

Board of Directors (Public)

Item 4

Board Report

Subject: SHO Cover – Short & Medium Term Plans
Date of meeting: 27th January 2015
Prepared by: Dr Glenn Russell/Medical Director
Presented by: Dr Glenn Russell/Medical Director

Data Quality Rating	BAF Ref	Impact on BAF Risk Rating?
Bronze	8	No change at present. Mitigation plan in place but residual risk around recruitment and financial implications

1. Introduction

The role of the SHO/F2 (Senior House Officer – foundation 2 year) doctor is crucial to patient safety and business continuity of a hospital, and a reduction in this workforce represents a real risk in both these areas.

The Trust faces two concerns with the recruitment of SHO posts. The Division of Surgery usually has a complement of 10 SHO posts. However, from February 2015 there will be a shortfall of up to six posts of these ten posts. The principal reason for this low recruitment is that the posts have had high service content and are viewed to be of limited educational value. This was highlighted at the last Deanery visit in October 2014. The issue is currently less acute in cardiology, with shortfall of one post at present.

Whilst the issue in February is largely local, in October 2014 we received notification from the Deanery that the Trust would lose up to eight Deanery SHO posts by August 2015. This was on the basis of the “Broadening the Foundation year policy” first released in March 2014. The aim of this national policy is to ensure 80% F2 posts have a community/primary care component by August 2015 and 100% by August 2016. Whilst we have protested this reduction it is likely to become a reality in surgery at least. As far as cardiology is concerned, we are working to mitigate this reduction with the GP Training Co-Ordinator, as these posts are seen as good training for potential General Practitioners.

As soon as the problem became apparent at the end of October, a multi-disciplinary steering group was established chaired by the Medical Director. The team comprised of clinical leads, educational leads, Director of nursing, Chief Pharmacist and Director of Education. A separate subgroup was set up by the Director of Nursing to consider nursing staff workflow. Both these groups have met weekly. The remit of the steering group was firstly to ensure patient safety, and then deal with business continuity.

Patient Safety:

It is crucial that any patient requiring urgent medical attention receives an appropriate response at all times. This will be provided by dedicated medical response teams with a primary remit to manage sick patients rather than routine tasks. The remit of the Team is defined in Appendix 1.

The Medical Response Team at night will comprise the 2 resident surgical registrars, 1 resident anaesthetist, 1 resident cardiology registrar, 1 resident Operating Department Practitioner with cannulation skills and 1 Hospital co-ordinator with clinical skills. The Team will not be responsible for routine activities but will focus on responding to the clinical needs of patients. A single combined tier of the 15 remaining SHOs from both specialties will support this team.

The Team will meet prior to the shift commencing and will be based in the Nurse Co-ordinators office. The office has been refurbished with computers and seating and will act as a base for the co-ordination of care both at night and also during the day. The key to success of this Medical Response Team will be the acceptance of team working across the divisions of surgery and cardiology, which will be reinforced by the Clinical Leads. The reduced on-call frequency of the SHO rota will increase time available for service provision but importantly for training.

The focus of the Medical Response Team in dealing with urgent clinical care has implications for the acceptance of inter-hospital transfers after 8 PM. Currently it is not unusual for the hospital to receive urgent transfers of patients after 10 pm for procedures planned for the next day. This has already been highlighted as poor clinical practice with inherent risk, and the process will need to cease. Communication with referring hospitals and the ambulance service will minimise this problem. Emergency transfer will, of course continue and these usually involve consultant presence. The extension of our existing cardiac transport vehicle to stable surgical patients is also being considered. This would ensure the early arrival of patients scheduled for the following day and reduce potential cancellations.

The Medical Response Team in the day will differ slightly. The existing rostered cardiology SHO will continue to train with cardiology and perform this function.

The surgical wards will be covered by a nominated rostered surgical registrar or SHO, again only for emergencies and deteriorating patients. The Day Registrar will be supported by the numerous other members of staff, including consultants, who are in the hospital during the day.

Currently, there is an ICU outreach service provided part time by a nursing team, who respond to deterioration patients. They will also become part of the Medical Response Team (Day). Currently there is an outreach vacancy which is being actively recruited to. The ITU based, F2 doctor, when available, will also work with the outreach team, which will be of educational value as well as supporting patients as these doctors are often high quality. Work is in progress to enhance this Team with the inclusion of the resuscitation Training Officer.

A rota will be produced that ensures nominated Medical Response Team cover is available 24 hours a day and including weekends.

The concept of Medical Response Teams is not new, and formed the basis of the Hospital at Night initiative some years ago. The issue of medical SHOs covering surgical patients, and vice versa, is also not without precedent. It is current practice at the Walton Centre, and these doctors will all have had medical and surgical exposure as F1 doctors. The key

requirement is they treat medical events within their competency, and as part of a team they have appropriate skilled support from middle grades and consultants.

