News, education and advice for all clinical staff in the Mid Yorkshire Hospitals NHS Trust and the surrounding region.

www.midyorksmesh.co.uk
Insight

Using anatomical products, delegates perform basic laparoscopic training in the Education Centre at Pinderfields Hospital in Wakefield.
© Mid Yorkshire Hospitals NHS Trust.
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Editorial team</td>
<td>4</td>
</tr>
<tr>
<td>Information for authors</td>
<td>5</td>
</tr>
<tr>
<td>Trust message from the Director of Medical Education</td>
<td>6</td>
</tr>
<tr>
<td><em>Dr Andrew Jackson</em></td>
<td></td>
</tr>
<tr>
<td>Update on Undergraduate teaching at Mid Yorkshire</td>
<td>7</td>
</tr>
<tr>
<td><em>Dr Grace McKay</em></td>
<td></td>
</tr>
<tr>
<td>Update from the Professional Development &amp; Education Unit (PDEU)</td>
<td>10</td>
</tr>
<tr>
<td>Life of a Royal College Surgical Tutor</td>
<td>12</td>
</tr>
<tr>
<td><em>Dooldeniya M</em></td>
<td></td>
</tr>
<tr>
<td>Unstable C-spine injury with normal C-spine radiographs</td>
<td>14</td>
</tr>
<tr>
<td><em>Razaq MA, Broom T</em></td>
<td></td>
</tr>
<tr>
<td>Healthcare Ethics</td>
<td>19</td>
</tr>
<tr>
<td><em>Stanners A</em></td>
<td></td>
</tr>
<tr>
<td>Help - I’m being sued! Help - I’ve been summonsed to court! Help - I’ve been asked to write a report for the Coroner</td>
<td>23</td>
</tr>
<tr>
<td><em>O’Connell, M</em></td>
<td></td>
</tr>
<tr>
<td>Falls prevention training programme</td>
<td>28</td>
</tr>
<tr>
<td><em>Bramwell-Walsh C</em></td>
<td></td>
</tr>
<tr>
<td>Pontefract project: Collaborative Learning in Practice (CLiP)</td>
<td>30</td>
</tr>
<tr>
<td><em>Timbs F</em></td>
<td></td>
</tr>
<tr>
<td>MY Freshers Class of 2017</td>
<td>34</td>
</tr>
<tr>
<td><em>Pressley C</em></td>
<td></td>
</tr>
<tr>
<td>Supporting sign-off: mentor training in the Trust</td>
<td>38</td>
</tr>
<tr>
<td><em>Shackleton I</em></td>
<td></td>
</tr>
<tr>
<td>How to thrive at (as opposed to survive at) Pinderfields Hospital</td>
<td>40</td>
</tr>
<tr>
<td><em>McKay G</em></td>
<td></td>
</tr>
<tr>
<td>Book review: how to change things when change is hard</td>
<td>44</td>
</tr>
<tr>
<td><em>Tjio E</em></td>
<td></td>
</tr>
<tr>
<td>Pathology quiz</td>
<td>46</td>
</tr>
</tbody>
</table>
THE INSIGHT EDITORIAL TEAM

Editor - in - chief
Dr Andrew Jackson
Consultant Histopathologist and Director of Medical Education.
andrew.jackson@midyorks.nhs.uk

Editorial co-ordinator
Elaine Walters
Deputy Manager (Medical Education)
elaine.walters@midyorks.nhs.uk

Graphic design and content layout
Adam Smith
Development Co-ordinator (Medical Education)
adam.smith@midyorks.nhs.uk

Specialist advisor
Denise Matthews
Assistant Director of Medical Education
denise.matthews@midyorks.nhs.uk

Disclaimer: Any views or opinions that may be expressed in articles appearing in the Mid Yorks Medical Journal (MMJ) are those of the contributor(s) and are not to be construed as an expression of opinion on behalf of the Editorial Team of the MMJ.
INFORMATION FOR AUTHORS

Submitting a manuscript
The INSIGHT journal accepts manuscripts sent to myclinicaljournal@midyorks.nhs.uk

Submissions can include research articles, case reports, conference posters or reflections, experiences of job roles or working within a particular department or service, careers advice.

We also accept newsworthy items that contain information or updates relating to a hospital department or service or educational institution with links to the local healthcare provider.

If you are unsure whether your piece is suitable for the journal or if you have an idea you wish to discuss, please contact the editorial team at mymedicaljournal@midyorks.nhs.uk

Patient consent
Should a manuscript contain personal medical information about an individual which could lead to them being identifiable (in text or photographic form), then written and signed consent must be obtained from them. When submitting a piece to the journal, a copy of this consent must be sent along with your manuscript.

Images, such as x-rays, ultrasound, laparoscopic and pathologic images can be used without consent, so long as they are made anonymous by removing any identifying marks and text. Whereby a disease is rare or particularly remarkable that it could lead to the patient being identified in the listed image types, consent would be required.

Peer review
All manuscripts sent to the above email address will be acknowledged by a member of the editorial team. They will then be considered for publication where once approved, will be sent for peer review. Delays may be encountered if additional advice or clarification is required during this process.

Acknowledgements
These should be in a paragraph at the end of the text and before the references.

References
All references must be in the Vancouver style. References should be numbered in the order they appear in the text. These numbers should be inserted as superscript each time the paper is referred to e.g. Trials elsewhere support this view;\textsuperscript{4-6} or if the author is cited e.g. Hill\textsuperscript{3} found the results to show…

At the end of the article the full list of references should give the names and initials of all authors. If there are six or more authors, the first three authors should be listed followed by “et al”. This is followed by the title of the article, title of the journal, the publication year, volume number and first and last page numbers. Books should be followed by the place of publication, publisher and year. The author is responsible for the accuracy of the lists of references at the end of their article

Example of referencing an article:

Example of referencing a book:

Example of referencing a website:
Welcome to the Autumn edition of Insight – just as the autumn is really picking up a pace outside!

In this edition we have a multi-professional input covering many areas of clinical practice including audits of falls, insights into the life of a surgical college tutor, tips for new doctors and even a pathology quiz. Particularly useful is the article by Mike O’Connell, recently retired Head of Legal services, who describes in detail the process of attending the Coroner’s court and the best approach to this – this is something I am asked about fairly regularly by junior doctors and hopefully the article will allay some of their fears.

Keep sending in your articles, audits, book reviews and feel free to write in any responses to the articles you have read in this and previous editions. The journal is clinical rather than medical, is open to all staff at the Mid Yorkshire Hospitals NHS Trust, is on the internet, and, most importantly, it is yours!
Update on Undergraduate teaching at the Mid Yorkshire Hospitals

McKay, G\(^1\)

It’s the start of a new university year and the Leeds Undergraduates, fresh from their summer of sunshine and relaxation, are starting to grace the wards again. For anyone interested in getting involved with undergraduate tuition, the following provides an update of teaching opportunities and staff contacts at Mid Yorks.

Clinical Fellows
First and foremost, we are excited to introduce our 3 new clinical fellows in medical education: Dr Lewis Bates, Dr Grace McKay and Dr Rebecca Robertson. The fellows will be based in the medical education centre at Pinderfields and are responsible for the assisted running of the undergraduate teaching programme and organisation of educational events. If you are interested in undergraduate teaching or need assessments for your e-portfolio, the fellows are your first point of contact. There are numerous opportunities to get involved including:

1. Breakfast club teaching
2. Medical student Simulation days
3. IMASS (integrated medical & surgical simulation) post finals
4. Mock OSCE’s
5. FOSCE’s
6. Basic Life Support for Sixth-form school students

Please email midyorksstudents@gmail.com to express interest or for any further information.

Calling all allied healthcare professionals
We are looking for allied healthcare professionals who would be interested in teaching 4th and 5th year medical students at our breakfast club. The breakfast club sessions are held in the DDH and PGH education centres from 8–8.45am. We are looking for volunteers to speak for approximately 20 minutes about their speciality and their role in the MDT.

