

Check	Targeted check
Date	11 January 2013
Location Visited	Queens Medical Centre
Team Leader	Professor Jacky Hayden
Visitors	Professor Simon Carley Dr Jennie Lambert Ms Jill Crawford
GMC staff	Jennifer Barron, Quality Assurance Programme Manager Rachel Daniels, Education Quality Analyst
Observers	Simon Mallinson, East Midlands Workforce Deanery* Dr Bridget Langham, East Midlands Workforce Deanery* Dr Richard Wright, East Midlands Workforce Deanery* Alan Swain, Care Quality Commission Representative
Serious Concerns	None

Purpose of the check

We have undertaken a series of checks to emergency medicine departments across England and the Channel Islands to explore risks to training in this specialty, to identify and disseminate areas of good practice and to gain further insight into local and national challenges including difficulty in the recruitment and retention of

doctors specialising in emergency medicine, and a continued rise in attendances and the severity and complexity of patient conditions presenting, without provision of adequate resources for assessment and admission.**

These checks were prompted by an increasing number of concerns reported to the GMC about emergency medicine and particularly relating to very junior doctors in training working at night unsupervised. In April 2012 we completed an audit of emergency department rotas, which found 20 sites that did not clearly demonstrate on-site supervision from a senior doctor in the emergency department overnight. In particular our standards for the supervision of foundation Yr2 doctors were being breached.

Our recent London regional visit highlighted issues with supervision, handover due to shift patterns and support for doctors in training which varied depending on the emergency department. We took the audit information together with evidence from the national training survey, deanery and college scheduled reporting and data from external partners including the Care Quality Commission (CQC) to identify seven local education providers to check.

The check was undertaken in a half day and comprised five meetings: foundation and core doctors in training; higher specialty doctors in training; hospital senior management team; emergency medicine consultants; and the head of the emergency department.

Evidence

Queens Medical Centre (QMC) reported to the GMC through our audit of emergency department rotas, that there is consultant cover from 8am until 2am, 18 hours per day. The department is managed by higher specialty doctors in training the rest of the time. When we visited the site, doctors in training told us that until very recently the department was unsafe at night due to workload and staffing, however the LEP has now brought in extra middle grade locums to cover night shifts. The College of Emergency Medicine recommends having a minimum grade of an ST4 trainee on duty to supervise at night time.

Two doctors in training raised specific patient safety concerns through the national training survey about the emergency department of the Nottingham University Hospitals NHS Trust. These related to workload, larger volumes of patients than numbers of beds and a lack of clinical supervision, especially at night time. The national training survey results show the LEP has below outliers in clinical supervision, handover, study leave, workload, access to educational resources and overall satisfaction.

*Health Education England is referred to as East Midlands Workforce Deanery due to the time of the visit

**College of Emergency Medicine Statement

The East Midlands Workforce Deanery reported to us in October 2012 concerns regarding the distance between the emergency department and the ward which provides clinical monitoring for patients who are not able to be immediately discharged. Only middle grade doctors cover the ward and at night, only one middle grade covers both parts of the emergency department. This raised a patient safety issue, since both areas could not be covered simultaneously. Nottingham University Hospitals NHS Trust had the most number of incidents reported to the Patient Safety Agency's National Reporting and Learning System (NRLS) between October 2011 and March 2012. However, this level of reporting is expected from such a large trust. It must be noted that 69.2% of the incidents reported to the NRLS had no degree of harm to patients.

Summary

Queens Medical Centre is a major trauma centre, and is one of the biggest and busiest in Europe. The emergency department see on average 450 patients a day, 164,000 per year. The LEP has a dedicated children's emergency medicine unit.

Patients from across the East Midlands have 24 hour a day access seven days a week to specialist teams of clinicians in intensive care and neurology at QMC. Patients who need these specialist services will be transferred directly to QMC by ambulance or air ambulance. There are nine resuscitation bays within the emergency department.

