’ carry out procedures numerous times on their own, building up knowledge rapidly. The team have also developed an iphone App, enabling trainees to track their simulation training.

UKETS cardiology lead consultant Dr Alan Bagnall said “It’s a great honour to have been shortlisted for these awards, but the real motivation for us is to improve patient safety. All doctors need to learn, and so by developing core skills on simulators beforehand, we ensure that any risks to patients are minimised”.

Visit www.ukets.org to find out more. You can see the films on www.youtube.com/ukets