The Royal College of Emergency Medicine

Report of the Royal College of Emergency Medicine

Invited Services Review visit to:

Weston Area Health NHS Trust

Friday 11th December, 2015

Authors:

1. [redacted]
2. [redacted]
3. [redacted]

Initial draft Jan 10th. Final version Feb 22nd, 2016

Contents

1. Summary

This report is from the invited service review visit undertaken on 11th December 2015. The findings from the visit can be found below, together with a set of recommendations.

The Emergency Department (ED) at Weston Hospital is facing a number of significant challenges, within a complex organisational picture both locally and regionally. The challenges are not new, although they may have become more difficult.

The visiting team have identified significant concerns regarding the capability of the Trust and its ED to deliver safe and effective emergency care. There are also concerns over education and training, particularly for trainee doctors. The department is unsafe at times. The periods of highest risk are evening, overnight, and at weekends. The root causes lie in a combination of:

- Organisational leadership and culture
- Leadership, management, and culture within the ED
- Medical staffing within the ED and the wider Trust, during evenings, nights and weekends
- Operational pressure, and ED crowding
- Progressive degradation of ED role and function within the local healthcare landscape, combined with a failure to develop and respond to the changing environment

The ED needs to start rebuilding from the ground up. This will start with determined and responsive leadership at both Trust and departmental level. It will require recognition of the significant challenges faced, and attention to medical and nurse staffing, basic processes, safety and governance, and education and training. Trust culture needs to be re-examined to ensure that patient care and safety is being placed ahead of headline performance statistics.

The visit team have recommended consideration be given to reducing the ED's opening hours in the short to medium term, in order to consolidate currently available resource. We have also recommended changes to how the most junior doctors are supervised and trained.

The College is grateful to all staff at the Trust for taking the time to speak with the visit team and for their constructive and open co-operation.

2. Visiting Panel

2.1 On 11th December 2015 the Royal College of Emergency Medicine conducted an invited service review at Weston General Hospital to review emergency care services. The visiting panel comprised of:

- [redacted] – Service Review Lead, Chair of Service Design and Delivery Committee, Royal College of Emergency Medicine
- [redacted] – South West Regional Board Vice Chair, Royal College of Emergency Medicine
- [redacted] – Training Programme Director, School of EM, Severn Deanery, Royal College of Emergency Medicine

3. Terms of reference and visit objectives

3.1 The visit was conducted against the following terms of reference agreed mutually by Weston Area Health NHS Trust and the Royal College of Emergency Medicine in advance of the visit:

1. To review current practice in the Trust's ED, particularly in relation to clinical leadership to ensure the ED is a safe environment for patient care 24/7.

2. To review the ED as an appropriate training environment both now and in light of the new GMC Guidelines for Training, Promoting Excellence: Standards for Medical Education & Training which come into effect in Jan 2016.

3. To review operational performance in ED in terms of efficient and effective working of the systems and processes that are in place. Ensuring the performance culture is balanced against the safety and training requirements.

4. To identify best practice from 'outstanding' rated ED departments to help Weston's ED identify what is required to move forward from current 'requires improvement' rating.

5. To identify both recommendations for improvement and how to action and address these issues (e.g. sources of potential support).

4. Background to the visit

4.1 In July 2009 the College of Emergency Medicine was invited to visit Weston General in order to provide informal specialist advice regarding the Emergency Department (ED). Following the visit, the College provided a report outlining observations and recommendations.

4.2 In May 2013 [redacted], a consultant in the ED, contacted the College to inquire about a further service review regarding workforce issues in the Emergency Department at Weston General. Details of CEM service reviews were provided to [redacted], Clinical Director of the Emergency Care Directorate, at Weston Area Health NHS Trust.

4.3 In January 2014 the consultants in the ED jointly wrote to the then Chief Executive of Weston Area Health NHS Trust [redacted] and to CEM, to make a further request for a visit by the College to provide advice regarding workforce and safety issues.

4.4 A further service review was undertaken by CEM in September 2014, and a series of recommendations was made.

4.5 During 2015 Weston Area Health Trust was visited twice by the CQC (reports in the public domain), and also became part of the Emergency Care Improvement Program. The CQC rated Urgent and Emergency Services as Requiring Improvement, (inadequate for safety). Of note Medical Care was rated as Inadequate overall.

4.6 Additionally, serious concerns were raised by trainee doctors within the 2015 GMC National Trainee Survey, triggering a visit by Health Education South West. Concerns were focused on the Emergency Department and related specialities.

4.7 [redacted], the recently appointed CEO, wrote to the Royal College of Emergency Medicine in October 2015 requesting a repeat ISR.

