

<b>Check</b>	Targeted check
<b>Date</b>	18 December 2012
<b>Location Visited</b>	The James Cook University Hospital
<b>Team Leader</b>	Professor Jacky Hayden
<b>Visitors</b>	Professor Simon Carley Ms Jill Crawford
<b>GMC staff</b>	Jennifer Barron, Quality Assurance Programme Manager Rachel Daniels, Education Quality Analyst
<b>Observers</b>	Helen Lingham, Northern Deanery* Representative Neil Halford, Northern Deanery* Representative
<b>Serious Concerns</b>	None

## Purpose of the check

We have undertaken a series of checks to emergency medicine departments across England and the Channel Islands to explore risks to training in this specialty, to identify and disseminate areas of good practice and to gain further insight into local and national challenges including difficulty in the recruitment and retention of doctors specialising in emergency medicine, and a continued rise in attendances and the severity and complexity of patient conditions presenting, without provision of adequate resources for assessment and admission.\*\*

\* Health Education North East is referred to as Northern 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 Year 2 doctors were being breached.

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

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

### **Evidence**

The James Cook University Hospital's (JCUH) reported to the GMC through our audit of emergency department rotas, that there is consultant cover 8am-11pm Monday to Friday and 8am-7pm Saturday and Sunday, with the department being managed by specialty doctors in training (ST) at all other times. We found this reporting to be accurate during the check and that appropriate supervision is provided at all hours. 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 found above outliers in feedback, induction, local teaching, study leave, adequate experience and overall satisfaction. There were below outliers in handover, workload and regional teaching. No doctors in training reported patient safety comments from the national training survey.

South Tees Hospital NHS Foundation Trust had 5,070 incidents reported to the Patient Safety Agency's National Reporting and Learning System (NRLS) between October 2011 and March 2012. This is the third highest out of the seven sites we visited for emergency medicine checks. However 73.5% of the incidents reported to the NRLS had no degree of harm to patients and 0.1% resulted in death.

### **Summary of site**

The emergency department at JCUH is the designated major trauma centre for the region and the hospital has a dedicated 24-hour acute admissions unit.

According to figures submitted to the College of Emergency Medicine in its Enlighten Me project and shared with us with the local education provider's (LEP) permission: the department treats more than 99,613 adult patients per year and approximately 13,000 of these cases are admitted onto a ward in the hospital. The emergency department has over 26,000 paediatric presentations each year and approximately 3,500 of these cases are admitted for treatment.

The emergency department currently has nine consultants with a protected budget to recruit a further three. The JCUH is a training site for military medics. There are nine posts for military doctors in training.

This LEP has a robust night time rota which means foundation and core doctors in training are not left unsupervised, and have easy access to seniors. There is always either a consultant or middle grade on site.

## The Report

### Good practice

<b>1.</b>	Foundation and core doctors in training are released for teaching; in addition to this there is protected time each week for consultants to complete workplace based assessments. Higher specialty doctors in training have teaching every two weeks, they also get time allocated for exam practice. Most are able to attend 75% of teaching sessions. (Domain 5 TD 5.4)
<b>2.</b>	The LEP appoints educational supervisors thematically, focussing supervision against grade and reducing the number of curricula educational supervisors must engage with. (Domain 6 TD6.3)

### Requirements

<b>1.</b>	Rotas must clearly specify the grade of a trainee to ensure that everyone within the department is aware of their competence and supervision requirements. The term 'SHO' should not be used and instead the specific training level should be given eg F2, CT1, and CT2. (Domain 1 TD1.2)
<b>2.</b>	All doctors in training must have access to learning opportunities to meet the curriculum in order to develop their capabilities and knowledge within emergency medicine. (Domain 5 TD 5.4)

## Recommendations

1.	The LEP should ensure that it communicates how education and training feeds into the LEP governance and ensure this is fully understood by the senior management team. (Domain 7 TD 7.1)
2.	The LEP should introduce a robust outflow plan from the emergency department to other departments within the hospital to ensure working patterns and intensity of work are appropriate to learning. (Domain 6 TD6.10)

## Findings

### Patient Safety

Out dated terminology, such as Senior House Officer (SHO) and General Practice vocational training scheme (GP VTS), is still in use within the department. This terminology does not adequately distinguish between foundation year 2 doctors (F2), core doctors in training and GP and emergency medicine speciality doctors in training, who will have different levels of experience and thus require different levels of clinical supervision.