The emergency department currently has 19 consultants, not all of whom are full time, 11 middle Grades (4 Vacant) and 26 doctors in training. The emergency department has the capacity and funding to increase consultants numbers to 27 including two to deliver local teaching.

Higher specialty doctors in training stated that due to workload, until very shortly before the check, they have felt unable to supervise foundation and core doctors in training as they spend most of their shifts within the resuscitation room and are sometimes unable to leave. Middle grade locum cover has recently been brought in overnight in response to trainee evaluation that the department was not safe.

Work intensity is making it difficult for doctors in training to make the most of learning opportunities and the LEP were not flexible with regard to local teaching and study leave.

The Report

Requirements

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| 1. | Handovers must be formalised within the department to ensure continuity of patient care. (Domain 1 TD 1.6) |
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2.	The LEP must communicate doctors in training' eligibility for study leave and the process to apply for it. (Domain 6 TD 6.23)
3.	The LEP must ensure all doctors in training are released for relevant timetabled teaching. (Domain 5 TD 5.4)
4.	The LEP must ensure that working patterns and intensity are appropriate for learning and add educational value. (Domain 6 TD 6.10)
5.	The emergency department must introduce a robust process of senior review prior to patients being discharged or directed to another ward by a core or foundation trainee. (Domain 1 TD 1.2, 1.6)

Findings

Patient safety

We found there was a focus on senior review of foundation and core doctors in training' patients when they are admitted but not discharged (with the some notable exceptions e.g. chest pain). This is potentially dangerous for patients; doctors in training are missing out on key learning opportunities and without senior review run the risk of becoming more confident without becoming more competent.

Induction

Doctors in training have a two day joint induction for both adult and paediatric emergency care. The induction consists of a department tour, lectures on specific conditions and a run through of how the administration works within the emergency department. Core and foundation doctors in training said in the past that the induction was not adequate for paediatric emergency medicine. The LEP has responded to this trainee evaluation and now uses simulation and paediatric mannequins during induction

Handover

Although handover does occur in the morning and evening on most days, effective handover does not occur when the department is busy and it is needed most.

We heard from higher specialty doctors in training that the morning handover in the resuscitation room only happens if the emergency department's workload is manageable and not when it is busy. At other times, patients are handed over on the electronic patient management system. A ward round is sometimes completed in the afternoon if consultants are not called into the resuscitation room. Higher specialty doctors in training also noted that there is no overlap in shifts, meaning if they want to hand over a patient fully they have to do this in their own time when their shifts have finished. This can result in large numbers of patients being handed over under time pressure.

This is potentially unsafe for patients and is a lost learning opportunity for doctors in training.

Feedback

Doctors in training reported that they only received formal feedback when there were problems with their performance and that positive feedback was rarely provided in a formal manner.

We heard from core and foundation doctors in training that work place based assessments (WPBAs) are offered to them; there is a consultant shift once a day for the completion of WPBAs. Core and foundation doctors in training are mainly rostered to work afternoon and evening shifts, which makes it harder for them to access protected WPBA time.

Rotas

Consultants and doctors in training we met felt that the shifts they work are not sustainable. They do not have a good work life balance and consultants feel as though they are fulfilling middle grade duties rather than the consultant role. Doctors in training felt they could not do their job to the best of their ability due to the intensity of the work and the four hour triage target.

Teaching and Learning Opportunities

We heard from core and F2s that they are unaware of their contractual allowance of study leave and it was unclear how study leave is calculated within their contracted hours.

Core and foundation doctors in training advised that they are so busy that they are rarely released for teaching. Some doctors in training we spoke to hadn't attended any teaching sessions since starting in the emergency department in December 2012, and others have taken leave in order to attend. They advised they can only be released on some twilight shifts and this is exceptional. F2 teaching happens on a Tuesday between 14:00-17:00. Doctors in training allocated to the day shift are always able to attend teaching.

Work intensity is preventing higher specialty doctors in training from making the most of learning opportunities. Higher specialty doctors in training advised that they do not get enough exposure to the minor injuries unit due to the lack of middle grade cover. Higher specialty doctors in training are required in majors in order to cover the resuscitation unit. In addition, work intensity has meant that higher specialty doctors in training have not had enough experience of managing the department.

