

Check	Targeted check
Date	19 December 2012
Location Visited	Leeds General Infirmary
Team Leader	Professor Jacky Hayden
Visitors	Professor Simon Carley Ms Jill Crawford
GMC staff	Jennifer Barron, Quality Assurance Programme Manager Rachel Daniels, Education Quality Analyst
Observers	Tony Browning, Yorkshire and Humber Deanery* Emma Jones, Yorkshire and Humber Deanery* Sarah Walker, Yorkshire and Humber Deanery*
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 the continued rise in attendances and the severity and complexity of patient conditions presenting, without provision of adequate resources for assessment and admission, has contributed to severe difficulty in the recruitment and retention of doctors specialising in emergency medicine.**

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 to Leeds General Infirmary (LGI) 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

Leeds General Infirmary reported to the GMC during the audit of emergency department rotas, consultant cover 8am until midnight 7 days a week, with higher specialty doctors in training (ST4-6) covering midnight until 8am. When visiting the site we identified that middle grade cover at night time is provided by sufficiently experienced doctors in training however they need to be more accessible during the shift. The College of Emergency Medicine recommends having a minimum grade of an ST4 trainee on duty to supervise at night time.

The national training survey 2012 reported that Leeds had below outliers in feedback, handover, study leave, workload, and access to educational resources. The local education provider (LEP) had an above outlier in local teaching. There were three patient safety concern comments from doctors in training based at Leeds General Infirmary relating to workload, larger volumes of patients than numbers of beds and a lack of clinical supervision, especially at night.

The Yorkshire and Humber deanery reported in its October 2012 deanery return, concerns regarding the increased number of patients and lack of hospital resources with initial care and assessment being overlooked due to the volume of patients. The LEP was asked to investigate and develop an action plan.

*Health Education Yorkshire and the Humber is referred to as Yorkshire and Humber Deanery due to the time of the visit

**College of Emergency Medicine Statement

Leeds Teaching Hospitals NHS Trust had 8,179 incidents reported to the Patient Safety Agency's National Reporting and Learning System (NRLS) between October 2011 and March 2012. However 74.7% of the incidents reported to the NRLS had no degree of harm to patients and 0.4% of incidents reported resulted in death.

Summary of site

Leeds General Infirmary is one of the largest teaching hospitals in the country. The hospital has an adult emergency department and a dedicated children's emergency department. There is also an additional adult emergency department at St James's University Hospital; staff are shared across both sites. These sites are situated approximately two miles apart from each other.

According to figures submitted to the College of Emergency Medicine in its *Enlighten Me* project and shared with us with the LEP's permission: Leeds General Infirmary emergency department treats approximately 77,568 adult patients per year with approximately 13,928 admitted to a ward within the hospital. The site sees approximately 38,377 paediatric cases per year with approximately 3,562 being admitted onto a ward for treatment.

There are 19.05 WTE consultants staffed by 22 consultant grade doctors who work a cross-city rota between Leeds General Infirmary and St James University Hospital

The emergency department is the hospital gateway for most patients who require hospital admission due to an acute illness or injury. The staff work with other hospital specialties to organise appropriate care and treatment for the patients who attend.

Leeds General Infirmary is a major trauma centre and holds a helipad, which means critically ill patients can be flown in from across the Yorkshire region.

Work intensity has an effect on clinical supervision at night. Higher specialty doctors in training often treat patients in resuscitation rooms throughout most of their shift and are therefore unable to supervise core and foundation doctors in training as fully as they would like. Consultants frequently work beyond their scheduled hours and return to the emergency department overnight when on-call.