Please contact Grace McKay grace.mckay@midyorks.nhs.uk if you are interested and can help out on any of the following dates:
Wednesday 25th October
Tuesday 14th November
Thursday 23rd November
Tuesday 6th February

1) Dr Grace McKay, Clinical Fellow in Medical Education at Pinderfields Hospital, Wakefield.
Social Media
We are excited to announce that we have launched a new medical education Twitter account for students and clinicians. We shall be using the new account in order to better communicate updates for undergraduate education. Please follow us @midyorksmeded

A chance to teach school students
And finally, the undergraduate team are delivering an exciting new event for prospective healthcare students titled ‘An introduction to basic life support and healthcare careers for 6th form students’ This evening event will be taking place on 18th January 2018 in the Medical Education Centre, Pinderfields. We are currently looking for willing volunteers to teach at this event; regardless of your grade or profession, if you are BLS trained and interested then we want to hear from you.
For further information please get in contact with Grace McKay.

That’s everything for now,
Below are links to our website and social media pages for further information.

http://midyorksmesh.co.uk/undergraduates/pinderfields/
https://twitter.com/midyorksmeded
https://www.facebook.com/midyorksmesh/

Undergraduate Teaching Opportunities at Mid Yorkshire
Are you interested in teaching? Need teaching assessments in your e-portfolio?

- Breakfast club
- 4th & 5th year simulation days
- IMASS (Integrated Medical & Surgical Simulation) for post-finals
- Mock OSCEs

Contact the team to see how you can get involved:
	terasa.broom@midyorks.nhs.uk
	or fiona.coia@midyorks.nhs.uk
New online journals!

The NHS Staff Library has recently added over 400 new online journal titles to their collection.

Shown below are a small selection of the new titles.

Access these online journals (and lots of other useful online resources) with NHS Athens.

Register at: openathens.nice.org.uk
Mid Yorkshire School of Nursing
The University of Bradford and Mid Yorkshire Hospitals NHS Trust have joined together to deliver a satellite nursing school and degree programme at Dewsbury and District hospital. The school aims to recruit up to 100 nursing students by March 2018, widening degree course participation in the local area. Ruth Girdham, Head of nursing at the University of Bradford said:

“The University of Bradford, School of Nursing was thrilled to have been asked by the Mid Yorkshire Hospitals NHS Trust to work with them to support the development of their nursing work force. The School of Nursing has an excellent reputation and is excited about working with the trust on this new development”.

David Melia said “Having the School of Nursing in the hospital will enhance the students experience - it will bring their studies to life”.

Students
The work being done to increase student numbers. The CLiP Model of mentoring. Supporting students and mentors.

Freshers

Juniors
Support for Learning and Assessment in Practice. In-situ simulation training. Learning styles in practice. Link nurses and how we can develop the role.

Seniors
RCN Clinical Leadership Programme. Band 6 Skills in Practice Programme (SiPP). Band 6 competency frameworks.

Supporting Learning and Assessment in Practice
The Trust has supported 98 staff to enroll on the distance learning Mentorship course that started in May. Isla and Emily both Practice Learning Facilitators have been visiting placement areas to support staff on the SLAIP course. Further funded places are available for SLAIP at Huddersfield and Leeds Beckett in September so to contact the team to apply at plfteam@midyorks.nhs.uk

Shortlisted for the Nursing Times Student Nurses Awards - Placement of the Year: Community
Members of the adult community nursing team (based at Tieve Tara Medical Centre) did a fantastic job in presenting to the panel of judges why they should win community placement of the year award having been shortlisted. Sadly they didn’t win the Nursing Times student nurse award, but the team must be congratulated on being shortlisted. This clearly demonstrates the
Update from the Professional Development & Education Unit (PDEU) continued...

Importance the team place on valuing students and ensuring they are welcomed when they first arrive on placement, also how the team assess individual learning needs to ensure they are met. The result is students experience the highest quality placement, and at least 8 previous students actually commented on social media they started working in the community as a direct result of having a placement with this team. The PLF’s will now use this teams approach and share as best practice with other placement areas.

Falls Prevention In-Situ training
We have had a great start to the acute phase of the falls In-Situ training on gate 20. With help from our volunteer service we have been able to provide a more realistic/hands on style of training which has had great feedback from the staff on gate 20, who say they have found the training ‘valuable and an efficient way of learning’, with results from the falls training survey showing 90% of staff trained in this method increases their knowledge and ability to assess a high risk falls patient and deal with the fallen patient. For more information please contact our Falls Prevention practitioner Catherine.bramwell-walsh@midyorks.nhs.uk or Lead Clinical Educator Kelly.jackson@midyorks.nhs.uk

Mentor support
The PLF team has been busy supporting the development of Mentors within the trust to improve a greater knowledge base and facilitate the stepping up of mentors to become sign off mentors. 40 staff have been trained to work with the current 3rd year students, presently on clinical practice placements within the trust.

There will be further sessions provided for the 2nd year final placement Masters Students, delivered towards the end of the summer. The PLF team will contact the area’s where the students will be placed and arrange support and delivery of further sessions, too ensure the student has the best quality placement possible.

New Placements
Are you a specialist Nurse/Midwife or team? The PLF’s would love to hear from you about your experiences that support their knowledge and skill development. Please contact us at: PLFteam@midyorks.nhs.uk
For all of you that don’t know me, my name is Mohantha (Mo) Dooldeniya. I completed my Basic Surgical Training in London before I returned to Yorkshire for my Higher Surgical Training. I spent 2 years at Mid Yorks, before getting a Consultant post in Southend University Hospital. I returned to Mid York’s in 2013 as a Consultant Urological Surgeon specialising in Uro-Oncology and minimally invasive surgery.

I have always had a significant input into Surgical Training. I am a faculty member and director for Basic Surgical Skills, Care of the Critically Ill Surgical Patient, Basic Laparoscopic Skills to name but a few. This was in addition to all the bed side and formal lectures that I am invited to give. I have taken on the role of Educational/Clinical Supervisor when I was appointed at Mid Yorks.

I have been appointed Surgical Tutor at Mid Yorks from May 2017, Succeeding from Mr Fawole. I have spent the last few months understanding the role as it relates to Mid Yorks, and its trainees.

As a Surgical Tutor my role entails integrating the Royal College of Surgeons, School of Surgery and Trust needs and requirements. I will attend multiple committee meetings as part of this role, including the Surgical Training Committee meetings. Although these meetings are important to ensure that national requirements are disseminated at regional and Trust levels, I see my role more as guide to the training of the trainees within our Trust.

As part of this I’m keen to ensure that our trainees get the opportunity to attend the many regional core training courses, such as the ones that I am faculty for. Our own MESH has a lot of training facilities that I am more than happy to supervise core trainees on. Included in this I am keen to support trainees in ensuring that their portfolio remains up to date, and that they get the training opportunities available within this unit.

I was a trainee here and know the multitude of pathologies that come in through the door to this particular trust. I know that there is more exposure here in a week than you would see in several months in another Trust. It does mean you must work hard, but you can walk away knowing that you can take on anything that the next Trust throws at you.
Since my time as a trainee, support for trainees has moved forward in leaps and bounds. ISCP had been set up in my last year as a trainee. It has revolutionised our ability to support you through your training. It provides a tool to hang all the important training opportunities you will undertake. It guides you to areas that require further work. Allowing you to go to your yearly ARCP virtually knowing the outcome. I would emphasise the need to work on your ISCP account throughout the year to ensure that it's not done in a rush at the end. Your trainers are also busy so may not be able to keep to a shortened timeframe.

With the change in your contract, we have been given a tool to ensure a balance between service and training. The exception report is a means of highlighting training opportunities that have been taken away to accommodate service needs. It allows your educators, quantitative evidence to take forward to alter your work load to improve your training. Please utilise this tool. It saves us waiting till your end of year feedback to find out what we could have done better to improve your time with us.

Finally, to increase the availability of access to your trainers, we are currently moving towards a regular frequent meeting (weekly or fortnightly) with your educational supervisors. This will mean that we can be on hand to help guide you through your training in a timelier fashion. This will be a move away from waiting for your 6-month meeting to find where the gaps are in your training are, and facilitate changes to help bridge those gaps.

My parting sentence is to remind you, that I am here to help you the become the best possible Surgeon you can be, because in a few years time I will be asking you to look after me, (and I have set myself high standards for the care of my patients)!

I look forward to meeting you and your trainers on an individual basis.
Unstable C-spine injury with normal C-spine radiographs
Razaq, MA¹, Broom, T²,

Summary
There is some controversy surrounding the optimal mode of imaging in trauma patients with suspected cervical (C) spine injury. Various rules (most notably the Canadian C-spine rules and the NEXUS rules) have been designed to help reduce the need for imaging given the poor yield. Some authorities advocate CT for almost all cases whereas others advocate three view radiographs unless the patient is at high risk, in which case CT is the preferred choice. One meta-analysis showed sensitivity of 58% (39–76%) for plain radiographs and 98% for CT in identification of C-spine injuries following blunt trauma. This case report illustrates how very unstable C-spine injuries may not be apparent on plain radiographs and a degree of clinical suspicion may be required for further imaging.

