

THE WALTON CENTRE NHS FOUNDATION TRUST
GMC – Thursday 10th October 2013
Action Plan

Named Leads

- Dr Peter Enevoldson – Medical Director
- Mr Simon Clark – Director of Medical Education

Action plan content:

- GMC Areas of improvement
- GMC Requirements

GMC recommendation	Timescale for action	Current Trust Position /Progress Update
Areas of Improvement 1: The Walton Centre understands the importance of providing trainers with the skills needed to train and there is a process in place to ensure this happens.		
Consultants at the Walton have the opportunity to train locally as there is an in-house course run by a staff member that has been well received and well attended. This course covers the core principles for training and is tailored for neuroscience.		As at 30 th September 2013 the Trust had achieved just over 90% with level 1 train the trainers, with 100% of Consultants Neurosurgeons being level 1 trained

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<p>Health Education North West set a mandatory recommendation following an Annual Assessment Visit in 2012 for all trainers to have level one training status. The Education Management Team informed us that over 90% of trainers have achieved level one training status. The clinical and educational supervisors we met with confirmed that educational supervisor training is available and all those we met with had completed the training.</p>		<p>Plans are in place to train outstanding trainers.</p> <p>With effect from 1st August 2014 this will become part of the Trust's mandatory training programme for all consultants.</p> <p>Regular updates will be offered and compliance will be monitored.</p>
<p>Requirements We set requirements where we have found that our standards are not being met. Our requirements explain what an organisation has to address to make sure that it meets those standards. If these requirements are not met, we can begin to withdraw approval.</p>		
<p>Requirement 1: Current terminology must be used when referring to the grades of doctors in training and designing rotas.</p> <p>We noted the doctors in training and their supervisors and the education management team frequently referred to 'senior house officers' (SHO) and specialist registrars (SpRs), which is out of date terminology.</p> <p>The doctors training in neurosurgery confirmed their understanding of 'SHO' to include doctors from F2 up to Specialty Training level 2. However, the expected level of competence and clinical supervision requirements for these different levels of training varies considerably. The appropriate level of clinical supervision and expected competence of an F2 that has just begun a four month post in a specialty is considerably different from a CT2. The elimination of these terms would ensure clarity of understanding for other staff members including nursing staff, especially given these grades are included in the same 'SHO' rota.</p>		<p>We accept that the term "SHO" is used as a short-hand for these different levels of junior medical staff, a practice which is very widespread throughout the NHS and borne of decades of use.</p> <p>We acknowledge the problems with this terminology and will try to eradicate it, but realise that this will require considerable and sustained education of all staff and of patients.</p> <p>We are drawing up plans which include considering:</p> <ul style="list-style-type: none"> a) Distinctive badges or even uniforms for different levels of junior medical staff b) Explanatory written information for ward nursing staff c) Explanatory written information for patients <p>Whilst we acknowledge that the competencies of the different levels of junior medical staff may be different, we also point out that in a specialist Trust like the Walton Centre, their roles almost entirely overlap and the degree of supervision by consultants and higher level specialist trainees is much greater than in other hospitals, and that significant management decisions are taken by these more experienced doctors.</p>