Business Continuity During Normal Working Hours:

There are two strands to the approach taken with this. The first is to ensure we remove any current inefficient and unnecessary steps in the patient pathway. The second is to backfill the remaining but critical service elements of the posts with alternative staff.

Pathway Efficiencies:

Currently, surgical patients seen by a consultant surgeon at O/P are examined (clerked) and consented by the consultant. They are then re-clerked by Clinical Nurse Practitioners, and occasionally clerked again by the admitting SHO. This is duplication and is a process that can take up to an hour for each patient.

The consultant takes a history and examines patients in the outpatient clinic. Using the electronic patient record template we will require the consultant to document their history and examination and this will not be repeated by the CNP or SHO. They will then be seen by the CNP for the nursing and social elements and documentation of medication in EPR which takes 20 minutes. Drug therapy entered by the CNP in EPR at the first visit will also be the basis of admission drug reconciliation and prescription. When the patient presents as an in-patient. The capacity freed up by the reduced time in OP with CNPs will be used on the ward to support admissions that have not been seen previously and to support drug prescription for patients admitted from outside clinics.

Patients seen at outpatients in hospitals without EPR will have a different process; the consultant clerking will be scanned in to the EDMS part of the patient record. The medical teams will be responsible for prescription on medication when the patient presents here for a procedure.

The current process for the discharge process is poorly understood by many of the medical staff. Pharmacy staff will reinforce training in best practice discharge planning including take home drug prescription (also known as TTO). The poor understanding currently causes multiple delays in the process which is unnecessary and inefficient. A review of the above two processes by the SHO steering group has highlighted the poor engagement of surgical staff with EPR. This will be an opportunity to use EPR to gain efficiencies and additional training has been scheduled for January.

Weekend Cover:

The Medical Response Team will function alongside the night time model. However, there will be two SHOs over a weekend, the second helping the admission process, particularly on Sunday. A Clinical Nurse Practitioner will also be available in the afternoon to help with the high level of admissions.

A standard ward round of all surgical patients currently occurs on Saturday mornings, run by middle grade surgeons. The use of EPR has been limited, resulting in a large number of retrospective entries by the SHO. This is poor clinical practice and cannot continue. EPR notes will be made contemporaneously with the use of templates and acronyms. This will require further training for middle grade and consultant surgeons. A senior Pharmacist will be involved with the ward round in January to establish the best form of pharmacy support with the TTO process.

A trial of consultant ward rounds in thoracic surgery will occur in January 2015, the aim is to speed up decision making. The feedback will be received by the Steering Group. If this

proves beneficial, it is hoped that consultant ward rounds at weekends may be possible to further support the care and discharge processes.

Backfill of Necessary Tasks by Alternative Staff:

Experience from other cardiac units suggests that a resident core of Advance Nurse Practitioners can manage most of the duties currently performed by SHOs, and these individuals will have a key part in the new structure. They can perform clinical examination, some procedures such as cannulation, and prescribe a limited range of drug therapy. As they are in post longer than SHO staff, they provide continuity in care and grow in the role. The Trust has currently gone to advert for six of these individuals and the immediate response has been encouraging.

It should be noted that the Broadening Foundation programme targets mean that all Trusts will be seeking these individuals and so the early response to recruitment by the Trust is vital. Once in post, ensuring that they feel fully valued members of the team will be vital to retention.

Diagnostic tests.

All patients admitted will require blood tests. The view of the nurse ward managers is that this will be undertaken as part of the nursing care bundle. Selected nursing staff will be authorised to order tests such as X Rays and CT scans after appropriate training

Prescription of routine and discharge drugs.

There is less room for flexibility in this area. If drugs are entered by consultants in the Outpatient Medicine Reconciliation menu, then transfer directly to inpatient use is relatively easy. Many patients will be seen in peripheral clinics and will need drugs prescribing on arrival at LHCH. In the absence of Advanced Nurse Practitioners, at least in February and March, CNP roles moved from outpatient will be some support, The CNP role cannot prescribe drugs and so it will be the responsibility of individual consultants and their teams to ensure all patients receive their admission medication during this transition phase, and this will be reinforced by communication with all consultants.

Discharge Process.

As mentioned earlier, we have considered the role of pharmacists in this process. Whilst it may be optimal to have a pharmacist on each ward round, this is both expensive and impractical. Once the medical staff have written a discharge history and selected the appropriate discharge drugs, then pharmacists can target their support to the rest of the process. The discipline to predict discharge and then provide pharmacist with appropriate accurate documentation will be reinforced to middle grades and consultants. The final role of the pharmacist in the discharge process will be defined based on feedback from trials in January 2015 as per recommendations for the pharmacy review.

