

Board of Directors (Public)
Item 3.1

**board
report**

Subject: SHO Medical Staffing Plan Update
Date of meeting: 31st March 2015
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Presented by: Dr Glenn Russell

Data Quality Rating	BAF Ref	Impact on BAF Risk rating
n/a	8	This risk is currently rated red on Corporate Risk Register – Amber rating for BAF Risk 8 (strategic objective on Workforce) is unchanged

1. Introduction

The Board of Directors has previously approved a plan to deal with the safety and business continuity issues presented by a reduction in surgical SHO (Senior House Officer) staffing from ten doctors to four from February 2015. This paper is to provide an update on the implementation of the plan.

The SHO programme started on the 28 January 2015 to allow a week of implementation with a full complement of staff still available. This allowed the Steering group to ensure there were no major issues that had not been anticipated and to learn any early lessons in a safe environment. From the outset, the major purpose of the plan was to ensure patient safety, if necessary at the cost of a reduction in clinical activity.

2. Patient Safety

The hospital at night model has gone well, with excellent team working across cardiology and surgery. Some initial anxiety over medical SHOs covering surgical patients has dissipated following additional education offered by the Surgical Administrative Registrar.

In addition there was the realisation that many of the out of hours issues are related to medical complications of surgery such as cardiac rhythm abnormalities that they are well placed to manage. There have been no safety issues, even when the hospital has been busy.

The time period from 5pm to 8 pm has been managed by ensuring a medical and surgical SHO are available to cover this period. It is a time of peak discharge in cardiology, so one SHO has a separate bleep until the 8pm handover to the night team. There have been no safety issues highlighted in this period, as many staff still are still on site and consultants are aware that it is their responsibility to evaluate patients prior to surgery the following day.

The 5-8 PM period is the most difficult for the Hospital co-ordinator. They need to process the following day's PCI referrals as well as filter routine bleeps from the wards. This was raised early on to the Steering group. As a consequence the Trust has now appointed additional administrative support both during the day but also to cover the 5-8pm period. This will allow the Hospital co-ordinator to focus on clinical rather than clerical issues.

During the day time, it is the prime responsibility of the rostered SHO to see any unwell patients with the Hospital co-ordinator. In addition the Trust has an ITU outreach nurse that will visit and evaluate post ICU discharge patients as well as any patient triggering the Trust's system for highlighting patients who are deteriorating on the wards (MEWS – Moderated Early Warning Score). All other bleeps for routine tasks are filtered through the Hospital Co-ordinator to ensure most efficient use of medical input.

3. Assurance on patient safety.

The Trust monitors any safety issues that arise in three ways.

- During the first three weeks, consultants were present at the 08:00 and 18:00 hour handovers. It became clear that the Teams were working well, and daily feedback did not reveal any concerns around safety. Following this period, any safety concerns were sought at the weekly SHO Steering Group chaired by the Medical Director. A significant medication error was raised on one occasion. However, this related to poor practice by an individual doctor and was managed accordingly. It did not demonstrate a system problem.
- Secondly, any individual can raise an anonymous concern via the Trust's critical Incident reporting system (PRISM). Review of reports since the implementation of the programme by the Trust's Governance Lead has not shown any reported incidents.
- Thirdly, the CEO holds a daily safety briefing for all senior members of the Trust. Importantly, senior ward nurses and Hospital Co-ordinators attend and would be aware of any concerns across the hospital. The attendance is noted and the discussions documented. Specific information on safety issues related to the SHO programme, as well as medication and medical review completion are sought at each safety brief.

There have been 29 safety huddles (as of 8th March 2015) The issues highlighted do not relate to major safety issues- correlating well with weekly Steering group feedback and the PRISM monitoring. Instead they relate mainly problems with documentation and the discharge process during the day. An example of an issue that was raised was the workload of the Hospital Co-ordinators. This has now been addressed by appointment of clerical support.

4. Business as usual – daytime working

This has been the area that has been most problematic. There are many routine tasks, such as Take Home Drug prescriptions and discharge summaries that need to be performed in a timely manner to allow patients to move through the system. These are best done by the teams who know the patient but in the past have been delegated by Middle Grade Surgeons to the SHO doctors. Indeed this kind of behaviour has been responsible for the high service level of previous SHO posts here, triggering the recruitment crisis.