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<p>Requirement 2: Learning opportunities available for core surgery and ST1-2 doctors in training must be communicated more clearly and opportunities taken to increase the overall educational experience.</p> <p>Since autumn 2012 services have been reconfigured into sub-specialty wards and this is supported by a rota for the F2, CST and ST1-2 doctors. This rota requires them to be attached to a ward rather than a firm of more senior doctors in training and consultants. The CST and ST1-2 doctors in training we met think this adversely affects the quality of their training experience and makes it difficult for them to attend theatre and clinics. They told us the current arrangements do not allow them to get to know individual consultants and informal training opportunities are now missed by having less contact with the consultants; for example, the opportunity to ask questions when walking between wards. They reported feeling demoralised and that much of the work is no more advanced than that expected in a foundation year one role.</p> <p>The current CST and ST1-2 doctors have arranged an additional rota that allows them to attend theatre one day per week. This enables them to have the opportunity to observe and where appropriate take part in neurosurgical procedures.</p> <p>Some of the educational supervisors we met understood the reasons for reconfiguring the service into different specialty wards. In theory this should improve efficiency, as the specialist doctors have to visit less wards in order to see all of their patients. However, they stated the current arrangements can be isolating for the more junior doctors in training who are based on the wards, as it reduces the opportunity to more closely interact with the consultants. Some felt there are valuable training experiences available for the CST and ST1-2 doctors, including managing wards and learning to recognise and manage critically unwell patients, in addition to attending clinics.</p>		<p>We think that it is incorrect to attribute these problems to the new specialty ward system of deployment.</p> <p>This grade of junior doctor (F2,CST,CMT,ST1-2) rotate around a number of Trusts very frequently. The group interviewed had not previously worked under the team based system.</p> <p>It is more a reflection of the necessarily limited role of the most junior doctors in a largely tertiary specialist trust, especially one where 80% of in-patients are neurosurgical. Nevertheless there are some marvellous training and experiential opportunities from such a setting for those who aspire to capture them .</p> <p>The new specialty ward system was designed to improve patient care and safety, not reasons of efficiency.</p> <p>This internal rota for day release for CST and ST1-2 in neurosurgery to attend theatre has been strengthened further and also extended to CMTs in neurology to attend clinic. There has been excellent feedback from current trainees, with ample opportunities for training in theatre. In addition we have arranged the trainees based on their speciality to cover the most appropriate speciality based ward.</p> <p>The additional rota also enables attendance at OPD Clinics 1 day per week</p> <p>The move from team based working to the introduction of a cohorted speciality ward system with an identified junior doctor was introduced for reasons of clinical quality and patient safety. This has been monitored and has proved to be a great success. Ward based working will continue until the numbers of doctors in training can be increased.</p>

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<p>The LEP senior management acknowledged the mismatch in the expectations and experience reported by these doctors in training and outlined the steps being taken to support them, including ongoing improvements to IT systems, expanding the numbers of advanced nurse practitioners, and supporting specialist nurses to obtain extra qualifications.</p> <p>It is hoped that such measures will reduce the amount of routine tasks for the doctors in training and thus there will be greater opportunities to attend clinics and theatre.</p> <p>The findings above support the recommendations in the Health Education North West Annual Assurance visit report from its visit to The Walton Centre on 8 May 2013 including keeping the balance between service delivery and education under close review, ensuring appropriate induction, consultant supervision, handover and feedback under the new arrangements and providing CSTs with the opportunity to attend theatre.</p>		<p>It is acknowledged that it has taken some time to amend Consultant job plans to reflect the new way of cohorted speciality working.</p> <p>Neurosurgical /Neurology combined teaching weekly led by Royal College Tutors for both specialties (F2, CSTs,CMTs and neurosurgery ST1 & 2).</p> <p>Weekly Surgery higher speciality training /teaching every Friday a.m.</p> <p>The number of specialist nurses has increased and their job profiles gradually changed (e.g. the balance of the work plan of the vascular surgery nurses): more are planned but training takes time. The Trust also took on several nurses as “clinical coordinators”, senior nurses to take on many clerking and ward “jobs” of the junior doctors. This has not been as successful as we had hoped and is being re-visited.</p> <p>There are also other measures which are being rolled out to reduce the more routine and perhaps less educationally stimulating tasks of the juniors:</p> <ol style="list-style-type: none"> 1. Electronic prescribing – EPMA rolled out from mid- March 14, reducing time spent on prescribing and especially on re-writing drug charts.. 2. Roll out Electronic prescribing order comms IT system planned for summer 2014 (delayed for IT reasons but contracts now signed) – this will benefit all by reducing time and effort of paper-based systems and carriage to departments.. 3. Further improvement of E-patient enabling “hand off” of jobs between colleagues, facilitating training periods away from the wards 4. As part of one of the “Forward to Excellence” workstreams to which the Trust Executive and Board are committed, the nurse-led (and consultant anaesthetist supported) pre-admission clerking of non-elective neurosurgery patients will be increased from the present 80%, and in particular the depth and reliability of the clerking increased so that the percentage who do not require any junior doctor clerking on admission will grow from the present 50%. 5. The percentage of routine spinal surgery cases dealt with as day cases will be increased over the next two years, so removing these patients from any contact with junior surgical staff.
<p>Recommendations We set recommendations where we have found areas for improvement related to our standards. Our</p>		