4.8 The Trust is currently seeking ways to improve its long-term sustainability following withdrawal of neighbouring Trusts from negotiations around a potential merger. At the time of this visit the Trust was appointing a new Medical Director, along with an interim Director of Nursing.

5. Visit findings

5.1 Configuration of emergency care services

5.1.1 There are approximately 54,000 new ED attendances per annum.

5.1.2 The ED operates a 24/7 service. The ED is not a trauma unit and protocols are in place for trauma to be diverted to Bristol. Patients suffering trauma do still arrive despite these. There is a limited paediatric presence on site, during the weekdays only, until 1900. Protocols are in place for paediatric cases to be transferred / diverted to the Bristol Children's Hospital or Taunton outside of these times. Peri-arrest cases might still be brought to Weston, and sick children may arrive by routes other than ambulance. Children and young people still attend the department with illness and injury when the Seashore paediatric unit is shut. There is an ambulatory care service. There is a weekday daytime stroke service, otherwise potential stroke patients are taken to Bristol. There is no dedicated Clinical Decision Unit, beds being shared with the Surgical Assessment Unit. The ED is split into the following areas: 4-bed resus, 8-bed majors, 8-bay minors, (including 1 dedicated paediatric bay), and 2 triage / assessment cubicles. There is no co-located primary care service, this having been decommissioned.

Comment:

1) The design of the department is suboptimal, reflecting a rebuild within space constraints. Two majors cubicles have poor visibility from the main nurses station, and the paediatric cubicle in minors is relatively isolated from the rest of minors, again with poor visibility. The resus room would not meet modern design standards due to cubicle size, lack of radiation protection between adjacent cubicles, and lack of privacy. Majors and minors are separated. The main waiting room is across a corridor from minors, and reception is isolated. Command and control of the department is therefore challenging. Patients queueing on ambulance trolleys are in a public corridor. There is no dedicated CDU.
2) Facilities and provision for paediatric patients within the ED are deficient. The designated Paediatric waiting area is a small closed room in the corner of the general waiting room with no external light. This was closed off when we visited despite there being children in the general waiting room. The cubicle designated as a 'paediatric cubicle' is an isolated space off minors, and was only identifiable as such by the presence of a few toys and weighing scales. There was no provision for specific paediatric clinical care or other environmental enhancement.

5.1.3 Senior overnight cover in the Trust consists of one medical middle grade doctor, and the ED middle grade. There is an orthopaedic registrar on call and

available within 30 minutes. There is no ITU/ anaesthetics, surgical, paediatric or gynaecology registrar, with consultants on call from home. Senior weekend daytime cover is similarly weak.

Comment: Trust overnight cover does not provide adequate support for an ED which is not fully capable to meet the demands which are, or may be, placed on it.

5.1.4 The ED computer system is Cerner Millennium. This provides basic tracking and administrative functions only, via a relatively clunky interface.

5.1.5 The Trust operates a policy where all attendances for urgent and emergency care go through the ED, including GP referrals.

5.1.6 The ED is part of the Medical division at the Trust. A new Clinical Director of this division is about to be appointed

5.2 Workforce

5.2.1 There are currently 3 substantive Emergency Medicine Consultants employed on 11-12 PA contracts (9-10 DCC / 2 SPA). There are 3 long-term locum consultants, all of whose contracts will expire in autumn 2016. None of the locum consultants are on the emergency medicine specialist register, and one has limitations on his working patterns. The middle-grade tier has 5.2 substantive middle-grades, against a funded establishment of 8 WTE. There is heavy reliance on locums, and additionally the Trust uses what are referred to within the department as "FY3" doctors (post-FY2 doctors), on the middle grade rota. The latter are not deployed as middle grades at night. There are 8 training posts for RCEM tier 2 doctors (FY2 and GP VTS), all of which are filled. There are c9.5 ENPs whose scope of practice is largely minor injuries. The ENP establishment has recently been increased to enable overnight cover.

Comment: RCEM workforce guidance would suggest ten WTE consultants are required. For Weston an absolute minimum would be six, although this will lack resilience, provide relatively light and truncated cover, especially at weekends, and would be unsustainable in the long term. Twelve middle grades are required to deliver a sustainable 24/7 rota. A 24/7 rota can be run on a bare minimum of eight, but is not sustainable in the long term. The use of doctors with insufficient experience or training, such as post-foundation doctors, to substitute as Middle Grades, (even in a supported day-time role), is not recommended. Senior medical staffing, at both consultant and middle grade level, is therefore a significant concern. Further detail can be sought from the RCEM workforce guidance: http://www.rcem.ac.uk/Shop-Floor/Service Design & Delivery/The Emergency Medicine Workforce/Medical and Practitioner Workforce Guidance.