All doctors in training advised that they get very good exposure to a complex case mix and have ample opportunity to develop their critical care

management skills, which they value. They have very good trauma exposure due to many specialties being available on site. Some doctors in training said that they have seen more trauma in two weeks than they have during two years in other posts.

Supervision

Higher specialty doctors in training stated that due to workload, until very shortly before the check, they had felt unable to adequately supervise core and foundation doctors in training at night as they spent most of their shifts within the resuscitation room and are sometimes unable to leave. An extra Middle grade locum cover has recently been brought in overnight in response to trainee evaluation that the department was not safe. Locums' level of experience and competence have been variable. If the locum on duty doesn't have emergency medicine experience, then the core and foundation doctors in training will continue to ask the middle grade in resuscitation for advice.

Trust Management

The sustainability and strategic direction for service and training in the emergency department is unclear. We also found that the leadership and coordination of the consultant workforce lacked a clear accountability structure with no clear decision making body to represent the views across all consultants and a lack of clear governance appropriate to the size of the department. Core and foundation doctors in training we spoke to said that they just turn up and work with whoever is on the rota, as there is no 'team' structure.

Meeting current challenges in emergency medicine

The LEP has a strategic development plan for the workforce, including the intention to expand consultant numbers and to develop advanced nurse practitioners. Consultant cover is available 24 hours a day, with on-site presence from 07:30 am - 2am. The department currently has an 11pm-8am locum consultant cover - this shift is funded by winter pressure money. The senior management team confirmed that this funding will continue beyond winter if the cover is required.

The Trust's workforce plan was written in October 2012 and, as recommended by the College of Emergency Medicine, the department needs 22.7 consultants to provide cover for 24 hours and one consultant to run research. The LEP has agreed to provide 27 consultants and has already started recruiting for these positions. Two consultants have already been recruited from other countries within Europe.

The head of the emergency department indicated that he would struggle to recruit so many consultants in the current workforce shortages, but that it was positive to have the funding already in place. 21 advanced nurse practitioners are also

required, six of which are already in place with the rest in training. The LEP hopes to have these staff in place by 2016.

Conclusion

Our findings support the findings of the 2012 national training survey in clinical supervision, handover, study leave, workload, access to educational resources and overall satisfaction. We have set requirements for the LEP to meet our standards in handover and study leave. There were also two patient safety comments in regards to a high workload and therefore lack of clinical supervision for junior doctors in training especially at night time and bed spaces in ratio to the number of patients seen. A requirement has been set in regards to study leave, workload which is high and supervision. The handover process still needs to be improved particularly when the department is busy. The key thing to note is that despite the challenges in the department many of the emergency medicine doctors in training reported overall satisfaction and the trust have been responsive to trainee feedback regarding patient safety and have made some positive changes to the way they work.

Monitoring

The Trust is responsible for quality control and will need to report on what action is being taken regarding the requirements listed above in the attached action plan. The action plan must be sent to quality@gmc-uk.org copying Health Education East Midlands by 30 September 2013.

Response to findings

Name of person responding on behalf of checked organisation

Mr Abdul Jabbar, Head of Service, Emergency Department, Nottingham University Hospital NHS Trust.

Requirements

This action plan is written in response to points raised at a visit by the GMC in January 2013. The purpose of this plan is to acknowledge the areas of further development and identify the actions the emergency department has and is putting in place to provide reassurance both within the NUH and to the GMC to support the department and to improve the quality of education and support to junior medical staff.

As a team in ED we welcome this feedback and the

opportunity it gives us to continually review our service and to support our ongoing service development.

The Emergency Department at the Nottingham University Hospital is one of the busiest in the country. It has recently become a Major Trauma Centre of the East Midlands. The department sees over 165,000 patients per annum with a good case mix of adult medical, surgical and paediatric presentations. This provides trainees with excellent opportunities by way of experience

LEPs at the Emergency Department Nottingham University Hospital NHS Trust are very keen to receive feedback from trainees. The department aims to be responsive to the feedback collected and has put various changes in place in order to help trainees gain maximal benefit from their time working within the emergency department.