Background
A potentially very unstable cervical (C) spine injury could have been missed on plain radiographs. The only reason for CT in this case was some evidence of neurological deficit. If there is clinical suspicion that a C-spine injury may be present it is important to progress to CT even if the initial plain radiographs look normal.

---

Figure 1: Lateral radiograph of cervical spine showing no obvious bony abnormality.
Case presentation
A 79-year-old man presented to the emergency department with severe neck pain and stiffness after a frontal impact in a road traffic collision at approximately 30 mph. Initial examination found evidence of soft tissue swelling and tenderness at the lower cervical spine. Adequate C-spine radiographs in three views (anteroposterior, lateral and peg view) showed no evidence of bony injury, soft tissue swelling or malalignment (figure 1). After having plain radiographs the patient developed bilateral parasthesiae in the extremities of both upper limbs. Therefore, the C-spine could not be cleared clinically.

Investigations
A CT scan of his C-spine revealed evidence of an unstable fracture at the C3/4 level. The CT showed an anterior superior fracture of the C4 vertebrae extending laterally through the anterior cortex of the transverse foramen, widening of the distance between C3 and C4 spinous processes, avulsion of the spinous process and abnormal alignment of the left C3/4 facet joint (figures 2 and 3). The patient was immobilised in an Aspen collar, transferred to the spinal injuries unit and had further imaging in the form of MRI. The MRI showed a shallow prevertebral haematoma extending from C1 to C5, impingement of the cord at C3/C4, a severe narrowing of both C4 neural exit foramina with likely nerve root impingement and narrowing of exit foramina at levels C6-T1 (figure 4). Management involved skull traction to disengage the facet dislocation at C3/4 and anterior discectomy and fusion at C3/4.

Outcome and follow-up
The patient had neurological defects postsurgery which made him initially dependent on a wheelchair. After rehabilitation, he progressed to the use of a Zimmer frame. He also required a urinary catheter for the first 6 months after the initial trauma.

Discussion
Analysis of 65 published studies shows the prevalence of C-spine injury following blunt trauma to be 2.8% overall and approximately 2% in less selective, prospective studies of consecutive patients. Less than 1% of patients will suffer a cord injury but for those that do it can be devastating to the individual and their family.

There is some controversy surrounding the optimal mode of imaging in trauma patients with suspected C-spine injury. Various rules (most notably the Canadian C-spine rules and the NEXUS rules) have been designed to help reduce the need for imaging given the poor yield. However, clinical suspicion of an injury still necessitates imaging. Some authorities advocate CT for almost all cases whereas others advocate 3 view radiographs unless the patient is at high risk in which case CT is the preferred choice. One meta-analysis showed sensitivity of 58% (39–76%) for plain radiographs and 98% for CT in identification of C-spine injuries following blunt trauma. The College of Emergency Medicine advises CT as the primary imaging modality in adults following blunt trauma if:

The Glasgow Coma Scale score is below 13 on initial assessment;
Figures 2 & 3: CT scan showing unstable C3/C4 fractures.
The patient is intubated; Plain radiographs are inadequate; There is suspicion of abnormality on plain films; The patient is being scanned for head injury or multiregion trauma. If high clinical suspicion of C-spine injury is present then CT may be used as the primary imaging modality.9

**Patient's perspective**
The patient was very happy with the management and is recovering well.

**Learning points**
Unstable cervical (C) spine injuries may not be visible on initial plain radiographs.
The presence of degenerative changes can make it extremely difficult to rule out C-spine injuries on plain radiographs. CT scans are significantly more sensitive than plain radiographs in identifying C-spine injuries. Use clinical judgement when deciding whether to progress to CT scan (even if plain radiographs are normal). Clinical signs may be subtle but the underlying injury may be potentially devastating.

**Footnotes**

**Contributors** TB is a supervising EM consultant at Pinderfields Hospital.

**Competing interests** None.

**Patient consent** Obtained.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**References**


Healthcare Ethics
Stanners, A

1) Dr Andrew Stanners, Consultant in Stroke Medicine at Pinderfields Hospital, Wakefield.

This is a personal overview, including brief descriptions of key concepts, pointers to resolving ethical dilemmas and some sources of further information. To start with, however, it’s worth saying a few words about “ethics” itself and why it is important, especially in healthcare.

Ethics, from the ancient Greek word for “character”, applies in any situation where a person has a choice about what to do and it’s not immediately clear which option is the best one. In healthcare, for example, options A and B may be different treatments for a patient, or perhaps option A is treating one person at the expense of treating another. It can be difficult to know what to do in these types of situation, but healthcare ethics can offer us a certain amount of guidance.

Ethical theory\(^1\) tells us that a healthcare professional faced with a difficult choice can adopt any of three approaches. In no particular order, first, she could follow some kind of generally applicable rule; second, she may do what will maximise the “utility”, or goodness in the world; and third, she could do what a “wise person” would do in the same situation. Unfortunately it’s not clear how helpful these approaches are in real life. Are there any generally applicable rules (apart from the obvious ones) especially in complex and unique looking cases? Next, how can we be sure that our choice really will maximise utility, and even if we are able to maximise overall utility, might we still cause harm? Last, who are these so-called “wise people”? So ethical theory offers some guidance, but this still leaves the healthcare professional with a lot of thinking to do.

Fortunately, Healthcare Ethics has been on the rise and there is now a lot more guidance on hand for the professional. The modern rise in Healthcare Ethics started after the Second World War, in response to Nazi medical atrocities. Initial breakthroughs in the regulation of medical research, which enshrine the importance of autonomy (“self-rule”) and consent, have now filtered into mainstream clinical practice. It’s difficult now to imagine a world without seeking proper permission - consent - for what we do to our patients/clients, but a paternalistic approach was the norm until the last half of the twentieth century. Respect for patient autonomy is at the heart of the Mental Capacity Act (MCA 2005). Why not take a look at the act itself for further background—it’s very clearly written\(^2\). So, respect for patients, for their right to make decisions about what happens in their lives, is at the heart of Healthcare Ethics.
Of course Healthcare Ethics isn’t just about respecting autonomy—think of unreasonable (but autonomous) requests for treatment, such as CPR for a person with an incurable illness who is near to death. In this type of case we should avoid harming people, for example by performing CPR when it will not be successful. Indeed the Tracey ruling\(^3\) says that medical professionals can’t be compelled to provide this treatment. Don’t forget, however, that if you are stuck in dealing with this type of case you should seek a second opinion\(^4\). A good way to bring out aspects of Healthcare Ethics that go further than respect for autonomy is to look at two different types of case.

Confidentiality cases are ones that may go further than respect for autonomy. First, however, we respect confidentiality because this is normally what patients (autonomously) want for themselves. And if we breach patient confidentiality without consent then we risk losing their trust with the potential result that they refrain from seeking help when they are unwell. There are well known situations, however, where it may be appropriate to breach confidentiality in the interest of avoiding harm to other people. Cases that spring to mind are patients who refuse to take advice about driving in a context of uncontrolled epilepsy, or people with HIV who are known to have put their partners at risk of contracting the virus. There are also difficult cases seen in the Emergency Department of injury that has resulted from firearms. There is more below about finding solutions to difficult cases.

Further types of case that go beyond respect for autonomy are ones where resources are scarce. Patients will normally (autonomously) want what is best for them, but this may put them in competition for resources with other patients who also want what’s best for themselves. These types of case are normally confronted away from the front-line, but front-line staff are rightly asked to consider use of resources. And I don’t need to remind staff about the pressures we are under to deliver safe care and meet various targets. So patients queueing in the Emergency Department may find themselves in competition with others who are not quite safe to be discharged from hospital. How should these two different sets of interests be balanced against one another?