The Report

Good practice

1.	Consultant led teaching in the emergency department happens once a week for a full day shift and this time is protected. Trainee evaluation of teaching had previously been poor and the consultant body introduced this protected consultant shift in response. (Domain 5 TD 5.4)
2.	The use of technology within the department is innovative. (Domain 5 TD 5.19)

3.	Risk is shared across the hospital and patient flow out of the emergency department has improved. The emergency department has been working with local GPs to reduce the operational demands on the department by facilitating GP referral directly to wards and launching a telephone advice line for GPs. (Domain 1 TD 1.6)
4.	Consultants shadow a higher specialty trainee (ST4 and above) for a full shift and provide feedback on their performance on a monthly basis. (Domain 6 TD 6.11)

Requirements

1.	The LEP must review staff rotas and ensure that those supervising the clinical care provided by doctors in training are accessible at all times while the trainee is on duty. (Domain 1 TD 1.3)
2.	The emergency department must have a well organised handover arrangement in place for morning and evening, ensuring continuity of care. (Domain 1 TD1.6)
3.	The LEP must ensure that the teaching programme content is reviewed and amended to suit the current stage of training. (Domain 5 TD 5.1)
4.	The LEP must ensure rotas allow doctors in training to attend or be released for teaching sessions. (Domain 5 TD 5.4)
5.	Rotas must clearly specify the level a trainee ensure that everyone within the department is aware of the supervision requirements and their competence. (Domain 1 TD1.2)

Recommendation

1.	The LEP should ensure that all consultants understand the requirements of their training role and the GMC standards for trainer approval. (Domain 6 TD 6.38)
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Findings

Patient safety

Out dated terminology such as Senior House Officer (SHO) and General Practice VTS (GP VTS) is still in use within the emergency department. This terminology does not adequately distinguish between foundation year 2 doctors (F2) and speciality doctors in training (ST). Staff are therefore not aware of the differing levels of competence and clinical supervision required.

The divisional managers complete a review of serious untoward incidents (SUI) to identify themes and gaps in doctors in training' knowledge which they then feed back into the emergency department via induction or handover and individually to all doctors in training involved.

Handover

We heard from doctors in training that handovers are less likely to happen at times when the department is busy. This is potentially a time that a handover is needed most. Consultants said that it depends on their shift times and the resources in the department as to whether they are able to facilitate a handover. We heard that many of the shifts overlap and consultants advised they always update the patient management system with patient details and conditions for the next shift to review.

Feedback

Higher specialty doctors in training we spoke to valued consultants shadowing them and advised us that consultants are generally around when they provide feedback to core or foundation doctors in training.

Rotas

Work intensity has an effect on clinical supervision at night. Higher specialty doctors in training often treat patients in resuscitation rooms throughout most of their shift and are therefore unable to supervise core and foundation doctors in training as fully as they would like. They often give advice regarding patients from the resuscitation room and would prefer to review the patient in person with their colleague; this would afford a better learning opportunity as well as providing safer patient care.

Core and foundation doctors in training in the paediatric emergency department advised that they cover the night shift without direct supervision by a paediatric emergency medicine consultant however the paediatric emergency department is collocated with the remainder of the emergency department where consultants are available until 12am. Core and foundation doctors in training advised the paediatric department is very supportive of the paediatric emergency department and is always willing to review a patient when asked. Consultants agreed that doctors in training and patients would benefit from increased direct supervision of doctors in training by paediatric emergency consultants.

Core and foundation doctors in training reported they can attend only 50% of teaching sessions due to the inflexibility of the rota. They are unable to attend due to the teaching session falling outside of their shift.

Teaching and Learning Opportunities

All doctors in training advised that consultants put aside three hours a day three days per week to complete work place based assessments (WPBAs) and you can book time with them or attend if they have a free slot.

Core and foundation doctors in training felt that the teaching content for their programme is not always suited to their current position in training with some doctors in training stating it is too basic. Core and foundation doctors in training are taught separately with the purpose of tailoring the teaching to the correct training grade.

Support

Doctors in training said that there is a high level of engagement from consultants with extended presence at night time and weekends. Doctors in training said that consultants generally work later than their shift and they are always available and approachable when on call.

There is positive engagement with the mental health service, with an office provided in the emergency department so a single point of contact is available 24/7.

The emergency department responds well to trainee evaluation. For example, introducing protected teaching time and sessions for workplace based assessments following trainee evaluation in 2012.

Retention of ST3s within the department is low, with 70% of the current ST3 cohort choosing not to apply for higher specialty training. We heard from doctors in training that the work is too intense and there is minimal work/life balance. They feel that a career as a consultant is not sustainable.