There is a good availability of consultants, who are willing to teach on the shopfloor. The department now has 24 hours consultant presence on the shopfloor (02:00 – 08:00 am by a locum consultant). Trainees are encouraged to discuss any sick or complex case with a supervising consultant on the shop floor. The consultant body is keen to teach and to develop a successful training programme. The majority have received specific training in clinical and educational supervision. Currently the department has a Foundation Programme Directors as well as a Director of Higher Specialty Training for Emergency Medicine. These consultants are assisted by the CEM college tutor to deliver the training curriculum.

The Trust has strategically developed “ED Workforce Plan” including the intention to expand consultant number and successful programme to develop Advanced Nurse Practitioners. Lack of availability of middle grade doctors nationwide and rotation of junior doctors every 4 months threatens to affect the quality of care delivered within the emergency department. in

	<p>addition the high volume of patients presenting to emergency departments can affect teaching and training. Our department is keen to develop Advanced Nurse Practitioners role in order to augment our permanent workforce. The aim is our ANPs to work along-side our consultant body to provide consistent and high quality patient care for our patients. ANPs will also provide shop floor cover in order to allow our trainees to consistently attend their scheduled teaching and training.</p>
<p>Handovers must be formalised within the department to ensure continuity of patient care. (Domain 1 TD 1.6)</p>	<p>The department has implemented a new shift handover from 3 April 2013 which coincided with the rotation of new doctors. Clinical shifts were amended to provide a 30 minutes overlap in the morning for all grades of doctors. The handover is led by the morning registrar and supervised by the consultant in charge of the morning shift. It is based on the "ABC of handover" developed by Imperial College, London, adapted to suit the local set up. The handover is aimed at providing brief teaching episodes for the junior doctors, identifying sick patients in need of senior review, highlighting patients who require further investigations as well as those patients waiting for beds in need of review for potential discharge/ provision of further treatment and care. Handover now occurs consistently irrespective of pressures in the department</p>
<p>The LEP must communicate doctors in training' eligibility for study leave and the process to apply for it. (Domain 6 TD 6.23)</p>	<p>The department has developed and implemented a new document which is now distributed at induction. This clearly highlights to trainees their study leave entitlement and how to go about applying for study leave and funding. A list of courses provided by the School of Emergency Medicine and the Foundation Programme Director is also distributed for their information. The department will endeavour to release trainees to attend courses specified by the Deanery and relevant schools.</p> <p>The department endeavours to provide the rota to all trainees coming to work within the Emergency Department 4-6 weeks in advance of their start date. Unfortunately however, at times, this timescale cannot</p>

	<p>be accommodated. This may be due to delays in recruitment or delays in rotation information received from the Deanery.</p>
<p>The LEP must ensure all doctors in training are released for relevant timetabled teaching. (Domain 5 TD 5.4)</p>	<p>Nottingham University Hospital is committed to be the best teaching hospital by 2016. The Emergency Department, as stated above, is a very busy place and sees over 460 patients a day. Despite this, ED is keen to maximise its opportunities for teaching and training.</p> <p>Higher Specialty Trainees are released for 1 full day of monthly Regional Teaching organised by the Training Programme Director. They are not rostered for a night shift the night before or the day of the teaching. HST are involved in the departmental teaching of junior doctors, Advanced Practitioners and nurses.</p> <p>ACCS trainees are released to attend ½ a day of monthly teaching arranged by their Training Programme Director. They are not rostered for the day and are allowed to take the rest of the 4 hours to do self-directed learning (E-learning).</p> <p>Foundation and VTS trainees are similarly released to attend their teaching programme arranged by the relevant TPD's.</p> <p>The department now also provides weekly teaching sessions supervised/delivered by a consultant. These teaching sessions are run separately for adult and paediatric trainees (1 hour each).</p> <p>The above teaching programme is also supplemented by the heavy shop floor presence of our consultant body providing bedside teaching in conjunction with every patient discussion/ contact.</p> <p>New Induction Programme; Department has implemented new 3 days comprehensive induction programme at the start of ED rotation, which covers acute and emergent conditions on scenario and simulated patients along with corporate induction.</p> <p>Teaching and training time is recorded on roster and is departmental priority. Department is also investing resources to provide cover to support releasing juniors</p>

for training (backfilling shifts is now in place, Advance Nurse Practitioners are also rostered specifically at the time to cover junior doctors teaching time).