### Rotas

The rota requires foundation and core doctors in training to work many weekends. Foundation, core and higher specialty doctors in training advised that they enjoy working in the emergency department and the exposure to trauma is good, however their education suffers because of the demands of the rota. We heard from foundation and core doctors in training that when they have a day off they are exhausted; in addition to this they feel that there is little to no work-life balance and a lot of pressure to make the right decision, adding to the intensity of work. The LEP has recognised the work intensity and arrangements have been put in place for a regular locum every weekend to alleviate some of the pressure on doctors in training.

### Teaching and learning opportunities

Consultants are allocated foundation, general practice, core or higher specialty doctors in training to supervise. This means consultants only have to become familiar with one curriculum, have to attend one type of supervisor training and means they are specialist in a particular area. However consultants and doctors in training advised that training and learning opportunities are prioritised for those who are going to have a career in emergency medicine, potentially at the expense of other training grades.

Acute care common stem teaching is delivered one to two times every three months, F2 teaching is one day per month however is not included in study

leave. Foundation doctors in training we spoke to said they have no access to study leave in F1, and F2s said they were denied study leave.

We heard from foundation and core doctors in training that they never feel under pressure not to attend teaching and if required the department will arrange for cover so that they can attend.

At present higher specialty doctors in training are given 1-2-1 opportunities seven times a year specifically to have workplace based assessments (WPBA) completed by consultants. Higher specialty doctors in training said they have the opportunity to talk through complex patient cases, mixed fractures, and patients with untoward outcomes with consultants. They stated that there is a positive attitude towards training within the department and that they feel well supported to develop to the next stage in their training.

Higher speciality doctors in training have teaching mapped into their curriculum and have time for exam practice. Higher specialty doctors in training can also access WPBA afternoons with consultants.

We heard from doctors in training and consultants that patient outflow to the rest of the hospital is not working well, patients are 'boarding' in the emergency department and risk is not being shared appropriately by other departments. Doctors in training felt they sometimes had to 'sell' their patients to other departments and must negotiate between specialties if a patient is borderline for both, for example, a pregnant woman with abdominal pain, the trainee would need to negotiate between the obstetrics and surgery.

The diversity of skills in the multi-professional team is valued by the doctors in training and the consultants. Consultants felt that the team is cohesive and works well together. Doctors in training felt comfortable asking for advice and calling consultants in out of hours. This is supported by protocols developed jointly by the consultant team. Nursing staff are encouraged to feed back to consultants regarding trainee performance.

A multi-disciplinary team meeting is held every fortnight to discuss significant cases, trauma, mortality rates and triage targets within the emergency department. Higher specialty doctors in training are always released and contribute to the meeting fully. The head of the emergency department is very engaged with doctors in training and runs a robust teaching programme. Doctors in training have the opportunity to talk cases through with more senior members of staff, if required.

There is a high level of engagement with education from consultants and they have an extended presence at night time and weekends. Higher specialty doctors in training said that consultants are very supportive and night time cover is good, with ST3s being joined by an ST6 to ensure there is enough cover and trainee support.

## Trust Management

It is unclear how education and training feeds into LEP governance, and not understood by those to whom we spoke to in the hospital senior management meeting.

The education centre team is familiar with the operational tasks but lacks strategic support from the LEP at senior management and board level. While it was clear the education centre team are working hard and training was a very high priority for the head of the emergency department, there was little evidence of engagement with the training agenda at divisional level. We were advised by Senior Management that this was not a priority and that the LEP has bigger issues to deal with.