Documentation by Middle grades and Consultants has also been poor, requiring the SHO doctors to retrospectively fill out the patient record. The reduction in SHOs has made this issue very clear, despite many discussions with this group by the Medical Director and Steering Group members.

A Registrar has now been rostered every morning to support the SHOs to complete these tasks. All other Registrars are expected to spend the period from 08:00 -09:00 on the ward following up on their patients, reducing the work required when they depart to Theatre whilst also enhancing continuity of care.

This has not been popular with some members of the group and triggered a letter of concern to the Care Quality Commission (CQC). However, with only 4 SHOs and 16 middle grades the option is not draconian and enhances patient care. Greater involvement in routine patient care by middle grades in surgery is key to the success of this programme. The Trust has provided a full response to the concern raised and the CQC was satisfied with the assurances received and has confirmed closure of the concern.

Medical Cover has been enhanced at the weekends. As well as the two SHOs that were available prior to the programme, we now have a Clinical Nurse Practitioner to help admitting patients on a Sunday afternoon. A pharmacist now accompanies the Saturday ward round to help the discharge process and this has been very effective.

The Consultant on-call for thoracic surgery also does a formal ward round on Saturday morning. This has been very successful in increasing discharges at the weekend, and is a great example of the engagement of our thoracic surgeons.

5. Recruitment Plan

A key element of the plan has been backfill of routine tasks by the appointment of other groups such as pharmacists and nurse practitioners. Recruitment of the proposed 6 Advanced Nurse Practitioners (ANPs) has been slow, with only one successful candidate to date. Two further interviews were scheduled for 18th March 2015. Two Band 7 posts in Pharmacy have been advertised, and a locum has been in place to support the discharge process.

Four SHOs from outside the EU have been recruited and are due to start towards the end of March. Whilst well qualified and with good spoken English, they have not worked in the NHS previously. A formal induction programme and assessment period will be put in place. They will also spend time shadowing existing staff before a final sign off to begin work.

6. Training

A key aspect of the plan is to ensure dedicated training time for the SHO group – this issue has been highlighted by the Deanery. SHOs now have rostered training time of a full day each week and are now able to get to theatre. However, pressure of work and

dedication to patient care sometimes prevents this. With more input from middle grades, and the arrival of more medical and support staff we should be able to deliver reliable training time.

Whilst appropriately expecting more direct patient care from middle grades over this period, it is not a sustainable solution over the long term. It is the College of Surgeons view that trainees become increasingly supernumerary, and there will be a bidding process to secure the reduced number of trainees in the future.

The future of surgical workforce depends on a system that delivers time to train, but also training opportunity. The new system, when fully implemented, will ensure this.

However, access to training is a problem. Whilst there are many surgical consultants who deliver good training, there are also a number who do not consistently deliver training in line with best practice. With a large number of trainees and a limited number of trainers, the situation is a challenge. The forward view will be presented to the Surgical Division by the Medical Director and Clinical Lead for Surgery. This needs to form the springboard for a comprehensive surgical staffing strategy for the next 3 years.

7. Conclusion

There is no evidence of any patient safety issues that have occurred over the last 7 weeks. However we are in the interim period when the reduction in medical staffing is occurring without the backfill of other workers. This pressure has been felt by the remaining SHOs and a concern was raised to the CQC on 6 March 2015.

The Trust has made a full response and the CQC has confirmed satisfaction with the assurances provided and has closed down the concerns raised. The SHOs are members of the Steering Group and fully understand the rationale for the plan. It is of note that one of them turned down a post in ENT to remain at the Trust and benefit from the training opportunities.

As additional staff are recruited and in place, the pressures on existing staff will ease. Business continuity requires additional effort from all staff and it is encouraging how supportive nursing staff, pharmacists and hospital Co-ordinators have been.

Joan Mathews, Head of Governance, has in particular, played a pivotal role in bringing the nursing and medical staff together. Consultant engagement in the steering group has also been excellent and there is a strong group of clinicians who appreciate the importance of education.

The weekly SHO steering group will continue to meet, to monitor safety and ensure the programme is completed.

Medical staffing is a key risk to the Trust over the next three years. A future surgical staffing strategy needs to build on the benefits of the new system and avoid the tendency to revert to the previous and unsuccessful surgical staffing model. It is only in this way that we will recruit high calibre trainees who will go on to join the Trust as consultants of the future.