5.2.2 Consultants currently cover until 2300 during the week, and 1800 at weekends. Overnight and late weekend cover is from the Middle Grade tier. Locum CVs are currently screened by the Medical Director, aiming for experience equivalent to CT4 and above.

Comment: ED out of hours, weekend, and overnight senior cover is weak and heavily reliant on locums.

5.2.3 Nursing establishment provides for 7 trained + 3 untrained daytime, 1 trained late, 1 trained twilight, and 5 trained + 1 untrained overnight. Senior nursing staff feel the establishment is about right unless the department is crowded. There is one band 8 matron and one band 7 senior nurse. There are 2.6 WTE paediatric nurses, not enough to have one on duty per shift.

Comment: There is no DH or NHS England guidance available for nursing requirements in the ED. However the RCEM reviewers, on the basis of layout and demand, would suggest Weston General ED requires 9- 10 trained nurses on duty to run effectively, (1 coordinator, 2+ in resus, 2 in majors, 2 in minors, 1-2 in triage, 1 float), with additional nurses required if the departmental caseload is high. The current mismatch between staffing levels and caseload is most acute during late evenings and early hours of the morning.

5.3 Leadership and management

5.3.1 There is an absence of effective clinical leadership in the ED. This applies to strategic leadership, departmental organisation around the key domains of quality (including performance, basic governance, and safety), training and education, and running the shop floor.

5.3.2 There is currently no designated clinical lead for the ED, the latest incumbent having resigned. The ED consultant body are not providing collegiate leadership to fill the void. The consultant team do not regularly meet.

5.3.3 There is a strong sense that Executive and Divisional management styles and decision-making have contributed to the leadership issues. There are some suggestions of a culture of directive or coercive styles being favoured over more collaborative options. There is neither effective communication, nor effective working relationships, between ED, divisional management, and executives. Appointments of an "external" ED consultant as the clinical lead, followed by the appointment of a non emergency medicine accredited ED consultant to the post, were counter-productive.

5.3.4 Crowding, and lack of perceived progress around crowding, have also contributed to the problem.

5.3.5 Within the ED consultant team there is considerable interpersonal and professional dysfunction. The consultant team also feel disempowered, and there is lack of drive to resolve these issues.

5.3.6 There is a disconnect between the Consultant and Middle Grade tier.

5.3.7 There has been a breakdown in relationships between consultants and senior nursing leaders in the ED.

5.3.8 Concerns regarding the capability of individual staff members are further detailed in a separate letter to the Trust management team.

5.4 ED and Trust processes

5.4.1 The visit had a wide remit and we can therefore only pick out key themes.

5.4.2 The ED is suffering from chronic crowding.

5.4.3 There were suggestions from some staff of lack of wide ownership of the problems of system flow, and of unreasonable pressure on ED staff to avoid breaches at the expense of patient safety.

5.4.4 Escalation is described as being ineffective.

5.4.5 Internal Professional Standards such as direct admitting rights need to be owned and supported by the Trust. All parties agreed that following previous reviews a process for ED consultants to have direct admitting rights to inpatient wards does exist in principal at WGH. However, in practice this does not happen and the reasons for this are viewed differently by all parties. At present there is a sense that the ED consultants lack both the confidence and empowerment to drive them, whilst inpatient teams can be obstructive when efforts are made to implement them. The latter view was supported by nursing staff who noted "consultants can have an absolute struggle to get patients admitted."

5.4.6 The system of using the ED for all emergency admissions, and urgent medical admissions from GPs in particular, is contributing to crowding and pressure on ED nursing and medical staff. ED staff report slow response times from inpatient teams to review their patients. ED nursing staff state that they are expected to undertake all the admission paperwork and investigations for such patients.

5.4.7 The lack of a consistent paediatric service is a significant concern. During the daytime the Seashore unit is open, and children presenting to ED with problems usually falling within the remit of paediatric medicine can be sent there for assessment. This unit stops accepting referrals at 1700, although ambulances may still

bring children to ED until 1900. There is no designated paediatric service during the weekends.

5.4.8 There is a lack of effective command and control of the ED shop floor by ED consultants.

5.4.9 There is a focus on triage following the recent CQC visit. This has been prioritised above other early interventions in the patient pathway.

5.4.10 There are no rapid assessment systems in place in minors or majors. Staff describe a lack of buy-in to the general principles around rapid assessment systems.

5.4.11 The ENP tier is a potential strength, but is currently under utilised. The ENPs are currently working to a traditional model, concentrating on minor injuries post-triage, and undertaking their own treatments.