Healthcare teams are usually adept at managing ethical dilemmas they face, but we may all get stuck from time to time, so it’s worth outlining one approach to case-solving from the UK Clinical Ethics Network\(^5\). First, it’s necessary to be clear about the relevant clinical facts, the key stakeholders and the timing of the decision. There may also be procedural rules to consider, such as involving an Independent Mental Capacity Advocate (IMCA). The available options and their morally significant features, e.g. potential consequences such harms and benefits etc., should be listed. What does the patient want? Is she/he competent? If she isn’t competent then what is in her best interests—for guidance here, refer to the MCA. Next, consider whether there is any other guidance or legal precedent\(^6,7,8,9,10\). Having set out these aspects of your case, a process of discussion or argument should follow.
So for each realistic option in your case, you and your team should identify the moral arguments in favour and against it. Are the arguments valid? If so, then choose your preferred option. Ask yourself if the option you have chosen shows respect for persons, for their autonomy. Ask, too, what the implications would be if your chosen option were to be a general rule, a precedent. Next you should identify the strongest counter-argument to your choice of option. Can you rebut this argument? What are your reasons? After settling on a final decision and enacting it, remember to review the decision and learn from it in the light of what actually happened.

Fortunately, help is at hand in very difficult cases! Mid Yorkshire Hospitals has a Healthcare Ethics Group with a broad healthcare and lay membership who can offer advice and guidance. The Group can be contacted via my email for the moment, but ICE requesting is currently being developed.

Last, a quick mention of some other aspects of Healthcare Ethics that have been missed-out in the above and opportunities for further training. MY has a set of core values\(^1\), and of course these—respect, caring\(^2\), high standards and improving—are ethical. We are also professionals, and as such, certain other values and concepts are important to how we function. These include being honest, “whistle-blowing”, conscientious objection and self-care to name four. There are many opportunities for further study of Healthcare Ethics including courses and meetings run by the UK Clinical Ethics Network and other bodies, a post-graduate Diploma/MA in Healthcare Ethics at the University of Leeds\(^3\) and reading journals\(^4\).

References

5. The “ETHOX” approach to ethical case-solving: http://www.ukcen.net/
10. http://adc.bmj.com/content/archdischild/100/Suppl_2/s1.full.pdf
11. https://www.midyorks.nhs.uk/vision-and-values-
12. The Mid Staffs Enquiry: http://www.midstaffspublicinquiry.com/home
14. http://jme.bmj.com/
The library service at Pinderfields provides, facilitates and supports:

- 24/7 access to PCs and a quiet study space
- Online catalogue via our website
- Inter-library lending
- Document supply (journal articles)
- Electronic books and journals
- Healthcare databases (including training)
- Current awareness services
- Literature services
- Critical appraisal (understanding research article)
- Clinical and non-clinical professional development
- Revalidation
- Research projects and finding evidence to enable decision making to inform best patient care.

www.midyorks.nhs.uk/library

Contact us
01924 543899
Ext. 53899
library.pgh@midyorks.nhs.uk

Find us in the Trust HQ and Education Centre

Staffed hours
Monday - Thursday
08:30 - 17:00
Friday
08:30 - 16:30

24/7 access is available
please ask a member of library staff for details.
Help - I’m being sued! Help - I’ve been summoned to court! Help - I’ve been asked to write a report for the Coroner
O’Connell, M¹,

As Mike O’Connell, Head of Legal Services approaches (slightly early) retirement, after 36 years in the NHS, 24 of which spent dealing with medico-legal matters, he tries to answer those questions you always wanted to ask, but were afraid to.

**Help – I’m being sued; what do I do?**
First of all, don’t panic. If it’s related to your work at the Trust, there’s help at hand. Most importantly, the claim is against the Trust, not the clinician, as the Trust employs the clinical staff and is responsible accordingly for any claims made by patients alleging failures in their care. The Legal Services team at Mid Yorkshire will deal with the claim and support you in any way they can. Relative to the thousands of patients we treat, the Trust receives relatively few claims for damages in relation to the clinical management of patients, but they can be very upsetting for clinicians to see, even if they are only peripherally involved in the care and treatment of that patient.

**Will I have to go to court?**
Not necessarily, as going to Trial in a clinical negligence claim is quite a rare event. Most cases are dropped, as the patient’s lawyers realise they do not have a valid or strong enough case; alternatively, the Trust appreciates that mistakes were made, protocols not followed, and so on, such that the patient is indeed owed compensation for the harm inadvertently caused, and an out of court settlement is achieved. However, there are occasions when the Trust believes it did everything right, and has the evidence to support it, but the patient’s lawyers also think they have a strong case, and going to court is the only option. In such a case, the key clinicians involved would be required to make a formal witness statement, setting out their involvement, and might be required to attend court, to attest to that statement, and be cross-examined on it by the patient’s barrister. If that was the case, the Trust’s Legal Services team would arrange to meet with the clinicians, together with the Trust’s solicitor, barrister, and independent expert witnesses, prior to the Trial, and all necessary support would be given.

**Am I covered?**
If you were acting in the course of your employment with the Trust, then the Trust is vicariously liable for your acts and omissions; this is sometimes called NHS indemnity. It doesn’t matter if you weren’t carrying out your usual job role, at your usual place of work, or during your

¹) Mike O’Connell, Former Head of Legal Services at Pinderfields Hospital, Wakefield.
usual hours of work, as long as you were acting in the course of your employment, you are still covered; consequently, any claim for damages relating to your care and treatment is against the Trust. In practice, such cover is provided under the Clinical Negligence Scheme for Trusts (CNST), administered by the NHS Litigation Authority (NHS LA), now called NHS Resolution.

If I'm covered by the Trust, why do I need to be in a union or defence organisation?
As described above, the Trust is responsible for dealing with clinical negligence claims brought by patients, or their relatives on their behalf, but there are rare occasions when a clinician does need their own personal representation or cover; for example, if a member of staff is referred to their regulatory body (GMC, NMC, HCPC) or in cases of disciplinary action by the Trust, they need someone to advise them in a personal capacity. Also, private practice is not covered by the Trust, and neither are so-called “Good Samaritan” acts, attending accident victims when not at work. Finally, if a clinician’s actions were considered to be of such a poor standard that it equated to a criminal act (not necessarily deliberate), and which involved action by the Crown Prosecution Service against that individual clinician, this would not, and could not, be covered by NHS indemnity or the Trust.¹ Fortunately, these occasions are rare and, hopefully, may never occur, but union/defence organisation membership is strongly recommended for such eventualities.²

What does a patient have to prove to make a successful claim?
Firstly, that the treatment fell below an accepted standard of competence; secondly, that he/she has suffered an injury; and, thirdly, that it is more likely than not that the injury would have been avoided, or less severe, with proper treatment.³

When a claim is made against the NHS, it will be alleged that clinicians have failed to work to a suitably professional standard and that, as a consequence, the patient has suffered injury and/or loss. This is known in legal circles as the Bolam/Bolitho test.³

What happens if I'm involved in a claim against the Trust?
Legal Services will deal with all correspondence related to the claim, but may well seek your comments on matters as they are raised; this could be at several points in the process which, unfortunately, can take some time. This may involve early views on the case at the outset (when the patient’s solicitors request copy medical records), when they serve a Letter of Claim (setting out in some detail their allegations/criticisms), when serving Particulars of Claim/Proceedings (the formal stage at which the claim enters the court process), when independent expert opinion is obtained on behalf of the Trust, or when a pre-Trial conference is arranged (with the Trust’s solicitor, barrister, clinical experts, and Legal Services).
Who decides whether a claim needs paying out, and who pays?

Ultimately, the decision about whether a claimant is owed compensation and, if so, how much, is made by NHS Resolution; this will be based on the views of independent clinical experts, advice from solicitors instructed on behalf of the Trust, information from the Trust’s Legal Services representative, and input from the clinicians involved. Actual payments, in respect of agreed damages to the patient/relative, or legal costs, are made by NHS Resolution; this is funded by annual payments made to it by NHS Trusts, based on their risk profile (acute, maternity, community, learning disability/mental health) and claims history.

Doesn’t saying sorry mean that you’re admitting liability?

No. Not only is it a moral and right thing to do - it is also a statutory, regulatory, and professional requirement. Everyone can say sorry, but you may need to be supported to do so. You may need the backing of more senior people and staff may need training, but it should not stop you from simply saying sorry. This is consistent with the Trust’s Duty of Candour/Being Open policy. Openness and honesty towards patients is supported and actively encouraged by many professional bodies including the MDU, MPS, GMC, and NMC.

I’ve been asked to go to court; what do I do?

Where do I go for advice?