Trust Management

Consultants within the department are making use of technological advances in the management of the department and have developed bespoke applications for smart phones. One is used to hand over patients, log events, feed back to staff members, and provide praise to other members of staff. The other is used to provide a full handover to the next shift of nursing staff, with department statistics being loaded on a regular basis. This is available to staff at St James's as well as Leeds General Infirmary.

The emergency department currently has 40 doctors in training. Staff are split across both sites, the Leeds General Infirmary and St James. Foundation doctors are kept on one site in order to familiarise themselves with one set of protocols, a team of staff and the department layout.

The harassment advisors scheme that the emergency department runs for staff that are being undermined or bullied in the workplace is a good initiative.

Some consultants told us that they are not absolutely clear of what is required to meet the standards of the GMC for approval of trainers.

Meeting current challenges in emergency medicine

The LEP faces challenges of a fragmented workforce, consultants shared across both sites. They have recently increased their consultant numbers. The LEP is approved to take 21 higher specialty doctors in training however they currently have only eight. This puts strain on the communication within the department however they are trying to overcome this by using a system similar to a social networking site to keep in touch with staff across both sites.

The LEP is planning to recruit a further 12 consultants over the coming months to facilitate a move towards 24/7 consultant cover.

The LEP is looking at ways to reduce the demand on the emergency department, such as the introduction of the General Practice (GP) helpline. The helpline allows GPs to call and gain advice before referring a patient to the emergency department and allows GPs to admit directly onto the relevant ward. This initiative was introduced to reduce the number of inappropriate referrals from local GPs, this unfortunately does not impact on the number of patients referred inappropriately by NHS direct.

The LEP face challenges of not having medicine on site, so paramedics have to take patients to both LGI and St James for treatment.

Conclusion

Our findings support the above outliers stated in the national training survey 2012 in local teaching, higher specialty doctors in training noted that local teaching is much stronger this year with the deanery focussing more on the Fellowship of the college of emergency medicine exam.

There were below outliers in feedback which has been addressed by the LEP through the WPBA sessions and the consultant shadowing shift; handover which we found takes place in the morning and evening when the department is quiet however not when the department is busy which potentially is when it is needed most; study leave which we heard from core and foundation doctors in training needs six week's notice and no guaranteed chance this is accepted however higher specialty doctors in training said this has improved and they are entitled to one day a week and said there is no problem in taking this; workload which we found was high and access to educational resources which was not raised as a problem by doctors in training during the visit. In addition to these there were three patient safety comments highlighted in regards to workload, patient to bed ratio and clinical supervision at night time.

We have made requirements in regards to supervision at night time and handover. The LEP has focussed a lot of work on bed flow into the rest of the hospital so to reduce the strain on the department and bed spaces.

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 the Health Education Yorkshire and Humber in by 30 September 2013.

Response to findings

Stephen Bush, Clinical Director of Urgent Care

Thank you for the detailed report from your visit to the Emergency Department (ED) at Leeds Teaching Hospitals NHS Trust (LTHT) in December 2012. We note that the purpose of the visit was 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. As a department we acknowledge the value and importance of this piece of work.

The report identified that middle grade cover at night time is provided by sufficiently experienced trainees however they need to be more accessible during the shift. LTHT ED would like to comment that the Local Education Provider (LEP) has already made significant changes in the workforce in that Emergency Medicine (EM) consultants are now working 24x7. However even prior to this, there was always a middle grade doctor (ST4 or above) working over night at the Leeds General Infirmary (LGI) and that quality indicators for consultant sign off, as agreed between the Department of Health and College of Emergency Medicine in 2010 1 have been monitored daily. We would disagree that all patients seen by trainees need to be examined by a senior decision maker and would respectfully suggest that this is not currently deliverable in any ED in the UK.

