

Check	Targeted check
Date	18 December 2012
Location Visited	University Hospital of North Tees
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	Helen Richardson, Northern Deanery* Neil Halford, Northern 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 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

University Hospital of North Tees (UHNT) reported to the GMC during the audit of emergency department rotas, that there is consultant cover between 8am and 10pm Monday to Sunday and middle grade cover 24 hours a day. 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 reported this site had above outliers in clinical supervision, local teaching and overall satisfaction. In the October 2012 deanery report, the deanery highlighted as good practice that the North Tees and Hartlepool NHS Foundation Trust made provisions for a three tier rota and training programme. A three tiered rota is one whereby doctors in training are grouped into their competence and experience level. There were no patient safety comments reported from the national training survey.

North Tees and Hartlepool NHS Foundation Trust had 2,309 incidents reported to the Patient Safety Agency's National Reporting and Learning System (NRLS) between October 2011 and March 2012. However 59.4% of the incidents reported to the NRLS had no degree of harm to patients and 0.1% resulted in death.

*Health Education North East is referred to as Northern Deanery due to the time of the audit

**College of Emergency Medicine Statement

Summary of site

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: there are approximately 49,376 adult presentations in the emergency department and approximately 11,299 of these are admitted onto a ward in the hospital. There are 15,421 paediatric presentations in the emergency department each year with approximately 1,652 being admitted to a ward.

Until August 2011 there was also an emergency department at the University Hospital of Hartlepool, 15 miles from UHNT. There is now a small nurse led minor injuries unit in Hartlepool and all emergency department services are provided at UHNT. By bringing together staff and doctors in training on one site the LEP is able to adequately staff its rotas and provide appropriate safe patient care, clinical supervision and a good educational experience for its doctors in training.

There are currently 11 consultants (8.4 Whole Time Equivalent), covering 14 hours a day seven days a week. The department is recruiting another consultant, which will take the department to just over eight whole time equivalents. Ideally the department require 12 whole time equivalents in total to be sustainable. Consultants currently work one in four weekends.

Supervision in the department at night time is good. The LEP has a three tiered training rota which groups doctors in training by grade and competence. Those that are new to the specialty may be placed on the core rota to gain more experience before having further responsibility. Doctors in training are happy with the training they receive and there are many learning opportunities readily available to them.

The Report

Good practice

1.	Patient safety is a high priority for not only those in the emergency department but also senior management, and the LEP has many initiatives in place to manage this. (Domain 1)
2.	The LEP reviews and learns from patient safety incidents, to create better learning opportunities for doctors in training. (Domain 1 TD1.2)
3.	The consultants coming on shift in the morning hold regular 'board' meetings to review patients that doctors in training have treated overnight. This is a great learning opportunity for doctors in training. (Domain 1 TD1.6)
4.	All doctors in training receive feedback from the multi-disciplinary team who can each contribute feedback on different aspects of a trainee's performance and competence. (Domain 5 TD 5.19)
5.	The emergency department is proactive in managing transitions from one stage of training to the next and from inclusion in different tiers of the rota. (Domain 7 TD 7.3)

6.	There is clear commitment to education within the department. (Domain 6 TD 6.11)
7.	All doctors in training have access to clinical supervisors and organised handover arrangements. (Domain 1 TD 1.6)
8.	The LEP appoints educational supervisors thematically, focussing supervision against grade and reducing the number of curricula educational supervisors must engage with. (Domain 6 TD 6.3)

Recommendations

1.	The emergency department should review its relationship with the mental health trust and continue to work closely with it to ensure patients receive appropriate care. (Domain 6 TD 6.17)
2.	The department should take into account consultants clinical and educational duties when job planning. (Domain 6 TD 6.32)

Findings

Patient Safety

The medical director and director of nursing review serious untoward incidences (SUI) and complaints on a weekly basis. If a complaint or SUI indicates that a trainee had negative involvement in the case, then an action plan is created and individual feedback for the trainee is provided to the trainee via their clinical supervisor. All doctors in training in the emergency department receive feedback on incident reports and the outcome data in addition to a monthly newsletter.