Again, don’t panic! Firstly, what sort of court have you been asked to attend, and who has “asked” you? Family Law court? Court of Protection? Criminal court? Coroner’s court? Civil trial (claim against the Trust)?

If it’s one party in a case that has asked you, such as the solicitors of a patient, then you may not have to attend; it may be optional, in which case, talk to your line manager/Consultant first and, if in doubt, seek advice from the Trust’s Legal Services team. If it’s a safeguarding case, then talk to either the Safeguarding Children or Safeguarding Adults team. If it’s Her Majesty’s Coroner’s office (their summonses, or subpoenas, often bear the West Yorkshire Police logo, who act on behalf of HM Coroner), then you will be legally obliged to attend, and indeed a clinician can be found in contempt of court for failure to attend coroner’s court when required to do so. Legal Services will offer all necessary advice and support in relation to Coroner’s inquests and Claims for damages cases (civil trials).

A colleague, who is making an accident claim against the Trust, has asked me to give a statement to their solicitors; do I have to do this, and what should I be aware of?

No, you do not have to give such a statement, but you can, if you wish. There is a rule in litigation proceedings that says there is no property in a witness. This means that, in such a case, the Trust cannot prevent you from talking to your colleague’s solicitors and making such a statement; however, equally, and conversely, your colleague’s solicitors cannot force you to make such a statement; they could, ultimately, subpoena you to give evidence at court, but they
would probably be reluctant to do so, without knowing first what you would be likely to say. If you do make a statement, to either your colleague’s solicitors, or indeed to the Trust’s, you should be prepared for the eventuality that, if the case did go to court, you could be asked to give evidence on the basis of that statement. Also, bear in mind that in signing a formal witness statement, you would be asked to sign a Statement of Truth, confirming on oath that the information you have provided was the truth. If in doubt, talk to your line manager or consultant, or seek advice from Legal Services.

Help – I’ve been asked to write a report for the Coroner, and I’ve never done one before; where do I start?
Firstly, talk to whoever has asked you to do the report; this will usually be the Bereavement Office or, on occasion, Legal Services. Secondly, look at the guidance given on Legal Services’ page on the Intranet. Essentially, you need to set out who you are, what you are, where you work (all to give context, especially for HM Coroner); then, set out details of your earliest contact with the patient, ensuring you refer to the medical records, to get the facts correct. Then set out the story - in chronological order, and make sure you state dates and times accurately - do get the year right, and spell the patient’s name correctly! Say what your involvement was – what you did, what you heard, what you saw; include details of your subsequent contact with the patient, your interaction with them, and relevant others. Conclude with a ‘Statement of Truth’ – i.e. I believe that the contents of this witness statement are true. Then, read your statement through carefully, check it for accuracy and spelling, before sending it off.

What is an inquest, and is it like a Trial?
An inquest is a fact-finding public inquiry conducted by a Coroner, and its purpose is to determine who the deceased was, when and where they died, and how they came by their death, and to work out the details the Registrar of Deaths needs for registration purposes. It is not a trial, and the Inquest conclusion (formerly known as a Verdict) cannot be framed in such a way as to appear to determine matters of criminal liability, on the part of a named person, or civil liability, on the part of a named organisation. Inquests are held without a jury unless the deceased died under certain circumstances whilst in custody or detention, if related to an accident at work involving the Health & Safety Executive, or if the Coroner thinks that there is sufficient reason for doing so.

I’ve been asked to attend Coroner’s court; am I in trouble?
No. HM Coroner will call those staff to give evidence who he thinks can assist him in ascertaining the answers to the 4 questions above. When the inquest date is known, and the staff identified who have been asked to attend, Legal Services will offer helpful advice, usually meeting with staff before the inquest, to explain the process, what’s involved, where to go, what to wear, how to get to the court – all the important stuff! – and will accompany them on the day, to give support at what can be quite an anxious time.
The death was also investigated as a patient safety incident; will this be explored at the inquest?

Quite possibly; certainly, where there has been a full Root Cause Analysis investigation, HM Coroner is routinely provided with a copy, and he often calls the author/lead investigator of the report to give evidence at the inquest, for 2 purposes: firstly, to set out a chronology of events (if other clinicians have not already done this) and, secondly, and most importantly, to set out what actions the Trust has taken to prevent a similar occurrence and ensure lessons have been learned. HM Coroner has a legal power, and indeed has a duty, to write to the Trust (usually the Chief Executive) if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a ‘report under Regulation 28’ or a Report to Prevent Future Deaths. This power is used sparingly and aims to ensure that similar fatalities are avoided in the future. The Trust is under an obligation to respond within 56 days, although the Coroner may extend this time limit.

The Trust will be required to explain what action is being taken or proposed, or why no action is proposed. Coroners’ reports and responses are centrally collated to ensure national oversight, and that lessons learnt are disseminated more widely if appropriate. For further information, see Legal Services’ home page on The Mid Yorkshire Hospitals NHS Trust intranet.

Now, the small print. DISCLAIMER: Mike is not a solicitor (and has never claimed to be, though, like the rest of the Legal Services team, he is trained and qualified to do what he does); none of this advice is intended to be formal legal advice and should not be relied upon as such. If in doubt, seek advice!

References

The Mid Yorkshire Hospitals NHS Trust, has developed a new style of falls prevention training. The aim of the training is to reduce preventable falls and improve staff confidence in managing the fallen patient.

Catherine Bramwell-Walsh, Falls Prevention Practitioner from the quality and safety team and Lead Clinical Educator Kelly Jackson in the Professional Development and Education unit, joined forces to cultivate this programme, using in-situ simulation methods which have been adapted to deliver the high frequency, low dose training within the ward environment.

This style of teaching allows ward staff to be taken from the working environment to complete the bespoke training in an allocated clinical zone on the ward. The training consists of two short scenarios, one delivering assessment and care plan implementation, the second instructing staff on post falls management relating to the Trust’s falls policy.

A recent pilot conducted on one of the Trust’s medical wards allowed the team to fine tune the simulation learning outcomes as well as assisting in the formulation of a assessment criteria which has been designed to give staff specific, relevant and meaningful feedback for all members of the multidisciplinary team (MDT).

The type of training has been adapted to the ward environment; by working with the ward managers to tailor a series of scenarios which have been adapted from the lessons learnt from recent route cause analysis investigations. This ensures that training is relevant to the ward environment whilst ensuring that it is patient centred. Recreating these ‘real life’ scenarios in a ‘risk free’ environment, facilitates learning whilst increasing learning retention by up to 75% compared to traditional teaching methods where by only an average of 5-10% of information is retained.

To ensure the scenario is realistic we have enrolled the help of our volunteer service, who ‘act’ as the high risk falls patient. The volunteer is often the ideal candidate to play this role as they are generally over 65, have a healthcare background, and often have experienced acute healthcare services first hand.

For the second simulation scenario the volunteer is substituted for a manikin, where the focus is more on MDT working rather than individual assessment. This moves away from the didactic instruction that was previously performed in the
classroom, and instead encourages communication, team working, prioritisation and delegation skills. Throughout the simulation scenario the participants lead, this results in the participants feeling more empowered and aims to increase confidence in clinical decision making. Constructive feedback is also an essential part of this process and is given at the end of each simulation scenario to improve performance and facilitate personal development.

This type of training and education fits with a recent report published in this month by NHS Improvement which released evidence from successful and sustainable falls prevention programmes which suggested that five key factors were key to reducing falls in hospitals. The in-situ training programme links with three of these recommendations including targeted training which is specific and ensures staff are fully aware of falls risk factors, engaging frontline staff in the falls prevention programme in their own environment to encourage ‘buy-in’ and finally encouraging a culture change where falls and safety awareness is recognised as the responsibility of all.

So far feedback from staff members and volunteers participating in the pilot study has been extremely positive with 90% of staff members reporting they preferred the simulation environment training compared to the traditional classroom based fall prevention education package. Following the positive results received by the pilot the simulation training package will now be adapted and rolled out to other wards and specialist areas within the Mid Yorkshire Hospitals NHS Trust.
Fiona Timbs, Lead Practice Learning Facilitator at Pinderfields Hospital, Wakefield

Introduction

“The CLiP model for supporting non-medical students originates in Amsterdam and was brought to the UK by Senior Lecturer Charlene Lobo, from the University of East Anglia (UEA). It has been running for three years now in Norfolk and Great Yarmouth Hospitals. Their pilot was a huge success and the project has now extended to most of their practice placements. Lord Willis, and members of the Royal College of Nursing and the Nursing and Midwifery Council have all visited these hospitals to see the project for themselves, and have advocated this as best practice to increase capacity, aid retention of students and enhance mentor/student satisfaction.” (HEE 2016, cited in Case Study: Implementing Collaborative Learning in Practice - a new way of learning for Nursing Students).