At a divisional level, training is not a priority and education is marginalised due to service pressures. The head of emergency medicine was very positive about educating the higher doctors in training in his department and developing them to become future emergency medicine consultants however this enthusiasm is diluted due to the pressures on service.

## Meeting current challenges in emergency medicine

The current workload and workforce is not sustainable and the LEP has said it will need to increase staff numbers with consultants soon to be covering the department 24 hours a day, seven days a week. The LEP is working with local general practice surgeries to offer feedback about inappropriate referrals.

## Conclusion

Our findings support the findings from the national training survey 2012 around feedback, induction, local teaching, study leave, adequate experience and overall satisfaction. There were below outliers in handover reported in 2012, although this is now working well with individual patient cases and board handovers taking place regularly. Regional teaching takes place every six weeks for higher specialty doctors in training and ACCS; this does sometimes coincide with night shifts, however didn't seem to be a significant issue for doctors in training. Workload is still high within the LEP as it is a major trauma centre and there is 24 hours a day and seven days a week consultant cover. The work is very intense.

## 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-](mailto:quality@gmc-)

[uk.org](http://uk.org) copying Health Education North East in by 30 September 2013.

<b>Response to findings</b>	Richard Bellamy, Director of Medical Education (DME)
<b>Good practice</b>	<p>The Emergency Medicine Department acknowledge the comments regarding good practice and continue to aim to improve training. This is evidenced by the excellent results in the GMC National Trainee Survey 2013. There were four green triangle outliers and no red triangle outliers and no lower quartile results. We believe that these excellent results are partly explained by the thematic allocation of educational supervisors. The Trust has acknowledged this in it's annual self-assessment report and aims to role out this practice more widely across the Trust.</p>
<b>Requirements</b>	<p>The Emergency Medicine Department produced an action plan immediately after receiving the GMC report. The term SHO has been removed from the rota and replaced with the specific training level of each trainee. All trainees have excellent access to training opportunities to meet the curriculum. This is evidenced by excellent ARCP results and excellent results in the GMC National Trainee Survey. Emergency Medicine was a green triangle outlier for overall satisfaction, adequate experience and local teaching demonstrating that trainees of all levels receive excellent training. Examples of training initiatives include:</p> <ul style="list-style-type: none"><li>• Higher trainees released to regional teaching programme.</li><li>• Timetabled in house middle grade teaching programme written with input from trainees to meet curriculum requirements.</li><li>• Standardised in house Junior trainee teaching programme to cover curriculum.</li><li>• One to one portfolio session for EM trainees with Consultants.</li><li>• All sessions above protected and in place for over 12 months.</li></ul>

## Recommendations

With regard to how education and training feed into the Trust's governance:

Within Emergency Medicine:

- All programmed teaching sessions occur in paid work time.
- Additional clinical cover is provided to release trainees to teaching.
- Junior trainees are supervised with 24 hour middle grade presence and 16 hour per day consultant presence.
- Trainees are instructed not to work beyond their competencies.
- All rotas are monitored and EWTD compliant.

Throughout the Trust:

- Education and training are core activities which are part of each directorate's and each division's responsibility. They are part of the quarterly performance review of each division by the chief executive and corporate directors.
- Education and training are monitored by self-assessment reports (SARs) and Quality action Improvement Plans (QIPs). These are active documents which should be regularly updated and discussed at each directorate and divisional governance meeting. They are submitted annually to the DME to contribute to the Trust's SAR and QIP to monitor progress and developments with training.
- The DME is accountable to the Trust Board for the delivery of high quality education throughout the Trust and must quality manage the training delivered by each specialty.

With regard to the outflow plan from the Emergency Department it is acknowledged that the huge annual increase in admissions has proved challenging. At times this has caused problems with patient flow and has created difficulties for the Emergency Department. The Trust is now making a huge investment in our front-of-house services in conjunction with a thorough analysis of procedures using a Rapid Process Improvement



Workshop (RPIW) methodology. This should improve future patient flow and ensure that intensity of work is appropriate to learning.