Consultants hold a monthly meeting. This is held immediately after the multiprofessional directorate Patient Safety Meeting. This meeting is an opportunity to discuss any training requirements evident from patient safety incidents that have happened within the department. The outcomes of the patient safety meetings are used to improve the teaching programme and initial induction.

A 'communications diary' is reviewed as part of the meeting, this is a book and is used within the hospital to share complicated patient cases and issues and during board rounds to maximise learning.

Escalation policies are robust and fit for purpose. Nursing staff are empowered to call upon consultants when they require advice and doctors in training are aware of how to escalate a case to a consultant. We heard from doctors in training that pathways are found easily on the emergency department website and there is access to computers across the department.

The emergency department has been working closely with other departments within the hospital on patient flow which means patients are no longer bottle necked in the emergency department and can move onto the wards without delay.

We heard that until recently, there was no central point of contact in the mental health trust and that referral is often complicated and delayed.

Staff from the mental health trust are no longer based on the same site as the emergency department. There is a liaison psychiatrist on site who works Monday to Friday, 9am-5pm, a crisis team who work out of hours and in children's services. Doctors in training said that the liaison psychiatrist will respond and see patients on acute wards. However, the crisis team, who work out of hours, face major challenges in covering a large hospital with a limited number of staff. Doctors in training told us that if they contacted the crisis team to refer a patient, they usually do not have bed space and ask doctors in training to hold the patient until the following day.

There is a policy within the emergency department which states that if satisfactory response is not received within two hours from the crisis team, staff can escalate their concerns to the consultant on call.

The emergency department plans to appoint a new psychiatric team in February 2013 based in the hospital whose sole responsibility will be to look after psychiatric and elderly patients in the emergency department. A mental health fast track assessment has been introduced to refer patients to a psychiatric ward if they do not have a medical need to stay within the emergency department.

Induction

Equality and diversity is included as part of the induction process and doctors in training have to answer correctly a certain number of questions about equality and diversity before completing the induction. Equality and diversity is also part of the teaching programme at the beginning of the placement.

Handover

We heard from consultants that board round's utilising the Emergency Department Information System are held every morning and at other significant points during the day. Consultants review patient notes from the night shift.

At shift handover, a board round is completed which provides opportunities for junior doctors in training to talk through complex patient cases with more senior clinicians. Doctors in training said that this is a good opportunity to gain advice regarding patient diagnosis and that they value this time.

Feedback

We heard that nurses are very good at reporting issues regarding doctors in training directly to them, and if they don't feel comfortable with what a trainee is doing, they will call the on-call consultant during the night.

Each month consultants and nurses meet to discuss individual doctors in training' performance, strengths and weaknesses in order to provide tailored individual feedback and targeted learning needs.

Consultants perform a 'night card' review every morning of the cases that doctors in training dealt with overnight so they can give feedback. In addition to this, higher speciality doctors in training are invited to attend regular meetings to share learning and develop management skills.

Rotas

The hospital currently runs a three tiered training rota; middle grades, core doctors in training and foundation, with a separate and supernumerary foundation year 1 (F1) doctors' rota. F1 doctors do not work weekends or night times.

Doctors in training moving from the core to middle grade rota begin as supernumerary with long term established staff covering night shifts. The core rota allows doctors to learn new skills, such as supervising others and managing the department, before having to do so without direct supervision. Those who have not worked in emergency medicine before will be put on the core rota until they feel they have had enough experience to move to the next stage.

Teaching and Support

Continuing Professional Development weeks on the rotas are protected and there is a degree of flexibility to allow all doctors in training to attend courses and teaching outside of that week.

Doctors in training commented that there are always consultants or registrars available to complete their work place based assessments (WPBAs) and directly observed procedural skills (DOPS).

