

Check	Targeted check
Date	22 January 2013
Location Visited	Royal Bournemouth General Hospital
Team Leader	Professor Jacky Hayden
Visitors	Professor Simon Carley Dr Jennie Lambert Ms Jill Crawford
GMC staff	Dr Mujtaba Husain, Clinical Fellow
Observers	Dr Mike Masding, Wessex Deanery*
Serious Concerns	Yes

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.**

*Health Education Wessex is referred to as Wessex Deanery due to the time of the visit

**College of Emergency Medicine Statement

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 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. Feedback was provided to the senior management on the day and by email within 48 hours.

Evidence

The Royal Bournemouth General Hospital (RBGH) reported to the GMC through our audit of emergency department rotas, that there is consultant cover 12 hours a day, 8am until 8pm. Middle grades supervise doctors in training between the hours of 8pm and 3am. The LEP highlighted a gap in supervision between the hours of 3am and 8am where the highest grade in the department may be a Foundation Year 2 doctor (F2). As a result of the audit the Wessex Deanery engaged with the LEP requesting that supervision arrangements be strengthened. At the time of the check this had not yet been resolved and we raised a serious concern as detailed below. The College of Emergency Medicine recommends having a minimum grade of an ST4 trainee on duty within the department to supervise at night time.

The national training survey 2012 reported that RBGH had above outliers for induction and local teaching with a below outlier in workload. An October 2012 report stated that the Wessex Deanery had concerns regarding out of hours supervision of F2 doctors in training. No patient safety comments were made about RBGH in the 2012 national training survey.

RBGH had 2,758 incidents reported to the Patient Safety Agency's National Reporting and Learning System (NRLS) between October 2011 and March 2012. However 62.2% of the incidents reported to the NRLS had no degree of harm to patients.

Summary of site

The RBGH emergency department is open 24 hours a day, 365 days per year and is consultant led. The department treats up to 70,000 patients per year from Bournemouth and the surrounding areas.

The LEP has no paediatrics, obstetrics and gynaecology or orthopaedics services on site; however Poole Hospital is less than eight miles away and offers these services. The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust will merge in 2013, it is anticipated that the emergency medicine service would be provided on a single site. Currently some rotas are shared across both sites. Education departments from each site have been discussing training and the senior management team thinks this merger will strengthen educational opportunities.

Levels of clinical supervision at night time are low and there is a gap in on-site supervision between 3am and 8am. All doctors in training we spoke to are happy with the training they receive and they feel they get good exposure to complex patient cases.

Concerns raised during the check

During night time and weekend working there is a lack of appropriate supervision for doctors in training. Between the hours of 3am and 8am there are three doctors in the emergency medicine department - all are either F2s, GPSTs or 'Trust SHOs' with no middle grade cover. Our understanding is that the 'Trust SHOs' have varying levels of experience from one year post foundation to two years post foundation and not necessarily all in emergency medicine. GPSTs may never have worked in emergency medicine previously and we heard that it is possible, other than in the early weeks in August, for all three doctors in training to be F2s. This, combined with a lack of paediatric and obstetrics and gynaecology services on site, constitutes a serious risk to patient safety. Junior doctors in training may have to deal with a very sick patient with no senior cover on site or available from those specialities. Although the LEP was intending to extend middle grade cover during the week, this would still leave gaps on weekend evenings which the LEP proposed to cover with locum middle grades, resulting in continued risk to patients and doctors in training.

While part of the hospital at night team, F2s were being asked to sign prescriptions for patients they had not examined and in clinical cases where they did not feel competent to make a judgement. This included paracetamol and fluids prescriptions for patients not seen, and in haematology, changes to antibiotic regimes where the F2s have had no haematology training and did not feel competent to make that judgement.

The LEP's Response

The trust have been very responsive to our concern and have implemented methods to remove the risk within 48 hours.

The LEP brought forward the middle grade 24/7 rota to start on the Friday 25 January 2013. In relation to the weekend gaps on the rota that we identified, they would have been previously covered by known locum doctors but arrangements were put in place to be covered by substantive contracted posts.

In relation to the concern around prescribing and the 'junior grade' input in to the hospital at night team, the LEP has since reviewed and risk assessed the situation, and the data shows on average there would be two to three calls per night. To rectify the issue the bleep was taken away from the training grades in the emergency department from the 25 January 2013.