LTHT ED would like to clarify that whilst some Higher Specialty Trainees (HSTs) will have spent significant periods of their shift in resuscitation for the purpose of patient care, and during these times were less able to support core and foundation trainees, this was only at

	<p>particularly busy times. The LEP was confident that the HSTs were fully aware of when to escalate to the on call Consultant if there were patient safety issues, that the consultant sign off quality indicators were being monitored and that it is not essential (or practical) for all patients in the ED overnight to be seen by a HST.</p>
Good practice	<p>LTHT ED appreciates the feedback of good practice in the department and would like to thank the GMC for recognising these achievements.</p> <p>LTHT ED would like to clarify that there are a number of differing consultant led teaching programmes that the ED delivers.</p> <ol style="list-style-type: none">1. The F2 and GPVTS trainees have a consultant led protected teaching once a week on a Thursday afternoon.2. CT1 and CT3 in EM have a consultant led regional protected teaching organised by the EM school on a regular basis.3. The HSTs also receive a consultant led regional teaching delivered by EM school which has recently been overhauled and is now more directed towards passing the college exit exam. <p>LTHT ED appreciates the feedback of good practice in the department and would like to thank the GMC for recognising these achievements.</p> <p>LTHT ED would like to clarify that there are a number of differing consultant led teaching programmes that the ED delivers.</p> <ol style="list-style-type: none">1. The F2 and GPVTS trainees have a consultant led protected teaching once a week on a Thursday afternoon.2. CT1 and CT3 in EM have a consultant led regional protected teaching organised by the EM school on a regular basis.3. The HSTs also receive a consultant led regional teaching delivered by EM school which has recently been overhauled and is now more directed towards passing the college exit exam.

	<p>The LTHT ED would appreciate it if the GMC could clarify which trainee doctor group feels teaching had previously been poor so this can be specifically addressed.</p> <p>LTHT ED would also like to comment that the Consultants have introduced workplace based assessment sessions three times a week in the afternoon during which all trainees can request assessments. Consultants also deliver individual extended assessment periods for HSTs. EM Trainees are all individually discussed at a faculty meeting fortnightly and these outcomes are actioned.</p>
Requirements	
Recommendations	
Other comments	<p>Patient Safety</p> <p>The report suggests there is a use of outdated terminology within the ED which does not adequately distinguish between different trainee grade doctors. LTHT ED believes there is a clear distinction between junior and senior clinical staff and the differences between the F2 and CT1 is defined by their curriculum. LTHT ED recognises that there are opportunities to better differentiate between trainee doctor grades by specifically describing each one on the ED rota.</p> <p>Rota</p> <p>The report notes that Core and foundation trainees in the paediatric emergency department advised that they cover the night shift without direct supervision by a paediatric emergency medicine consultant. However, the paediatric emergency department is co-located with the remainder of the emergency department where consultants are available.</p> <p>LTHT ED would like to clarify that all EM Consultants are competent to provide, and are revalidating against, Paediatric EM practice. They are often in the department into the early hours of the morning and are available on call.</p> <p>Teaching and Learning Opportunities</p>

The report suggests that Core and foundation trainees felt that the teaching content for their programme is not always suited to their current position in training with some trainees stating it is too basic. LTHT ED would like to comment that Core and foundation trainees are taught separately with the purpose of tailoring the level of teaching to the correct training grade. The LTHT ED would appreciate it if the GMC could clarify which trainee doctor group feels teaching is too basic so this can be specifically addressed.

Support

The report notes that the retention of ST3s within the department is low because the work is too intense and there is minimal work/life balance. LTHT ED would like to respond that this is a recognised national issue not unique to the LGI which is replicated across the whole of the UK, with similar fill rates and dissatisfaction because of workload.

Conclusion

LTHT ED believe that the GMC visit has evidenced that there have been significant improvements in: feedback as confirmed by the HST; handovers which have been strengthened and are taking place regularly; study leave which is offered is within the guidelines and HSTs have commented on improvements and; there are no issues with access to educational support.

LTHT ED recognises that there is further work to be progressed in addressing trainee workloads; however efforts have been consistently made in this area. LTHT ED also acknowledges the GMC observation of the level of supervision at night but believes this is was not deficient and compares favourably with many peer departments. LTHT ED would like the GMC to clarify if this was a significant issue with supervision at night as LTHT ED believes it was compliant with current guidelines, recognising that this has been superseded by 24x7 consultant working with Major Trauma Centre status.

Once again, thank you for your report and allowing an opportunity for the department to respond. We are always working to improve the teaching and environment we



provide to our trainee doctors. We look forward to working with our trainee doctors and the GMC to further improve this.