This model is also running at Preston Hospital part of Lancashire Teaching Hospitals NHS Foundation Trust. MYHT Lead Practice Learning Facilitator visited earlier this year to find out more information about the progress they have made with CLiP. The feedback from mentors, students and ward sisters was hugely positive. Students reported being more confident in delivering handover within 5 weeks of their first placement, this was echoed by the ward sisters who added that students were also competent at handovers in this timeframe; additionally patients perceived increased staff members were looking after them and reported positively on this.

The current model of mentorship (figure 1) is unsustainable and unaffordable as it requires a 1:1 mentorship relationship between nurse and student.

Therefore with an ever decreasing nursing workforce and uncertainty about the impact of Brexit on nursing numbers means we have to think differently.

MYHT plan to implement CLiP at Pontefract Hospital on the Elective Orthopaedic Suite, hence the Pontefract Project, when 1st and 3rd years are on their placement blocks beginning in January.
Learning in practice is a vital component of student nurse training making up 50% of the students dedicated learning time. “It is through learning in practice that students develop many of the competencies, attitudes and values as well as the skills of person centred caring.” HEE 2014. The CLiP model demonstrated above relies on students ‘stepping up’ to deliver patient care while mentors ‘step back’ and support them through coaching style learning. Students can learn from any member of the health care team, (whilst still maintaining 40% access time to a mentor). All members of the team, including AHPs, will be encouraged to share their knowledge and skills by coaching students.

Essentially Students are allocated 1-3 patients commensurate with their level of learning. Second and third year students will be involved in supporting and facilitating learning for other more junior students.

This model relies on strong partnerships between NHS Trusts and Higher Education Institutions (HEIs) and a steering group has been set up including ward staff, Huddersfield University and Health Education England Yorkshire and the Humber colleagues. The CLiP project plan details key pieces of work that need to be completed prior to the commencement of CLiP on Elective Orthopaedic Surgery at Pontefract. This includes training the ward staff in coaching style questioning. Metrics will be developed and used before the project starts and repeated once the student placement block is complete to understand the success of the project and learning that can be used prior to rolling the CLiP model out to other ward areas.

In summary CLiP is coming to MYHT, this is a hugely exciting project so watch out for updates on progress.

If you would like any further information please contact Fiona Timbs, Lead Practice Learning Facilitator, 01924 546015 or email Fiona.timbs@midyorks.nhs.uk
BMJ Simulation & Technology Enhanced Learning is an online journal focused on the use of simulation and innovative technology as an educational method or intervention for professionals in all areas of health and social care education, workforce development and quality of care. This peer reviewed journal is jointly owned by BMJ and ASPIH and available internationally.

The journal contributes to research, innovation and knowledge translation for practitioners, teachers, students and leaders in all health and social care professions who wish to improve clinical outcomes, patient experience, and safety.

USE YOUR ATHENS ID TO ACCESS TODAY. PROVIDED IN PARTNERSHIP WITH YOUR INSTITUTION.
Resources for newly qualified Nurses
Available in print at your NHS Staff Library

Search the library catalogue:
www.midyorks.nhslibraries.com

Request a book:
www.midyorks.nhs.uk/request-a-book
Nursing workforce gaps are serious and growing. The Department of Health predicts that by 2026 the NHS could have 42,000 nursing vacancies

Global, national and local shortages are challenging healthcare organisations and solutions are critical to preventing escalating adverse health outcomes.

Realising an organisational context that succeeds in retaining nurses is one of the most effective strategies for dealing with nurse shortages.

Nationally 30% of graduate nurses leave employment in the first year and 57% by the end of the second year. 29% of Mid Yorkshire NHS Hospitals Trust (MYHT) 2016 graduate nurses have left or transferred positions within the first 8 months of employment, evidencing this is a live and ongoing concern for the organisation.

How the graduate nurse programme will improve retention discusses retention theory and the direct link between effort reward imbalance and intention to leave. The transition from student to graduate nurse is reportedly chaotic, painful and traumatic; contributing to feelings of isolation, vulnerability and uncertainty.

MYHT Support Lead Nurse (SSLN) identified 2016 graduate nurses followed a similar transitional journey through the four stages of competence and each of the six stages of transition.

4 Stages of Competence

Graduate nurses who sustained learning in the stretch zone progressed significantly better than those who felt overwhelmed and tipped into panic.

The Learning Zone Model

Surviving as a new nurse in the first few months of qualifying takes a lot of effort, becoming consciously competent takes great effort; and being challenged and sustaining learning in the stretch zone requires fortitude and resilience.
Six Stages of Graduate nurse Transition; gliding, surviving, beginning to understand, sheltering under the umbrella, knowing how, We’ve come a long way.

MYHT recognised if new nurses are putting lots of effort into becoming competent, confident new nurses they need to be equally rewarded to prevent them from wanting to leave. New nurses will not remain working at an organisation if their needs are not met. Empirical research at MYHT identified that new nurses wanted to work in supportive teams, receive regular feedback, have access to ongoing education and to feel valued at work.

Understanding these retention coordinates has allowed strategic recommendations for improvement plans to be implemented.

Recognising that graduate nurse programmes can have a positive impact on retention and turnover rates MYHT has implemented a Graduate Nurse Programme (GNP) to support new nurses transition into practice. The programme was designed around Health Education England 2015 preceptorship guidance and written to encompass the values of the organisation. MY Freshers Class of 2017 is a graduate nurse programme designed to facilitate professional socialisation and support new nurses to develop knowledge and skills in a safe supportive environment.

The graduate nurse programme starts when the new nurses are appointed to the organisation 4 months prior to qualifying. Final year student nurses express concerns with how they will adjust to their new role, manage increased accountability for patient care, handle the anxiety associated with the fear of making mistakes, and increase confidence interacting with health professionals.

New nurses at MYHT are called Freshers and are identified with a pin badge. The caveat of being a fresher nurse recognises them as potentially needing a higher level of support as they are inducted into their new role.

Upon appointment to the organisation final year students are invited to attend four workshops prior to qualifying intended to empower new nurses encouraging them to step up and take accountability on their journey towards autonomous practice.

Educating new nurses about transitional theory and teaching the tools to manage their transitional journey.

MY Freshers receive information about the transitional journey to prepare and offer
reassurance that they will be supported. Theory is then referred to when the SSLN meets the new nurses out in practice to coach them to progress through the stages of competence and stages of transition to sustain learning in the stretch zone\(^6,7,8\).

**Workshop 1** explains graduate nurse theory, empowering new nurses to become more emotionally intelligent to step up on their final placement, in preparation for when they qualify.

**Workshop 2** explores the issues that makes graduate nurse transition challenging and teaches tools to overcome these. MY Freshers start a quality improvement project encouraging inter-professional working and occupational health attended to discuss resilience and stress management.

**Workshop 3** considers accountability and delegation, team working and raising concerns as a newly qualified nurse.

**Workshop 4** prepares new nurses with the practical elements needed to start work such as uniforms and IT access. New nurses are shown around their wards and invited to meet the cohort of nurses that graduated in 2016.

Each workshop is followed up with a newsletter to reinforce learning and graduates are invited to join a social media platform offering peer support.

**Managing the theory – practice divide**
In the first weeks of starting at MYHT, MY Freshers new nurses attend nine education days taught by the Clinical Educators from the Professional Development and Education Team and prior to starting out on the wards graduates are assigned to a named mentor. Upon receipt of their registration MY Freshers receive a robust supernumerary period enabling new nurses get off to a flying start.

Graduate nurses receive ongoing preceptorship support for up to 11 months post qualifying. Fresher nurses are visited regularly out on the wards by the SSLN to ensure that they are receiving the support they need as they progress towards becoming junior nurses.

On completion of their band 5 nurse core competencies study booklet, at around 11 months post qualified MY Freshers graduate from their preceptorship and are promoted to junior nurse status.

**Mid Yorkshire NHS Hospitals Trust values**
Recognising that new staff must be rewarded for the efforts they invest working at the organisation engenders the values of MYHT. The graduate nurse programme is a mark of how the organisation prioritises and values investing in its future nursing workforce.