Future Developments.

ED website

Department has commissioned its new website, which would also provide further opportunities for web based learning. It would also provide opportunities for anonymous feedback and the development of Trainees forum.

The LEP must ensure that working patterns and intensity are appropriate for learning and add educational value. (Domain 6 TD 6.10)

There is a well-recognised tension between reconciling service provision and the training needs of the juniors. This is not unique to the QMC and affects all EDs nationally.

At QMC this has been managed by the following

- Service provision;
 - o Workforce Plan: a detailed 5 years ED workforce plan detailing the needs of department has been developed and submitted to the trust. The Department has already started to recruit against it.
 - o Proactive annual job planning with the senior consultant team balancing service provision, service development and education
 - o Dedicated Direct Clinical Care, teaching, supervision, shop-floor educator sessions
 - o Proactive 24/7 roster management with a secretarial support and with financial support from DMT at short notice for service gaps to fund locums.

- Training Needs of the Juniors:
 - o We have a flexible, senior and well established cohort of trainers who have to deal with specialty training needs (EM, VTS, GP, paed, Surgery, ACCS, and advance Nurse Practitioners), deanery's requirements and The Colleges training requirements.
 - o Set Training Days; we have established; 3 days induction each for adult and paed

trainees x four monthly. Foundation Trainings fortnightly teaching, ACCS monthly teaching on 4th Tuesday of the month, EM Higher Speciality training day 3rd Tuesday of the month, weekly VTS Training day every Wednesday and Departmental Weekly teaching (2 hours) alongside the training of Trainee and graduate Advance Nurse Practitioners.

- DREEAM: multidisciplinary approach to teaching and training of different calibre of staff.

- Overtime the feedback from Junior and Senior trainees and Advance Nurse Practitioners shows this balance has been met. This is as a result of implementation of our strategy

- The department has seen significant expansion in its consultant workforce in recent years. This does provide challenges not least with regards communication and strategic decision making; we have a well-structured and formally minuted consultant meeting in order to overcome this. Clear allocation of roles underpinned by standard operating procedures for lead roles within the department have been put in place with feedback to individual where required (relating for example to training and education) occurring within this forum.

In addition to this the development of DREEAM is providing an exciting opportunity to focus still further on the matters of education, research and training and will support a further developed governance structure focused specifically on this within the Emergency Department and acute medicine at a multidisciplinary level.

The emergency department must introduce a robust process of senior review prior to patients being discharged or directed to another ward by a

Trainees are encouraged to discuss the majority of cases with the consultant present on the shop floor before making a decision to admit or discharge. A method to record such discussions between consultants and juniors has been introduced on EDIS. This allows such activity to be audited. Discrimination is made in the recording between case discussions and actual

core or foundation
trainee. (Domain 1 TD
1.2, 1.6)

patient reviews. In line with CEM guidance juniors must discuss all chest pains with the consultant on the shop floor. In other cases, the need for discussion is left in the hands of the juniors. That said a low threshold for early discussion is consistently encouraged at all times.

The department has recently implemented a trial which runs from 0800-1800 hours necessitating senior reviews for all patients for whom admission is planned. This has been fuelled by a shortage of available beds as well as a requirement to comply with the Department of Health recommended conversion rate of approximately 23%. This has not however been at the exclusion of discussions relating to patients in whom the trainees are considering discharge and should in no way disadvantage this patient subset.

The growth in the number of consultants and senior shopfloor presence has supported the action above.