5.4.12 Mental Health Liaison is effective 0800-2000 during the week but the service degrades considerably when the crisis team take over at night and at weekends. Another cause of long waits in the ED.

5.4.13 The ED staff cite changes in the configuration of a dedicated Trust team seeking to reduce admissions, as having been detrimental.

5.4.14 The lack of an effectively functioning CDU is a significant problem. The CDU which was previously under ED management and direction has been re-designated as a 'mixed CDU/SAU' and there is no longer any ED nursing input to the area. In theory a maximum of 6 beds may be used by ED however, in practice staff consistently report that only 2-3 beds per day may be available for use by ED. Patients are remaining in the ED for unacceptable length of time waiting for CDU beds. Data provided by the Trust shows patients staying in the ED for 18 – 28 hours each month. Some of these are patients waiting for a CDU bed. Lengths of stay of this nature are unacceptable. Staff questioned whether or not these patients were being reported as 12-hour breaches.

5.5 Safety & Governance

There are significant concerns regarding actual safety, risks to patient safety, and around systems designed to reduce this, at Weston. The department is unsafe at times. The risks are highest in the evenings, overnight, and at weekends.

5.5.1 Crowding & Patient Flow

5.5.1.1 Crowding represents a significant risk to patient safety. It is associated with increased morbidity and mortality in patients, and with harm to staff.

5.5.1.2 Crowding is a daily issue in WGH ED with attendant impact on patient safety and the erosion of staff morale.

5.5.1.3 As noted above a number of current processes, or absence of processes, exacerbate this issue and there are presently no contingencies in place to mitigate against this. It was apparent from interviews with all ED staff groups that they feel that they have repeatedly raised these issues but with limited impact. They feel "isolated" as a department.

5.5.2 Medical workforce skill mix

5.5.2.1 As noted above medical and nursing staffing levels within ED are inadequate. These deficiencies contribute to the clinical risk within the department and also to the pressures upon existing staff.

5.5.2.2 Junior medical staff reported being expected to work unsupported and in excess of their level of competence.

5.5.2.3 The risks associated with both staffing numbers and capability are particularly high during the weekends and overnight periods, when general staffing levels within the whole Trust are also weak, limiting the level of support available to the ED.

5.5.2.4 Concerns regarding the capability of individual staff members are further detailed in a separate letter to the Trust management team.

5.5.2.5 Although there was widely expressed satisfaction and confidence in the majority of the permanent Middle Grades, there was doubt as to how many of them possess the requirements to be appointed at ST4 level or above in UK EM (i.e. completed MRCEM and a minimum of 6 months in all ACCS modalities – ICU/Anaesthesia/Acute Medicine/Paediatric EM + 12 months EM).

5.5.3 Relationships & Team working

5.5.3.1 A consistent theme throughout the day was the breakdown of relationships and a lack of professional respect both within the ED and between the ED and clinicians and managers within the Trust.

5.5.3.2 This dysfunction creates a clear impression of parties working in isolation and often in opposition, within a 'blame culture' which perpetuates and compounds clinical risk.

5.5.3.3 The reasons for this are doubtless multi-factorial and appear to have evolved to the current level over the last few years.

5.5.4 Guidelines & Pathways

5.5.4.1 There is no readily accessible and up to date repository of clinical guidance to support the ED juniors. Juniors reported that there are a series of inpatient guidelines on the intranet, which are often difficult to navigate and not relevant to immediate ED care. They can access them but find them of limited use. There is no ED specific guidance.

5.5.4.2 The juniors report that they do receive departmental induction, but that this has a clinical rather than operational focus. It is "too much to take in in one session" and there is no resource to back it up. Their induction does not contain briefings on systems, pathways, rotas, workforce etc..

5.5.4.3 We also picked out particular areas of concern

1. Management of critically ill patients is often led by medical registrar or anaesthetic junior (often ST1 level) rather than senior ED staff (even when they were present in the department). There seems to be a culture for juniors and nursing staff to call for outside help when dealing with ill patients rather than escalating issues within the ED.
2. Children and Young People: there is a high risk around the management of sick children in this department from the combination of deskilling / lack of skills in ED staff, lack of availability of paediatric support when the Seashore unit is closed, and lack of facilities / guidelines / governance around this important group.
3. Trauma: although WGH is not a designated Trauma Unit patients will regularly arrive with significant traumatic injuries. In-hours the ED response is to put out a 'Trauma Call' which will generate a response from the T&O, surgical and anaesthetic team juniors who then manage the patient, but it is felt that this is not well coordinated and has variable input from ED staff. Out of hours we are told there is no such response due to the scarcity of staffing across the Trust, and the Senior Nurse in ED will simply call the Anaesthetic junior covering ITU for support.
4. Cardiac Arrest: there is no clear pathway for who is responsible for the management of cardiac arrests brought to WGH ED. In practice it appears that the ED nursing staff will put out a cardiac arrest call through the hospital switchboard.