The Department of Health predicts NHS nurse staffing deficits will continue to increase. As an agile proactive employer MYHT is rising to the challenge at a local level to retaining its graduate nursing workforce, confident that new nurse’s transitional needs are being met.
References


Introduction

Within Nursing and midwifery the Sign off mentor (SOM) role is a requirement of the Nursing and Midwifery Council (NMC) ‘Standards for Supporting Learning and Assessment in Practice (SLAiP) (2008) the aim is to ensure that students achieve the required standard of proficiency that demonstrate they are safe and effective in their practice to allow them to gain entry on to the mentor register. This is a national web based system which records the details of mentors, including their annual update date and their triennial review date, both of these are mandatory requirements from the NMC to stay active on the register.

Whilst supervising and assessing students, mentors must work within the NMC 8 domains below to ensure proficiency to practice. These domains are:

- Demonstrate effective relationship building skills
- Facilitate learning
- Assessment and Accountability
- Evaluation of learning
- Creating an environment for learning
- Context of Practice
- Evidence based practice
- Leadership

Background

There are 742 nursing mentors in MYHT, of this figure about a third are sign off mentors across the Trust covering 3 areas Pontefract, Wakefield and Dewsbury in both acute hospital and community setting.

The Practice Learning Facilitator (PLF) team sit within Professional Development and Education Unit (PDEU). Their primary role is to support pre-registration non-medical students who are on a clinical practice placement within the Trust and the registered professionals who provide mentorship/supervision for them. The PLF team are required to plan and develop all senior staff in to mentor’s and those who are mentors in to SOM’s.

The PLF team review all current practice placement areas the Trust offers as clinical placements to ensure that we have an accurate picture of mentors and sign off mentors across all of the divisions.

Each area is described as a hub or spoke area, a hub is a placement area suitable for an eight to twelve week placement and a spoke lasting one to four weeks. The areas are rated using the Red, Amber Green (RAG) system, (red for high risk...
areas who had 0-1 sign off mentor, amber/orange for a non-urgent risk and green for no perceived risk). The criterion reviewed was for the skill mix of mentor and sign off mentor. Areas that were deemed to be at risk of not having a sufficient number of sign off mentors were targeted.

The SOM must meet set criteria which includes:

- Currency and capability in the field of practice the student is being assessed in
- Has a working knowledge of the students program and practice assessment requirements
- Has an in-depth understanding of their accountability to the NMC for their assessment decisions
- Sign off mentors are required to spend one hour of protected time with each final placement student to give feedback and facilitate learning (NMC, 2008)

The training is delivered in two hours block sessions across the acute and community settings in the Trust.

The training is facilitated by the PLF’s and is structured around the approved sign off mentor workbook. The group work through two scenarios. The PLF details issues that the SOM may encounter working with a student. This work is transcribed in to the work book using a reflective model (examples are provided in the work book). The final stage of the training includes working collaboratively with a student and SOM to participate in a live situation; this could be any of the interviews that are required to take place within the students practice placement time.

The competency form is completed and signed off by the trainee and the supervising sign off mentor who then return a copy to the PLF who then enters their qualification on to the local mentor register.

The Trust supported 38 staff to participate in this training during May and June 17.

Next Steps
There are 98 registered staff enrolled on the current supporting and assessing learners in practice (SLAiP) course, which is provided by the local universities and is accredited by the NMC. This course enables staff to develop their knowledge and skill in supporting individuals who are on a pre-registration course for nursing or midwifery. Next year the PLF team will look to support these staff develop further to attain SOM status.

References
Nursing and Midwifery Council (NMC), 2008. Supporting and Assessing Leaners in Practice. London: NMC.
How to thrive at (as opposed to survive at) Pinderfields Hospital

McKay, G¹

So, you are now a month into your Foundation training. You’ve read all the survival guides and the oxford handbooks and the online blogs on ‘how to survive being an FY1’, and yet you were still utterly unprepared for the perpetual deluge that is hospital medicine. The patients are more unwell, the paperwork is more onerous and there just doesn’t seem to be enough hours in the day to accommodate this ‘work-life balance’ that you were promised.

The following advice is an amalgam of pearls of wisdom from your immediate predecessors, right before they hung up their lanyards and departed from this mid yorkshire temple of fun.

This is not meant as a step by step ‘how to’ guide for requesting PEG tubes on ICE and neither is it a generic anecdotal lecture on remembering to eat, drink and use the bathroom during an on-call shift (obviously do these things). Instead consider this as a quick reference crash course in ‘how to thrive at (as opposed to survive at) Pinderfields Hospital’.

Why don’t I just send you a pigeon?
The fax machine was invented by Alexander Bain in 1843. It was a cantankerous and unreliable form of communication. Since the 1800’s a lot has changed, numerous ingenuitive and shiny new technologies rendered the noble fax machine obsolete. Despite this fact you will find yourself on a near daily basis using one of these beastly anachronisms to refer to the various specialities throughout Pinderfields hospital. If you don’t know how to work one ask someone who looks like they can’t work their smart phone- they usually know the ancient secrets of fax technology. Top tip for faxing; find the secretary’s phone number for the referral speciality, call said secretary before faxing and then again after faxing. These extra steps will confirm that your referral has actually been received and will ensure that you won’t be scratching your head on ward round and wondering why the surgeons STILL haven’t reviewed your patient.

Super nurses
Pinderfields is fortunate enough to boast a cadre of highly trained specialist nurses, available for almost every condition or ailment. This crack squad of nurses are the SAS of their specialties; highly trained veterans who are able to solve most of your problems without so much as breaking a sweat. Moreover they can write legibly (a skill almost unknown amongst specialty...
doctors), they follow up patients in clinic and the community and they will put you in contact with senior docs when appropriate. Some examples of specialist nurse services include palliative care, alcohol liaison, tissue viability, stroke, diabetes and chest pain. If they can’t immediately review your patient, they are always happy to give advice over the phone and they are ubiquitously friendly and approachable.

**Crash tour**
You’re in a new hospital and it’s a labyrinth. The lucky few of you who rotated through during medical school may be aware that, similar to Hogwarts, the building is always changing. For instance the ARCU (acute respiratory care unit) is no longer tagged onto the back on G45 but instead is now sat snuggly and anonymously on G27. No one knows why. If you’re going to hold a crash bleep it’s a good idea to familiarise yourself with the different wards in the hospital. Crash calls will occur literally anywhere (including the eye hospital #anecdote) and there is nothing more stressful than being pumped up with adrenaline, ready to bust out your new ALS training, and having no idea where it is you should be running to.

**Give a doctor a fish.**
So you are probably now just getting to grips with the door code for the ward toilet, writing a TTO and focussing on getting through the next ward round. You most likely haven’t even begun to consider the ways to ‘get more’ out of your FY1 year. This is my opportunity to inculcate my passion for medical education, and although I may be a smidge biased on the subject, I make no apologies for my enthusiasm towards the MESH (Medical Education & Simulation Hub) at Pinderfields. There are heaps of opportunities to get involved with teaching undergraduates at Mid Yorks. Whether you’re delivering a ‘breakfast club’ seminar, volunteering on our ‘Sim days’ or trying your hand at being a mock-OSCE examiner there are myriad ways to participate. Students really value relatable tutelage from junior clinicians.

In addition, the medical education centre offers practical skill courses such as chest drain insertion or orthopaedic skill workshops. These can be booked via the MESH website. Furthermore, the MESH hosts educational RCP videocast events, resuscitation training and houses the library. It really is the hub for all activity at Pinderfields. You can all expect to be badgered with emails from myself about teaching opportunities. For the ultra keen, I have email addresses for people in the MESH to contact.

**Not just service provision**
After a few months it’s possible you will be feeling resentful and rancorous towards your ‘clinical’ duties and it can start to feel like your role in the hospital is a glorified secretary/TTO generator. Remember that your FY1 is a training position and therefore it is imperative for training to sometimes occur. Whilst patient safety is a priority, as you start becoming more efficient at your job try to take opportunities to engage with
your specialties’ non-ward based activities. Most departments have weekly teaching sessions, MDTs, outpatient clinics and interventional procedures such as EBUS or lithotripsy. Try to work out a rota with your fellow juniors to extricate yourself from the ward and the TTO pile now and then.

