Report on Visit to Ninewells Hospital

The Scottish Government
Riaghaltas na h-Alba

Report on visit to Ninewells Hospital
Monday, 15 June 2015
Dr Catherine Calderwood, Chief Medical Officer

Purpose of Visit

Summary:

- BBC reported Wednesday 9 June 2015 that two whistle-blowers claim surgeons are being 'banned' from seeing patients in the Emergency Department of Ninewells hospital so the hospital can meet its waiting time targets.

- Health Secretary Shona Robison asked the Chief Medical Officer (Dr Catherine Calderwood), and the NHSScotland Chief Operating Officer (John Connaghan CBE) to visit Ninewells Hospital on Monday 15 June 2015, to investigate these allegations.

Format of Visit

The visit comprised of a 'patient journey' walkthrough of the Emergency Department (ED), Acute Medical Unit (AMU) and the Acute Surgical Receiving Unit (ASRU), with the opportunity to speak with clinical staff within each area. This was followed by individual meetings with a multidisciplinary team from surgery and anaesthetics, medicine and emergency medicine followed by meeting with senior management team.

Background Information

Information provided by NHS Tayside on Ninewells Hospital

- Approximately 48,000 A&E attendances per year
- 60% of attending patients are 'minors'
- 24/7 senior clinical staffing
- All inpatient specialties receive GP referrals directly into their own units (AMU / ASRU)
- 30% of medical admissions come from the Emergency Department
- 20% of surgical admissions come from the Emergency Department

- 21.5% reduction in Hospital Standardised Mortality Rate from Oct-Dec 2007 to Oct-Dec 2014. This compares to 16.1% in NHS Scotland.

Findings

The NHS Tayside Emergency Department model has been in operation since 1998. There is consultant presence within the Emergency Department (ED) at Ninewells Hospital 16 hours per day (8am – midnight), with either a consultant or ST4+ trainee resident overnight. All admissions are discussed with the senior clinician on duty.

The fundamental principle of the NHS Tayside ED Model is the improvement of patient safety by reducing unnecessary waits within the ED and reducing ED overcrowding due to the known negative impact this has on patient outcomes and experience. The operational principles include:

- Rapid access to senior clinical decision makers
- Discharge, transfer and admission rights for senior decision makers in the Emergency Department
- ED undertake appropriate emergency investigations, 'routine' or 'baseline' bloods will not be done routinely in all patients being admitted.
- Attendance in ED by specialty medical staff is by invitation and is based on the clinical condition of the patient.
- 'Push Policy' – for clinically suitable patients

In discussion with the surgery & anaesthetics multi disciplinary team (MDT), both medical and nursing staff confirmed that they believed the current ED model to be safe. They acknowledged the basis for such a model and the benefit to patients in early access to their definitive specialty of care. Although they acknowledged the 4-hour access target for ED, in their opinion this was not the driver for patients being admitted to their unit.

The surgical MDT did however describe the model as ‘rigid and inflexible’. In particular they noted that new incoming medical staff (of all grades), particularly those from other hospitals and NHS Boards, found the ED model and interface challenging however no member of the team we spoke to had personally experienced being ‘barred’ from the Emergency Department. In their opinion the ED model has been developed in isolation with limited input from surgical services and with no acknowledgement of feedback from those in the units receiving the patients. Nursing staff also reported a disconnect between the manner in which patients are seen and treated in ED and their subsequent management on the ASRU. Some improved communication channels with the ED have been developed in the recent past.

The surgical and anaesthetic team advised that they would welcome a more collaborative approach to the interface between their specialty and the emergency department particularly in relation to pre-admission diagnostic tests for their patient cohort. They believed that this could improve the patient experience without adding significant delays.

The medical multi-disciplinary team confirmed that they believe the current ED model to be safe with the operational principles being patient safety based as opposed to target driven. They noted that in the past 3 years they had re-designed the Acute Medical Unit and improved communication links with the Emergency Department. They did however discuss the ‘rigid’ nature of the operational principles, and had some reservations regarding particular aspects of these. In particular they highlighted the need for further clinician-to-clinician dialogue re the implementation of the ‘push’ policy and the level of diagnostics performed within the ED.

The emergency department multi-disciplinary team advised that their ED Model was originally established in 1998 and had ‘evolved for patient safety’. They noted that the clinical model was based on good medical practice ensuring radiation guidelines are followed and that only clinically appropriate tests and investigations are performed.

The emergency medicine department staff noted that this model had delivered significant evidenced improvements in patient safety such as compliance with the sepsis 6 bundle (the surgical unit within Ninewells is achieving 100% for the Sepsis 6), a reduction in the Hospitals Standardised Mortality Ratio (exceeding the national average reduction). The team confirmed that improved patient waiting times, and consistent attainment of the 98% target is a by-product of early senior review, decision-making and focused investigations.

The findings of the General Medical Council (GMC) review (October 2014) were discussed. At that time the GMC recommended that improvements could be made in regards to the interaction between the emergency medicine department and other specialties. The ED team acknowledged the findings within the GMC report and advised that as part of the action plan they were in the process of producing a document, which described the principles of the ED model in operation. The team advised that the intention was that this document was to be provided to new incoming doctors at their induction in August 2015. It was noted that this recently prepared draft document had been produced solely by the Emergency Department however they advised that they intended to share the document for discussion with surgical and medical colleagues.