5.5.5 Safety systems and culture

5.5.5.1 We asked about their views on patient safety within the WGH ED some of the comments from junior doctors were:
"Quite often felt I was doing my own thing"
"Felt like the leader of the team seeing more patients than the MGs"
"I was often left in resus and majors by myself and was out of my depth a lot"
"Patients were being moved before being seen because of target pressure, I couldn't formally handover. From a safety aspect this is a problem."
"There were variable times of it being unsafe, generally OOH. On weekdays we were supported in numbers from each other. Rapid assessments being completed by F2s rarely / never consultants. The nurse in charge would and do it. The nurses take charge in the department "
"ED staff running arrests makes me scared, I literally shudder. After 4 months I am still not clear about the procedure, who runs an arrest in ED? Competencies in staff and workforce numbers are both an issue".
"I have had sleepless nights at times leading up to night shifts. Daytimes felt more supported, at night you are left on your own."

5.5.5.2 Although, a handover process has been implemented following the last review, it was felt to be haphazard, inconsistent and sometimes only practised by the middle grade or senior staff with little involvement of the junior staff.

5.5.5.3 There are inadequate governance and patient safety review systems within the ED, with limited feedback to staff or learning from events. This is acknowledged by the staff in ED at all levels.

5.5.5.4 There is no robust ED Morbidity/Mortality forum for reviewing deaths, although the Trust inform us they have established a mortality review group.

5.5.5.5 Following previous reviews and advice the department has established a monthly 'Clinical Governance' meeting. The minutes of this meeting show it to be very poorly attended with sparse content or useful outcomes. When asked about this one nurse commented: *"The safety Clinical Governance meeting is supposed to happen monthly. You get an email basically saying "just turn up if you fancy" it's not seen as a priority. It's not an obstructive thing, it's the pressure of the department."*

5.5.5.6 There is a Trust incident reporting system which staff are aware of and have accessed, but the overriding impression from those interviewed was that this was not seen as a priority for the Trust with the structures in place for the purpose of external evidencing only. When questioned about the Trust reporting system and feedback from the wider organisation a junior doctor

stated: "*I once completed an incident form after a night shift. The Medical Director contacted me, but I didn't see any changes and don't know what happened about it.*"

5.5.5.7 ED staff expressed their perception that the Trust's priority is the attainment of performance targets over patient safety: There was feeling that the Trust was more concerned about preventing 4-hour breaches rather than completing the safe medical care of a patient before transferring out of the department, thus further impacting on safe management plans for care and treatment. This was more prevalent when the department was busy to create space for new patients, especially in the evening and overnight.

"*I am a Band 6 nurse and I basically sit at a computer the whole of my 12-hour shift making sure no patients go over 4 hours, if they do it will come back on me personally. I will get snotty emails or pulled into an office and questioned. If a patient is in the department for over 4 hours it's our fault*"
"*4 hour target is prioritised, it's a push culture*"

5.5.5.8 The Trust has reviewed but not yet implemented the 'SHINE' safety checklist in ED. This is a positive proposal but this is just a checklist and should not in anyway be considered as addressing the deficiencies in other areas of governance. The checklist is to monitor compliance with good practice and to identify any remaining deficiencies. It does not assure safe practice where it does not exist.

5.5.6 Training & Education in general

5.5.6.1 Provision of quality-assured training and education is integral to the delivery of quality assured patient care and patient safety.

5.5.6.2 Education and training for trainee doctors is covered in the next section.

5.5.6.3 There is a middle grade teaching program which happened once per month. This is Middle Grade led with occasional consultant input. Again, no governance issues were discussed at this forum.

5.5.6.4 There was no evidence of any structured teaching education program for nurses, ENPs or multidisciplinary teaching between medical & nursing staff.

5.6 Education and training for junior doctors (Foundation doctors, and GPVTS)

5.6.1 The main body of trainees in ED (FY2 & GPVTS) felt it is a busy department that deals with a wide variety of EM presentations but that it is a service commitment post rather than a training post. The learning environment was described as being more one of 'osmosis' rather than formal supervised learning/teaching events. Any supervision for trainees was provided by a small handful of staff, mainly one or two middle grades and one consultant.

5.6.2 In general, the trainees felt they were integral to the functioning of the department and wanted to contribute towards providing good and safe clinical care for patients attending the ED. The also felt that at present it is not an environment for training & education.
"Anything learnt was through exposure of seeing and managing patients."
"*It is not a good training job."*
"No difference from being a locum than an F2."