**Tasting the specialities**

As an FY1 you are entitled to have ‘taster days’ whereby you sample the tempting delights of other specialities. These days can be an enlightening and informative opportunity to explore some unfamiliar areas of medicine and develop your own interests and career aspirations. However, **nobody** will organise these for you or even **remind** you that they exist. It’s in your own interest to invest time organising these.

**Supervisors**

If you happen to be allocated a clinical/educational supervisor that motivates, encourages and supports you, then you are set. Sometimes finding a mentor in medicine can be a more challenging endeavour. It’s worth considering how you like to work and what motivates or inspires you and then seeking a clinician who seems to fit in with that ethos. Leeds University offers an online mentoring service for clinicians and also a careers advice service if you are struggling for inspiration or guidance. **(Besides anything else, you will need two references when you emigrate to Oz, so try to keep your supervisors on side J)**

**Cannulation- in vein not in vain**

The majority of you will be Leeds graduates and will have therefore completed the MUST (medical student ultrasound training) course. Now is your opportunity to bridge the gap between that chunk of silicon jelly and a real life limb. If it’s 3 a.m. and you don’t think you will succeed in cannulating Mr Smith’s already abused forearm; instead of escalating up the ranks or handing over his crashing AKI to the day docs, locate a portable ultrasound. If you’re not feeling confident to perform ultrasound by yourself, no problem. I guarantee that senior clinicians will be willing to help you upskill. And Mr Smith will thank you for the patient centred consideration.

**Lunch over list**

The more organised amongst you may generate a prodigious list of patient ‘jobs’ at the beginning of the day and then spend the rest of the shift burdened with anxiety and then creeping despair if you haven’t coloured in all the ‘completed’ boxes. Firstly, this is a normal phenomenon; there is a superfluity of things to do during the working day and you could quite easily stay rooted until dawn attempting to complete them all. For your own self preservation, organise that list into a descending priority of tasks and then **TAKE YOUR BREAKS** regardless of whether there are outstanding non-urgent things to do. Your health is a priority so prioritise it.

**Pinderfields pals**

In the unlikely event that you get some breathing space during your shift (or you have misplaced your bleep); and if you are feeling eminently
generous, give your colleagues a call and offer to help them out.

**Closing the work gates**
You may find yourself outside the hospital participating in work related activities such as exam revision, audits or trying to scrape together a case presentation for tomorrow’s departmental teaching. Whilst this is an inevitability of a medical career, be wary of spending too much time out of work, doing work. Emails in particular are a blessing and a curse. Beware going home from work writing your eportfolio and an audit and subsequently answering an inbox full of emails. Try to build a wall between Pinderfields and your home life.

**Reflection (don’t you just love it)**
Sometimes you may feel like everything is going wrong, you've failed that 17th cannula (see point 8), your referral to orthopaedics bounced back, and you've lost your smart card on G44 (...or was it G43?). Everybody has shifts where they feel like they are sinking. A final top tip from one of the ex-FY1’s was to keep a note of all the times you do something right. Whether it's a thank you from a patient's relative for explaining something, or the registrar complimenting your DOPS, make a note of it. When the chips are down, look back at your positive reflections and remember that you're probably a good doctor after all!

So that was your whistle stop tour to triumphing Pinderfields. On a final note, this journal (the one you are eyeballing right now) is yours to sculpt and nurture as you please. If you have a reflective piece or a clinical audit or you just want to plug a really useful course you attended / app that you invented, then please get in contact and submit to myclinicaljournal@midyorks.nhs.uk

See you all on the wards!

List of useful contacts at the Medical Education and Simulation Hub (MESH)
grace.mckay@midyorks.nhs.uk Clinical Fellow in medical education
Rebecca.Robertson@midyorks.nhs.uk Clinical Fellow in medical education
Lewis.Bates1@midyorks.nhs.uk Clinical Fellow in medical education
andrew.jackson@midyorks.nhs.uk Director of medical education
Fiona.coia@midyorks.nhs.uk Senior Clinical Educator
Adam.smith@midyorks.nhs.uk Development co-ordinator
Today’s NHS is undoubtedly undergoing huge transformation. Budget cuts, shifting patterns in service provision, increasing demands – it is very overwhelming.

But if change is inevitable, how can we increase the likelihood of achieving desired outcomes?

Switch – How to Change when Change is Hard is written by 2 brothers Chip and Dan Heath, who illustrate their key points using several powerful anecdotes. They address change and making change work in a variety of scenarios, ranging from how a ‘5 minute room rescue’ could be the strategy to a cleaner house to multinational companies like BP reducing the number of dry holes drilled. It is clear that these principles can be extrapolated to the NHS, and indeed there are several examples in the book reflecting on improvements made in healthcare service delivery.

The premise is that effective change can only come about if 2 key players are involved and on the same page. These are termed the Rider and the Elephant. The Rider is the analytical, number crunching, rational side of an individual / organisation that is able to understand the benefits of change (just as most people recognise that singlehandedly eating a family sized bag of Doritos all at once is unhealthy), and the Elephant is the emotional, passionate side which is instinctive (pit of stomach Doritos craving). For change to happen, both the Rider and Elephant have to work together harmoniously. Without the Rider, there is no purpose, and without the Elephant, there is no motivation. Both the Rider and Elephant function mostly at the individual
level, and together they navigate the Path, which is the situational context where change is being implemented (i.e. organisational level).

The book opens with the ‘1% milk campaign’. It is a fine example of how public health can work. American health researchers were considering ways to persuade people to eat healthier. However, ‘eating a healthier diet’ is a vague concept at best. What should people eat more of? What should people not eat at all? Where to start? This already signals the beginning of willpower fatigue due to lack of clear direction.

Then they struck gold. Most Americans drink milk, and milk is the single largest source of saturated fat in a typical American diet. By simply making a switch from whole milk to 1% milk, the average diet would be within the recommended levels of saturated fat. How did they effect this change of milk drinking habits? Just by changing purchasing behaviour. They ran a 2 week campaign with a direct message – one saying that a glass of whole milk had the same amount of saturated fat as 5 strips of bacon (a shocking and visceral message). Then they monitored milk sales data within the intervention area. Before the campaign, the market share of low fat milk was 1.8%. After the campaign, it was 41%. 6 months later, it was still high at 35%. So instead of telling people to ‘make healthy choices at the supermarket’, they were told ‘drink 1% milk instead of whole milk’. What’s more, these were changes that were sustainable.

This illustrates a few important points. 1) The clarity of the message is important for change, and that 2) what appears to be resistance to change may in fact be a lack of clarity. In this particular scenario, the Rider would have been flummoxed with an ambiguous message, leading to analysis paralysis (Can I eat more and exercise more? What about good fats and bad fats?). Without clear direction from the Rider, the Elephant will rapidly lose interest and motivation. Cue project stalling.

The book then goes on to flesh out how to enlist all interested stakeholders in further detail:

1. **Direct the Rider**: Find the bright spots, script critical moves, point to the destination
2. **Motivate the Elephant**: Find the feeling, shrink the change, grow your people
3. **Shape the Path**: Tweak the environment, build habits, rally the herd

I enjoyed this book (I am glad to say, on a Rider and Elephant level!), and found it very readable and inspirational. I would strongly encourage anybody keen to have greater awareness about the psychology of motivation to read it. Although I cannot claim to have come up with any ground-breaking revolutionary ideas (yet), it is a useful toolkit to have when trying to effect change, big or small, be it as an individual or within an organisation. It also has made me look at change with more optimism and creativity. Importantly, it does not dispute that change is daunting, but it arms us with some handy strategies, and remind us that even small changes can produce remarkable results.
Pathology Quiz
Dr Andrew Jackson, MB BS FRCPath MIHM MFMLM AKC

A new feature of the INSIGHT journal is the Pathology quiz. There are no prizes, just a brief description and/or patient history together with an image of a tissue sample. Answers can be found at the bottom.

Slide 1
53 year old man, chronic, worsening cough. Recent haemoptysis. Enlarged nodes in mediastinum. Bronchial biopsy. What is this lesion? What could be some possible causes? What other tests might be useful?

Slide 2
Tissue around a vaginal ulcer. What description can be given to this type of tissue reaction.? Why is it so called? What is its cause?

Answers
Slide 2: Granulation tissue. The surface looks granular due to many small capillaries Chronic inflammation and ulceration. Learning point for both pictures: Granulomas and Granulation tissue are not the same thing (but can coincide) and have different causes.