Co-ordinating care requirements and staff availability during the day –bringing it all together.

An office by the nurse co-ordinators area has been designated and prepared at the base for care co-ordination during the day and night. It will form the central meeting point for the hospital at night and weekend teams.

At 08:00 during the day, the available medical and nursing staff for the day will meet in the room.

The nurse co-ordinator will have information on the number of proposed admissions, transfers and sick patients outside ICU areas. A plan to focus the available medical and nursing resources will then be made. The nurse co-ordinator will act as a bleep filter to ensure tasks are directed and prioritised appropriately. The usual bed co-ordinating tasks will, for a trial period, be performed by the Discharge team so as to free up co-ordinator availability.

With regards medical staff, there will always be a rostered trainee to form part of the day medical response team. Any other available SHOs in surgery will also attend the meeting and tasks defined by the team. This may include allocation to training opportunities available at that time.

The Advanced Nurse Practitioners will attend this meeting; there are at present four surgical ANP and with their, and consultant agreement, they will work flexibly on the surgical wards as defined at the 08:00 meeting. When recruitment of ANPs has been completed, it is envisaged they will return to working within surgical sub-specialties.

Communication:

When an organisation undertakes change of this magnitude, particularly in a short time frame, communication within and outside the Trust is vital.

The Steering Group, as a multi-disciplinary team, have ensured proposals are disseminated in their specific areas. We have met with large numbers of nurses and nurse managers, who have had input in to the plans being formulated and have actively engaged with the problem. We have separately met with consultant surgical and anaesthetic staff, as well as trainees in surgery on a number of occasions. Engagement meetings with the cardiology middle grade will take place in January. Two members of the middle grade surgical staff have joined the steering group and we have encouraged others to do so when they feel ready.

Prior to the go-live date of February 4th, each consultant will receive personal communication with details of the plan, and reinforcement of the need to be vigilant particularly during the transition period.

Deanery, Health Education North West and Training:

The Medical Director has written to the Deanery, drawing attention to our proposals. Key to acceptance will be the priority given to training in the new solution. The proposed single rota of 1:15 for the SHOs will include mandated theatre and clinic time, and allocation to an educational supervisor with a genuine desire to teach. The Trust must ensure that we are able to maintain a core of 4 or 5 dedicated surgical SHOs, as these are the seed corn for the future. In the transition period more will be required of the middle grade staff, and it is vital that their training needs are continually addressed. Failure to do so will simply result in recruitment problems in the years ahead.

Regaining a reputation for good training will take time, but the new system will ensure that the opportunity is always available.

The solutions we propose here are exactly those demanded of us by the October Deanery visit, and also by the Broadening Foundation Programme requirements. When embedded and refined, we will be able to focus high quality training on a smaller number of trainees with genuine aspirations to become surgeons. These will be supported by the constant presence of high quality nursing and other staff that can only further enhance patient experience and safety. An active focus on a strategy for education of all groups is key to the longer term recruitment of sufficient numbers of high quality staff .

Financial Impact:

The previous two months have been used to define a working model to ensure patient safety and business continuity in a very short time. As the model becomes clearer, the full financial impact of these changes will need to be established to enable an understanding of the release of funding for unfilled SHO posts by the Deanery to offset the costs of Advanced nurse practitioner recruitment.

The Transition Period:

Enhanced Recruitment process for SHOs.

The final staffing model will involve smaller numbers of SHOs, backfill of the service aspect of the posts will require recruitment of staff that may take some months depending on their availability. The decision has been made to continue to recruit to the vacant SHO posts for the next six months if suitable candidates can be found. The recruitment process has included enhanced focus in the major medical journals, and opening recruitment to suitable candidates out with the EU. This has resulted in an additional three appointments but these will be delayed due to visa requirements.

Consideration was made to employing locum SHOs, but these are of generally very poor quality and variable availability, they are also extremely expensive. Building a plan based on locums was therefore excluded by the Steering Group.

The transitional period, starting in February will be a time of high risk and some uncertainty. The steering group will have in place all systems, individuals and process that can be achieved given the very short time frame. It is clear that all members of staff will need to be as flexible as possible and extremely vigilant at all times in order to maintain a safe hospital at this time. The steering group will continue to meet weekly during the implementation phase to receive feedback and address issues as they occur.

Recommendation:

The Trust has had to develop a response to the loss of SHO doctors in a very short period of time. Whilst this had been both difficult and demanding of time and resource, the Board of Directors is asked to review the proposed model outlined in this document and note progress.

The final solution, if carried through to completion, will result in a highly skilled nursing and non-medical workforce supported by consultants and a smaller number of SHOs who receive excellent training. If this is underpinned by an active strategy for education these changes can only benefit patient care and future recruitment to the medical workforce.