5.6.3 There was an overwhelming feeling that the lack of clinical leadership on the shop floor by consultants led to poor supervision and support. This was felt to be more apparent overnight and at weekends. No formal procedures were in place of who to report to when starting a shift: trainees based themselves in the busiest area in the department at that time. They were not sure which consultant was in charge of the shift when they come on duty.

5.6.4 It was felt that although the consultant body do not work as a team, the nursing team were very good. They are a mainstay of support.

5.6.5 Trainees were often left to deal with critically ill/unwell patients with little support from consultants even when they were present in the department. They felt more supported by the middle grade tier, when present and of sufficient quality.

5.6.6 There were many comments from trainees about the unease they felt before starting nights as well as during their night shifts. It is very dependent on the calibre of the Middle Grade on duty.

5.6.7 Some trainees felt concerns had been expressed within the department and within the organization, but little has happened or changed.

5.6.8 Some trainees have been reluctant to pursue their interest in EM as a career choice due to their current experiences in ED.

5.6.9 Observations documented in sections 5.5.4, and 5.5.6, regarding weaknesses in induction and clinical guidance are not only relevant to safety, but also to education and training.

5.6.10 The trainees do attend a weekly hour-long departmental teaching program which is of reasonable quality and often led by a middle grade or consultant. Although these sessions are protected time, the trainees felt they return to a department that is extremely busy and chaotic. They also have access to the hospital FY2 teaching program, although not many trainees had attended these sessions.

5.6.11 There is no structure in place to enable feedback to trainees about clinical governance issues. No systemic processes are in place to inform juniors about missed XR reports, and there is no learning from incidents etc. as part of teaching program.

5.6.12 Formal supervision was felt to be very 'hit or miss.' Clinical supervision was poor and most WPBAs were completed by a small number of middle grade staff, hardly ever a consultant, it was often very difficult to get time with them. If there was a particular issue that the trainees wished to raise, they all named one ED consultant they would go to even though they may not be the clinical lead or their education/clinical supervisor.

6. Recommendations

The visitors have identified a number of concerns and made a number of recommendations. We have attempted to keep these recommendations focused and achievable for both the Trust and ED. They would represent a good start. Patient safety in the ED, which is currently compromised, will be improved through adoption of these recommendations.

The visiting team note the similarities between some of the recommendations from this visit, and from the last.

We would recommend that this report is shared appropriately with regulators, HESW, the executive team, and with senior managerial, medical and nursing staff within the ED.

6.1 Leadership and Management

6.1.1 For the Trust

6.1.1.1 There needs to be a reboot in the whole approach to how the ED is managed from above. Trust culture should reflect the fact that the performance of the ED is a combination of effective internal function of the ED, and effective management and support of the ED particularly in relation to flow and escalation. The Trust should seek to maximise its use of collaborative leadership styles, seeking and valuing the opinions of staff groups working within its devolved services. Encourage a culture of transparency and openness to replace the current perceived and predominant blame culture. There is an opportunity to achieve this with the CEO taking up a substantive position, new appointments due for MD and Clinical Director, and a void to be filled in local ED leadership.

6.1.1.2 Consider mediation between Trust executive and senior medical management, and the ED senior medical and nursing team, to rebuild trust and confidence which has clearly been lost.

6.1.1.3 The pervasive effect of ED crowding should not be underestimated, and efforts to reduce it assigned the highest priority.

6.1.1.4 The recommendations of the last RCEM report around leadership should be implemented. This requires the appointment of a credible clinical lead, with time to do the job, if necessary managed outside of the normal divisional structure to enable coaching, support, collaboration, and the development of effective working relationships.

6.1.1.5 The Trust should, as part of its sustainability work, seek to develop a regionally networked model of ED leadership and senior staffing.

6.1.1.6 We recommend that the Trust liaises with the ED consultants regarding enlisting help from other EDs or Emergency Physicians, to take forward the improvement agenda.

6.1.2 Within the ED

6.1.2.1 The ED consultants and nursing team should develop an effective structure focussing on cohesive ownership and leadership of the department, developing quality, ensuring safety, and optimising education and training opportunities within the ED.

6.1.2.2 This should be supported by job planning as per the recommendations of the last RCEM visit.

6.1.2.3 The ED team senior nurses and substantive consultants may benefit from some facilitation to strengthen relationships.

6.1.2.4 The ED consultants should adopt an effective command and control model of running the shop floor as a priority. This will improve quality, education and training, and performance. There are several models available and ECIP will be able to supply pointers. This model should continue even when consultants are not present on the shop floor.