The Emergency Department team acknowledge that they have not focused on communication with specialty colleagues regarding the ED model which they appreciate has resulted in a lack of 'buy in' from other specialty groups and the ASRU and AMU and that this is an area they need to focus on.

Conclusions

- From observations and discussion with NHS Tayside clinicians I am satisfied that the current emergency department model of care is safe and clinically appropriate. The rates of patient satisfaction are very high. See appendix 1 for NHS Tayside's and NHSScotland's

Hospital Scorecard performance, and appendix 2 for Scottish Inpatient Patient Experience Survey results for NHS Tayside

- Following discussion with the emergency department multi disciplinary team it is evident that the principles that underpin NHS Tayside's ED model are patient safety and outcome focused and not target driven.

  There is no evidence to support the allegation that patients are admitted to specialty wards, or specialty doctors are unable to see patients within the emergency department, purely to attain the access target.

- Following discussions with the surgical & anaesthetics and medicine multi disciplinary teams it is evident that they do not feel involved in the development of the current ED Model and therefore 'buy in' by the receiving specialties is lacking. The specialty teams are keen to develop better communications with the emergency department and a collaborative approach to the development and improvement of existing operational policies for all departments.

- It was acknowledged that at times the communication regarding the principles of the ED model was not always optimal and thus misunderstandings arose between members of the ED and other specialty teams as to the rationale behind some decisions when patients were admitted.

Recommendations

- To improve communication link consultants from all specialties that interact with the emergency department should be identified.

- There should be specialty specific operating procedures drawn up with ED and receiving teams which ensure adherence to the principles of the ED model and ensure optimal patient care as they progress through the system. Staff should meet regularly and these meetings should also be attended by nursing and other staff working between ED and the receiving units.

- The existing draft document – 'Guide to Tayside EDs for doctors interacting with Emergency Medicine', should be shared with all stakeholders and a collaborative approach taken in its development.
  The agreed final document should be shared with all existing healthcare staff who interact with the ED within NHS Tayside.

- Emergency department consultants should have a participative role in the induction of new medical, nursing and other relevant healthcare staff to ensure understanding of the agreed operational model within the emergency department.

- The ED team should consider disseminating the positive outcomes from their ED model across NHS Tayside to ensure whole hospital system 'buy in' and improve collaborative working.

- Early work in NHS Tayside on 'whole system patient pathways of care' should be continued taking into account these recommendations. It is important that each individual unit or department see themselves as part of the larger 'hospital team' ensuring best patient care including flow through the hospital.

- The concerns raised by whistleblowers who come forward should continue to be investigated as previously through the existing channels within the east of Scotland deanery and escalated to the GMC if appropriate.

Appendix 1 - Hospital Scorecard - July-Sept 2014 - Standardised Rates per 1,000 admissions

	NHS Tayside	NHS Scotland
Surgical Readmissions within 7 Days	21.19	21.84
Surgical Readmissions within 28 Days	39.88	42.00
Medical Readmissions within 7 Days	51.11	49.58
Medical Readmissions within 28 Days	121.01	111.33

Source: ISD Scotland SMR01

Appendix 2 - Scottish Inpatient Patient Experience Survey 2014

In NHS Tayside 1,074 people responded to the survey (49%) from 13 hospitals. These included 8 community hospitals, 1 general hospital, 1 large general hospital, 1 long stay hospital, 1 other hospital and 1 teaching hospital.

Compared to this year's results for Scotland, NHS Tayside patients were significantly more likely to report a positive experience in the following areas:

- In A&E patients were told how long they would have to wait to see a doctor/nurse. (**61% ; +17%**)
- How patients felt about the time waiting to be seen by a nurse or doctor in A&E. (**90% ; +7%**)
- In A&E patients were kept informed about what was happening after seeing a doctor/nurse. (**72% ; +12%**)
- In A&E patients' conditions were explained to them in a way they could understand. (**75% ; +8%**)
- Overall rating of hospital admission process. (**89% ; +6%**)
- How patients felt about the time they waited to get to a ward. (**92% ; +6%**)
- Overall rating of hospital/ward environment. (**91% ; +3%**)
- Patients were happy with the drinks they received. (**89% ; +5%**)
- Hand-wash gels were available for patients and visitors to use. (**97% ; +2%**)
- Overall rating of care and treatment during hospital stay. (**91% ; +2%**)
- Patients were involved as much as they wanted in decisions about their care and treatment. (**66% ; +5%**)
- Doctors knew enough about patients' condition and treatment. (**93% ; +3%**)
- Nurses discussed patients' condition and treatment with them in a way they could understand. (**88% ; +4%**)
- Patients felt there were enough nurses on duty. (**70% ; +6%**)

- Staff worked well together in organising patients' care. (**78% ; +5%**)
- Patients felt they got enough emotional support from staff. (**71% ; +4%**)
- Staff treated patients with compassion and understanding. (**78% ; +4%**)
- Patients knew who to contact if they had any questions after leaving hospital. (**84% ; +4%**)

Compared to this year's results for Scotland, there were no areas in NHS Tayside where patients were significantly less likely to report a positive experience.

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