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<p>recommendations explain what an organisation should address to improve in these areas, in line with best practice.</p>		
<p>Recommendation 1 Ensure CST and ST1-2 doctors in training are given the opportunity to lead handovers as this is an educational opportunity to learn a new skill which is currently being missed.</p> <p>Doctors training in both core surgery and neurosurgery reported robust arrangements for handover that they feel work well. This included morning handovers with the night manager and the consultants.</p> <p>While the arrangements appear to be appropriate and safe, handover is at present led by consultants and there are potential learning opportunities available for the doctors in training, through leading handover.</p>		<p>We suspect that there has been a misunderstanding here. There are two distinct handovers each morning. The first (7:45am) is between the night shift (junior doctor and senior nurses) and the forthcoming dayshift (all the junior doctors and senior nurses). This hands over the ward issues of all inpatients (neurological and neurosurgical). Immediately following this the surgical juniors join the neurosurgical team meeting (starts 8am) in which the senior specialist trainee and the surgical “fellow” and the consultant neurosurgeon who were on the day and night before discuss and hand over to all the other consultant neurosurgeons and the middle grade staff: this meeting deals with the numerous (30-50) “emergency” neurosurgery referrals made to the Trust in the previous 24 hours from its catchment 16 DGHs and beyond, the majority of whom are still in the DGHs and many never become inpatients. The former handover meeting is designed for the junior medical staff, whilst the latter has to be at a much higher level. The CSTs and ST1s & ST2s attend and can ask questions etc, but could never lead this second handover.</p> <p>DME suggests that Senior 2nd on call trainee from previous evening should attend 7.45 meeting for mentoring purposes –all can then attend Consultant meeting at 8am.</p> <p>There has always been an evening handover at 8:30pm where the outgoing two evening junior staff and senior nurses hand over to those coming onto the night shift.</p> <p>In addition a quick handover has commenced just between the daytime junior staff at 5pm and those who are still here in the evening, for handover of issues on present inpatients and of expected emergency admissions. This started on ***** and is working well, facilitated by the iPod system for swapping of information on patients.</p>
<p>Recommendation 2 Provide additional support and mentoring to ST7-8 neurosurgery doctors in training to support their selection of a special interest.</p> <p>The ST7-8 doctors in training we met emphasised the importance of selecting the right special interest for them, and that they would benefit from some mentoring in this area which would take account of their special interest and the likely future service need. They explained that the consultants are respectful of their personal choices, and freely offer support and advice once they have made a decision. They would however value support in making the decision, ideally at an earlier stage in their training.</p>		<p>All ST3-7s already have regular meetings with their educational supervisors and on a daily basis with the consultants on the firm to which there are allocated on a rotation, During these years, they rotate around the various neurosurgical sub-specialties, which is essential to meet the full training curriculum. Those who express an interest are encouraged to pursue this by conducting an in-depth audit or case series review, or undertaking more formal research in an out – of-programme. Many take these opportunities for marking out their special interest subject. Advice is already freely given to those who ask.</p> <p>To cater for all neurosurgical trainees, we will arrange for them to be asked on an annual basis by their educational supervisor specifically about their subspecialty interests and if they wish for any advice or mentoring about career opportunities and any other issues plus reinforcement of support from consultant colleagues.</p> <p>Post CST subspecialty fellowships are also readily available in almost all subspecialties.</p>
<p>Recommendation 3: Increase the level of involvement of neurosurgical training with the School of Surgery.</p>		

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<p>The Mersey Deanery School of Surgery Annual Report dated October 2012 reported an ongoing lack of engagement from neurosurgery with the School of Surgery. The report noted that as a consequence of this, progress in compliance with the e-platform for surgical training, the Intercollegiate Surgical Curriculum Programme, lags behind other specialties.</p> <p>We were advised that the Training Programme Director (TPD) attends the School of Surgery Board meeting; however, there was some uncertainty as to the extent to which these meetings add value. Increased engagement with the School of Surgery would provide the opportunity to learn from good practice in other surgical programmes. We heard that the TPD also attends meetings at the Royal College of Surgeons to ensure the Walton keeps up to date with changes to the curriculum, and is actively involved.</p>		<p>The current TPD will ensure engagement at regional and local level, and that WCFT is involved in teaching at Junior surgery levels and higher ones also if ever requested -College tutors/TPD to co-ordinate.</p>

SIGNATURE OF ACTION PLAN TRUST LEAD _____ DATE _____