6.2 Workforce

6.2.1 Consider reducing the hours of operation of ED services at WGH to, for example, 08:00 -22:00 in the short to medium term. This will improve safety, and other aspects of quality of care, within current workforce and capability restrictions. This would have the secondary effect of improving other areas of concern such as capacity to develop the department, training, and staff experience.

6.2.2 If the ED remains open 24/7 then out of hours staffing both in ED and across the Trust should be reviewed. At present ED capability is inadequate, and support to ED is also limited both in its availability and capability.

6.2.3 The Trust should seek to make progress towards RCEM medical and practitioner workforce standards referenced above.

6.2.3.1 Support and invest in the development of the current substantive consultant body. Focus energies/efforts toward expanding the number of appropriately trained and qualified appointees in such posts. Any further appointments substantive or otherwise should include input from the substantive post holders rather than being externally enforced in isolation as has previously been done with negative effect. This will require sustainable job planning allowing sufficient SPA allocation to ensure training and adequate time for personal/service development. Specific incentives may be required to ensure the appointment of individuals of a suitable calibre and should be considered.

6.2.3.2 The Trust should seek to appoint substantive consultants even with locums in place (no efforts are currently being made because the funding envelope is reached).

6.2.3.3 The Trust should continue to explore ways of obtaining support from other regional departments, for example through consideration of networked solutions or joint appointments.

6.2.3.4 Continue to expand the Middle Grade tier aiming to secure appropriately experienced individuals rather than focusing solely on definitive numbers of appointments. This will necessitate appropriate job planning with training/development opportunities ensured for any appointees.

6.2.4 Reduce the working hours of Foundation doctors (at a minimum) to times when an appropriately qualified and competent Emergency Medicine consultant is present on the shop floor.

6.2.5 Review the nursing establishment to reflect the geography of the department, and current workload. Allow for variability, and include resilience for when the department is crowded.

6.3 Processes (and crowding)

The visiting team have not seen the report currently being prepared by ECIP and it is likely this will contain more detail. We would recommend that the Trust follows their recommendations and utilses the support they offer. The Trust is also referred to The NHS England publication "Transforming Urgent and Emergency Care Services in England." Further information and advice regarding crowding in ED can be accessed via the Royal College of Emergency Medicine website on the following link: http://secure.rcem.ac.uk/Shop-Floor/Service%20Design%20%20Delivery/ED%20crowding

However the following brief recommendations are offered:

6.3.1 The Trust should actively seek to develop a culture of widespread ownership of the problem of ED crowding, if calibration suggests that this is indeed absent. At the same time the Trust should seek to ensure that the culture is indeed of quality driving performance, rather than prioritising targets over patient care.

6.3.2 The Trust should redesign the admission pathway for acute admissions in particular, with a view to having urgent and emergent medical and surgical admissions routed through the MAU/SAU rather than ED in the first instance.

6.3.3 Internal Professional Standards should be revisited and driven by the Trust senior management teams, if necessary via a focused and empowered group. It should not remain the responsibility of ED clinicians to enforce. Specialities declining to engage should be held to account.

6.3.4 At the same time the ED needs to engage with efforts to improve its own internal processes.

6.3.5 There should be effective command and control of the ED shop floor using a combination of the doctor in charge, nurse in charge, and available administrative support (e.g. patient tracker).

6.3.6 Effective handovers and "board rounds" at regular times between medical staff and nurse coordinator (not just senior staff) will improve safety but also improve the learning environment for trainees with presentation of cases during handover.

6.3.7 Review the escalation policy for ED crowding and once all parties are convinced it is fit for purpose, effectively implement it. It should include response/actions from within the wider Trust staffing and not solely rely on the ED staff 'coping'. This should be based on clear triggers and actions. It should include Trust management escalation to inpatient team consultants if not adhered to.

6.3.8 A working CDU should be developed which is owned and operated by the ED, preferably with junior doctor support to minimise ED consultant time. In the meantime patients for whom there is no available CDU bed should be admitted under the best fit clinical team, to avoid prolonged stays in ED.

6.3.8.1 Review the current reporting of waiting times for patients spending long periods of time in ED, to ensure that transparent reporting is taking place and that all 12-hour waits are appropriately reported. Ensure that ED staff understand the process. This will help improve perceptions around prioritising performance data over patient care.

6.3.9 The ENP tier should be empowered and developed to extend their scope. Consider improving their efficiency by supporting them with HCAs.

6.3.10 Introducing rapid assessment in majors is a lower priority than getting the basics of shop floor management sorted out. However, consideration should be given to developing a culture of bringing care forward in minors where it is possible, rather than the absolute focus being on triage.