The Report

Good practice

1.	Simulation training access for all doctors in training in paediatric emergency care is a good learning opportunity. (Domain 6 TD 6.11)
2.	All doctors in training have the opportunity to learn with and from other healthcare professionals including the liaison psychiatrist working within the emergency department. (Domain 6 TD 6.17)

Requirements

1.	The LEP must ensure that working patterns are appropriate for learning in accordance with the curriculum, add educational value and are appropriately supervised. (Domain 6 TD 6.10)
2.	The LEP must ensure that those supervising doctors in training are clearly identified, are competent to supervise and are accessible and approachable at all times. (Domain 1 TD 1.3)
3.	The LEP must ensure that rotas allow for core and foundation doctors in training to attend regular timetabled teaching. (Domain 5 TD5.4)

Findings

Patient Safety

At night there is a single consultant covering the emergency departments in both Bournemouth and Poole. The split site responsibilities may compromise the ability of consultants to respond to patient concerns in both emergency departments. This also means that doctors in training may be supervised at

weekends and evenings by consultants with whom they are unfamiliar, as they are based at a different site.

In some cases F2 were required to sign prescriptions and make judgements in cases where they did not feel competent and have not had relevant haematology training.

Induction

The LEP runs a two day induction which includes information about equality and diversity, paediatrics, fractures and hospital protocols. Doctors in training said that this prepared them well, however it would have been beneficial to have more time spent on paediatrics. The LEP is aware of this and trying to address it through the simulation training in paediatrics.

Handover

Morning handover is working well. The emergency department currently uses an electronic patient management system which assigns doctors to patients. This means that everybody can view the patient list and who is assigned to each patient. Each weekday morning there is a consultant handover and either a consultant or middle grade will hand over in the morning at the weekend. All clinicians within the emergency department attend these sessions. At other times throughout the day clinicians rely on individual patient handover and patient management systems. There is also review of patient notes in the morning if a patient has been discharged without review by a middle grade.

Rotas

Clinical shifts for core and foundation doctors in training in the emergency department were incompatible with effective training at the time of the check. The shifts were frequently of long duration and doctors in training expressed difficulty in taking adequate breaks and were exhausted as a result of runs of 12 hour shifts and one in four night shifts.

The high proportion of out of hour shifts combined with the current level of consultant out of hours cover and variability of experience and competence of middle grades, reduced the training and supervision opportunities for core and foundation doctors in the emergency department.

All doctors in training within the emergency department have an opportunity to access simulation training for paediatric emergency care.

Historically the LEP has relied on a crisis team for mental health patients, however the crisis team had a large area to cover and it was often a challenge to get the patients seen in a timely manner. The LEP has now appointed a liaison psychiatrist who works five days per week in the

emergency department. This role provides clinical support, and training to core and foundation doctors in training on treating emergency department patients with mental health concerns.

There is low attendance at formal foundation teaching due to the high proportion of out of hours work. Foundation doctors in training we spoke to said they had not been able to attend one teaching session since starting their post in emergency medicine in December. However higher specialty doctors in training had no problem in attending the teaching, which was encouraged by consultants.

Training is supported by a motivated group of consultants with a unified, mature and pragmatic vision. Consultants are dedicated to their roles as clinical and educational supervisors and are very supportive of doctors in training, which doctors in training of all grades acknowledged. Doctors in training we spoke to said that consultants are always willing to attend at night when on call, and are very supportive when asked for advice and they feel like they work in a good team.

Meeting current challenges in emergency medicine

The LEP is creative in its response to challenges with an increase in emergency attendances; it is trying to manage the admissions and transfer of patients safely and ensure timely discharge. The emergency department works well with colleagues in other specialties including the liaison psychiatrist and the local social care team. The LEP has created a general practice led ward to relieve the emergency department and this is working well.

Conclusion

Our findings support the good induction programme noted in the 2012 national training survey. However attendance at local teaching was reported to us as a problem for core and foundation doctors in training. We have set a requirement for the LEP to ensure that rotas allow doctors in training to attend local teaching. Workload was a below outlier for this LEP; all doctors in training we spoke to noted the high workload and intensity however this did not generally affect their educational experience.

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 Wessex by 30 September 2013.

Response to findings	Dr Tanzeem H Raza, Director of Medical Education
Good practice	It is encouraging to note that the Trust's investment in simulation have been acknowledged as 'good practice'. With the appointment of a simulation trainer, we are extending simulation training within ED as well as the rest of the hospital. The 'team' approach to this training has been particularly welcome. The Trust continues to work towards more multidisciplinary training and team building.
Requirements	Rota has been changed to improve the working pattern. Educational and clinical supervision has also improved with more consultant and middle grade presence. The doctors in training have direct access to seniors for advice. All consultants have completed training courses as education supervisors. ED runs its own time tabled teaching programme which cover major parts of Foundation Curriculum. It was agreed with the deanery that those F2 doctors in training who are based in ED will attend ED teaching sessions instead of the Trust teaching sessions. That ensures maximum attendance. They also attend teaching at Bournemouth University with other F2s within Dorset.