IMPLEMENTING NEW DEAL AND WORKING TOWARDS EWTD COMPLIANCE – LESSONS FROM GREAT ORMOND STREET

The changes outlined here were carried out in a specialist children's hospital, so the specific solutions used will not necessarily translate to other hospitals. However, the general principles and lessons learnt are generic, and should translate to any setting.

Phase 1: The immediate temptation is to try and duplicate existing roles, work patterns and hierarchies. This is the approach that superficially results in least change to culture and service and is achieved by recruiting more doctors to provide 24-hour cover with the same multi-tiered SHO, SpR and consultant staffing structure. It may be necessary for all Trusts to go along this flawed route in the first instance, purely to facilitate local ownership of more radical solutions. However, this approach doesn't achieve the desired goals, because:

- It almost always fails to achieve New Deal compliance, with rotas continuing to run 'close to the wind' in terms of New Deal regulations.
- It is not sustainable in the long-term because of problems in recruiting enough doctors of suitable calibre.
- It leads to greater fragmentation of care.
- There are risk management, competency and governance implications around having an increasing part of the workforce in 'unregulated' non-training grades.
- It will not be viable from 2004 in light of SiMAP and the WTD regulations.

Phase 2: Many hospitals, ours included, will inevitably have been adopting the Phase 1 approach outlined above, because of the change management implications of more radical solutions. In many cases, consultants, managers and juniors will be burnt-out from seeking New Deal solutions, and at loggerheads because of the resultant ill will. We felt that we could defuse this by moving the focus away from junior doctors' hours to broader consideration of the workforce. We achieved this by:

- Asking teams to stop thinking about New Deal solutions and instead think about issues of process from the patient perspective. In particular, they were asked to think about tasks and roles that could be better done by someone else.
- An emphasis was placed on maximising clinical time at all levels and across all professional groups. We recognised that removing administrative tasks from nurses was just as important as removing them from junior doctors; partly because they might then take on some of the clinical tasks performed by doctors, *but equally* because they would have more time to undertake clinical tasks within their own specialist workload.

Phase 3: The issues flagged up through Phase 2 were used as the basis for a 1-day toolkit workshop, supported by the Changing Workforce Team. Apart from the value of this exercise in developing new roles, it was an important change management tool for addressing cultural divides – by bringing small multi-disciplinary groups of both clinical and non-clinical staff together to tackle issues of shared concern. Some examples of new roles and processes that came through this workshop include:

- Clinicians' Assistants, who would take on many of the administrative tasks carried out by both doctors and nurses. They were specifically so-named to get away from the image of 'Physicians' Assistants' whose role is to work for the medical team alone, rather than the broader clinical team.
- Extension of the role of the team of Clinical Site Practitioners. These are H/I grade nurses, primarily from an intensive care background, who provide 24-hour senior clinical cover for the hospital.
- Developments in protocol and supplementary prescribing.
- A new post (ultimately set up for someone from a nursing background, although other options were considered) to manage outpatient leukaemia maintenance therapy. This could obviously be applied to a range of chronic conditions.
- A review of the management of external clinical calls to the hospital, with preliminary plans to set up a call centre to reduce unnecessary bleeping of doctors and nurses.

Phase 4: Against a background of new role development and a focus on evolving the workforce around the needs of the patients, it was possible to re-open discussions about rotas in a more radical way. In the context of working in a specialist children's hospital, we planned cross-cutting changes to our paediatric rotas, which involved reducing tiers of cover overnight *and* increasing cross-speciality cover. The end-point of this process would be a reduction in the number of junior doctors working overnight - from 11, in various on-call and partial shift rotas, to 3 working full shift plus one 'sleeping' doctor as emergency backup. There were several steps to this process:

- Widespread consultation – the proposed changes were clearly going to impact on staff groups across the organisation, and we therefore conducted a formal consultation in line with Trust procedures, as well a having a number of open fora to debate the issues.
- Auditing of workload by day – the proposals entailed a reduction in the number of doctors available by day (although those working day shifts would be able to provide better continuity of care through longer blocks of full day-time working). Audit of the day-time workload of junior doctors was therefore necessary to determine whether, as anticipated, a substantial proportion of their time was taken up by inappropriate duties that could be undertaken by the Clinicians' Assistants, as described above.
- Auditing of workload by night – one of the most overriding concerns emerging from the consultation process was that patient safety would be compromised by reducing the number of doctors on call, with the perception that several doctors were frequently busy simultaneously. The audit involved employing medical students doing agency work during their summer break to 'walk the wards' and document the number of junior doctors awake, as well as the nature of their work. They also collected parallel data for the Clinical Site Practitioners, who were by this time undertaking many of the roles previously carried out by doctors (a quite tangential benefit was the insight afforded to the medical students participating in this audit). By classifying the work undertaken in to true emergency work and semi-elective work, it emerged that much of the bulge of activity that took place between 10pm and 1am involved finishing evening tasks, and that 3 doctors and 2 Clinical Site Practitioners could safely cover for true emergency workload through the night. In addition, SHOs were largely unnecessary, partly because once they had been called they often had to wake the registrar, and partly because a night team of 5 (comprising 3 middle grade doctors and 2 Clinical Site Practitioners) easily had the capacity to cover the balance of the SHO workload.