6.4 Guidelines & Pathways

6.4.1 Support access to an on-line ED Handbook or other such resource which will encompass easily accessible guidelines/pathways for acute presentations. Developing this in conjunction with inpatient colleagues would ensure continuity in care and could enhance the dysfunctional/adversarial relationships that currently pervade. This will require supported time to develop and deliver.

6.4.2 Support the development of a departmental induction programme that better meets the needs of the junior doctors. Include provision for locums also. This will require supported time to develop and deliver.

6.4.3 Ensure there are clear and implemented pathways for particular groups of patients where confusion and clinical risk are currently identifiable – (e.g.) critically ill patients, children and young people, trauma, cardiac arrest, mental illness. These should be developed in conjunction with relevant inpatient teams/adjacent Trusts.

6.4.4 Review the provision of paediatric areas to make them fit for purpose under established standards

6.5 Governance Structure & Incident Reporting

6.5.1 The ED monthly Governance meetings need to be made fit for purpose and given due regard outwith ED to highlight their importance. Attendance should be supported in job planning and rotas. The development of relevant, reportable metrics with clear, accountable feedback and learning systems should be supported and include participation of clinical and non-clinical staff.

6.5.2 Review wider Trust reporting systems and feedback mechanisms as clear concerns were also expressed with regard these Trust-wide systems.

6.5.3 Address the perception amongst ED staff that the Trust management places performance target attainment above patient safety by acknowledging this perception exists, and addressing the root causes.

6.6 Education & Training

6.6.1 The New GMC Training Standards for 2016 state education and training should proceed in departments and organisations where patient safety is paramount. Additionally, shop floor supervision needs to be effective, and undertaken by appropriately qualified and competent senior medical staff. Currently, our belief is that the department is unsafe at times, with the risks being highest in the evenings, overnight, and at weekends. Safety systems that should be present to mitigate risk are not effective. Supervision of trainee doctors is clearly described by them as being inadequate, particularly during the times of highest risk. We considered recommending complete withdrawal of trainees from the department, but for now have suggested it is inappropriate for, at a minimum, FY2 trainees to continue working in the department when there is not a competent and suitably qualified consultant present.

Consolidating the shift patterns for juniors to coincide with consultant presence would offer the best chance for consistent and effective supervision within the current system.

6.6.2 Improve formal supervision of trainees by consultant staff with appropriate SPA time allocated to staff to provide this support. This is essential for regular feedback and completion of appropriate assessments. This may require the existing substantive consultants to take more responsibility for all trainee supervision and training rather than the locum staff.

6.6.3 Ensure all staff have the adequate skills and competencies to supervise trainees, including clinical skills and up to date educational/clinical supervision skills.

6.6.4 Re-organisation of the junior rota may allow better allocation of trainees on teaching days to enable attendance at teaching sessions. Alternatively, increased allocation of other staff (cons/MG/ENP) on teaching days may avoid the backlog of work trainees feel they encounter after teaching.

6.6.5 Regularly review the ED teaching program to ensure updated curricula and feedback are incorporated.

6.6.6 Consolidation of the FY2 workforce to daytime and evenings would enhance other teaching/learning opportunities (e.g. use of junior doctors on CDU ward rounds).

6.6.7 As suggested above, ED induction and improved education / feedback around governance need to be addressed as part of teaching program.

6.6.8 Ensure trainees have access to support, feel valued within the organisation and continue to have access to the Deanery support services. The trainees must feel they are being listened to and can also suggest changes to improve the department.

6.6.9 Ensure that both the education and development needs of the middle grade tier are met, since this not only improves quality but also leads to improvements in recruitment and retention.

6.6.10 The lack of attention to education and development for ENPs, and lack of formal in-house teaching, should be addressed.

6.6.11 The lack of education and development for general nursing staff should be addressed.

6.6.12 A more multi-disciplinary approach to teaching may have huge benefits for the department in the long term.

Appendix 1

Interviews were conducted with

Chief Executive

Director of Finance

Director of Operations

Medical Director

Clinical Director for Medicine

ED consultants x 2

Locum ED consultant X1

ED Matron

ED Service Manager

ED Middle Grade X 1 (only one on duty)

Trainee doctors X 8 (from last attachment, and current attachment)

ENPs X2

Nursing staff X 3 (pressure on shop floor prevented more attending)

We were unable to meet with one substantive ED consultant who was on a late shift, and would have liked to have met with more ED middle grade doctors and nurses

The College of Emergency Medicine
7-9 Breams Buildings
London
EC4A 1DT
Tel: +44 (0)20 7400 1999
Fax: +44 (0)20 7067 1267
www.collemergencymed.ac.uk
Incorporated by Royal Charter, 2008
Registered Charity number 1122689