Staff are fully engaged with their responsibilities as trainers. The LEP releases all doctors in training for their training sessions and is responsive to trainee evaluation of the content. Internal relationships in the emergency medicine department are strong and there is capacity for good communication. Doctors in training commented that they are encouraged from induction to ask for support if required.

Consultants noted that they can hold training sessions around areas they have particular interest, for example the safeguarding leads holds regular training sessions on this topic.

We heard that there is a 'can do' culture amongst staff within the emergency department. All doctors in training are empowered to make decisions in a very supportive environment with learning opportunities readily available. Some doctors in training identified their experience at UHNT as the reason for them converting from a different training pathway to emergency medicine.

The LEP provides educational supervision and development opportunities for specialty doctors. This enables them to learn the skills needed to teach junior doctors in training.

Foundation and core doctors in training said that it was difficult to get their portfolio work done in clinical hours. They are expected to complete three reflective pieces of work a week, but struggled to find time in their shift to complete these, usually only completing one. We were told that the LEP is very flexible regarding circumstances and it will make allowances, should the trainee have a problem, one trainee was given extra time to complete their portfolio.

Many staff have worked for the LEP for a long time and acquired educational experience which was valued by the doctors in training. Doctors in training commented that there are always people around to offer advice or support.

Consultants we spoke to said that they are finding it difficult to find time for their educational role. They have a lot of clinical and out of hours work to deliver in addition to fulfilling their role of education supervisor.

Consultants currently work one in four weekends. Consultants advised that at present this works well, but that if they were to extend their shifts during the night, this would not be sustainable in the long term.

A review of programmed activities (PAs) is currently underway, with focus to ensure a consistent, appropriate distribution of PAs across governance, education and management in consultants' job plans.

Meeting current challenges in emergency medicine

LEPs are under pressure to deliver care within the four hour triage target while also maintaining quality of patient care. The strain on staff and resources within the emergency department is apparent; there is frequent burn out for doctors in training within this specialty due to the intensity of the work. UHNT has designed its rota in three tiers which compliments trainee supervision and teaching sessions. The staff we met at UHNT were very dedicated to education, support of doctors in training and the importance of retaining doctors in training in this area of medicine.

Conclusion

Our findings support the above outliers stated in the national training survey 2012 in clinical teaching, supervision and overall satisfaction. There were no below outliers from the national training survey and the LEP received no requirements as a result of the check.

Monitoring	The LEP 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 and copied to Health Education North East by 30 September 2013.
Response to findings	Mr Andrew Simpson, Clinical Emergency Care
Good practice	<p>It was extremely valuable to have so many areas highlighted as good practice, in particular those that contribute significantly to the quality of patient care delivered.</p> <p>The highlighting of both the commitment to education and supervision was extremely pleasing and is testament to the hard work put in by individuals to achieve this and a reflection of the general ethos of the trust in relation to medical education and training.</p> <p>The most welcome aspect of both the findings of the visit and the GMC trainee survey has been the positive feedback from our own trainees.</p> <p>In moving forward the highlighted areas of good practice will be used as a platform to build on.</p>
Recommendations	<p>In regard to the recommendations;</p> <p>1) Work was already in progress to improve the relationship between the directorate and mental health services and due to the hard work between staff in both the acute and mental health trust we now have a much better system in place. Liaison mental health staff are now based in the acute trust 24 hours a day providing an active presence in the Emergency Department. Patients who present at triage with a</p>

purely mental health related problem are now seen directly by mental health staff, others, such as those presenting with self-harm can have a joint assessment. This has improved care for patients and reduced the concerns of our own staff in managing this group.

2) A further consultant has been recruited and approval has been given to advertise for another. Consultant roles have been reviewed with in the directorate and re allocated taking into account all aspects of clinical, administrative and educational duties. Plans are in place to bring in electronic job planning into the directorate. The consultant rota now includes allocated trainee teaching sessions.