- Reduction of tiers of cover overnight - SHOs were therefore removed from the overnight rota and instead provide full shift cover from 8.30 am to 10pm, 7 days a week. Since GOSH does not have a casualty department and our SHOs had already had substantial acute on-call experience in other settings, we felt that they would not lose important experience overnight. However, both they and the clinical service would gain by having them provide better continuity of care by day. Educationally we felt that is would be beneficial for them to have more daytime experience, with better access to teaching sessions, outpatient work and other supervised training. Both the RCPCH and the Deanery supported this rationale.
- A changed strategy to the non-training grade staff – we recognised that in order to staff the full shift night rota described we would still need a number of non-training grade posts. However, we wanted to move away from a migrant workforce on fixed term contracts for whom we did not have long-term development responsibility. We therefore removed all SHO-level Trust posts, and set up a number of new staff grade posts. Our philosophy in relation to these posts was that we would actively support the incumbents to *either* gain the experience they needed to return to the training grade *or* to progress within the NCCG structure to Associate Specialist level or whatever supervenes it. In doing this, we had to combat the prejudices in relation to nomenclature, whereby 'Trust fellow' is perceived to be professionally more acceptable than 'staff grade', despite the fact that the latter is a post with national terms and conditions that demonstrates a commitment of the Trust to the post-holder.
- Broader cross-speciality cover – the rota changes outlined above meant that we would no longer have a registrar covering each sub-speciality; instead each would have lead responsibility for a 'sister-speciality' by night, as well as for their own. We anticipated a consequent increase in overnight consultant workload that the Trust would need to address, particularly for acute specialities where the majority of the consultants are over 50.

Phase 5: Once the principle of a night team was established, a major cultural shift was required to make it function successfully. Perhaps because the hospital lacks the focus of a casualty department, there was a strong tradition of silo working, which translated at junior doctor level to individuals only covering for their own specialities, and not helping each other out at night. We tackled this by:

- Appointing the senior Clinical Site Practitioner (CSP) as the night team leader.
- Arranging for a formal hand-over to take place at 9pm each evening in the Doctors' Mess, chaired by the senior CSP.
- Giving the senior CSP authority to resource-manage the team. Within the system, the senior CSP takes responsibility for organising workload immediately after hand-over, so that although each doctor takes lead responsibility for particular specialities, they may be allocated to assist a colleague if a particular speciality is busy. The team meet to have a break and review workload at 12-1am.

Phase 6: Some interesting service and governance issues have emerged through the rota changes. For example:

- The poor quality of daily record keeping in hospital notes, which usually focuses on what has taken place in the day, but rarely outlines a clear management plan. We are now working hard to ensure that junior doctors do write management plans (which have almost always been discussed on the ward round) into the notes, so that the night team is able to respond appropriately.
- The need for guidelines and protocols to be web-based rather than hard copy kept in specific ward areas or on shared drives only available to specific teams. We are currently setting up a guideline resource on the intranet, which we will ultimately make available on the internet once it has been piloted internally.

Results to date

The above systems have only been in place for 2-3 months so it is too early to draw definitive conclusions. However, preliminary findings are as follows:

- At formal training review meetings 6 weeks into post, the SHOs are generally much happier with their new rota arrangements, and are benefiting from increased educational opportunities in the day.
- Despite initial resistance, most of the middle grade staff are also happy with the new system, although there were initial low-grade complaints about doing SHO-work at night. For the most part, they have now accepted that traditional demarcations of 'SHO-work', 'nurse-work', 'doctor-work' no longer exist at night, and there is only 'night-team' work.
- The junior doctors have all started to acquire much better hand-over skills, under the guidance of the CSPs.
- After initial surprise, rather than resistance, at being managed by a senior nurse, the doctors have responded well to the cultural changes driven by the new system.
- The Doctor's Mess has become more 'live' after a long period of inactivity, with the potential for better morale amongst the junior staff.
- The anticipated increase in consultant workload has thus far been much less than was feared.
- Some important governance issues, such as the standard of medical notes, are being addressed as a further spin-off benefit.

Hilary Cass

October 2002