Audit

Closing the loop: feedback to accident and emergency SHOs on their referrals to hospital specialists

RSK Florance, N Garneti, N Burchett

Accident and Emergency Department, The Queen Elizabeth Hospital, Kings Lynn, Norfolk, UK

Objectives: To determine whether A&E SHOs in the Anglia and Oxford region receive regular case-specific feedback on their referrals to hospital specialists.

Methods: A telephone survey of an A&E SHO from each hospital in the region, using a semi-structured questionnaire and written protocol. The main questions asked were: (i) do you receive regular feedback about specific patients you refer to other specialties? If so, which one(s)? and (ii) do you think personal regular case-specific feedback about your referrals would be useful?

Results: Overall, 18 A&E SHOs and one staff grade were interviewed, one from each hospital (response rate 100%). Over the whole region, there were 106 hospital specialties to which A&E SHOs could directly refer out-patient cases. However, regular case-specific communication or feedback was received by the referring A&E SHO from only 5 (4.7%). There were 237 hospital specialties to which A&E SHOs could directly refer in-patients. However, regular case-specific feedback was received by the referring A&E SHO from only 3 specialties (1.3%). The A&E doctors at 18 of the 19 hospitals (95%) felt regular case-specific feedback would be useful. Of these, 13 (72%) would prefer written feedback – 5 (38%) would prefer a copy of the discharge summary or GP clinic letter, 6 (46%) a letter written specifically to the A&E SHO, 1 a letter to be sent via the A&E consultant, and 1 wished for 'any written feedback'. All 18 doctors wanted feedback from at least one of the specialties of general medicine, paediatrics, trauma and orthopaedics, and general surgery.

Conclusions: A&E SHOs in the Anglia and Oxford region do not receive regular case-specific feedback on their referrals to hospital specialists. Almost all A&E SHOs in this study would welcome it. The situation could be rectified by routinely sending them copies of clinic letters or discharge summaries.

Key words: Accident and emergency – Senior House Officer – Feedback – Training

The post of accident and emergency Senior House Officer (A&E SHO) is important in the provision of emergency healthcare and the training of junior doctors. These posts have both a service role and a training

commitment, with the training value widely recognised by the Royal Colleges.^{1–4}

The A&E SHO grade as a whole sees most A&E patients,⁵ and hence is an important gatekeeper to

Correspondence to: Dr Robert Florance, Consultant in Accident and Emergency, The Queen Elizabeth Hospital, Gayton Road, Kings Lynn, Norfolk PE30 4ET, UK.

Present address: N Garneti, Specialist Registrar in Trauma and Orthopaedics, Pontefract General Infirmary, Pontefract, West Yorkshire WF8 1PL, UK

specialists. However, SHOs are at an early stage in their careers. Their practice must, therefore, be based on knowledge and learning rather than experience. Although general appraisal of SHOs by their consultant trainer occurs regularly,⁶ it is increasingly apparent that, in order to learn effectively, doctors are likely to benefit from feedback concerning their management of individual patients, in a cycle of experience, reflection, theorising, and new actions.⁷

We wished to discover whether A&E SHOs in the Anglia and Oxford region received regular case-specific feedback on the cases they refer to hospital specialists and, if not, whether they felt that such feedback would be useful.

Methods

After a pilot survey, 19 A&E departments in the Anglia and Oxford region employing SHOs were identified from the British Association for Accident and Emergency Medicine's *Directory 1998/99*.⁸ Between 20 May and 3 August 1999, each A&E department was contacted by telephone, and a request was made to speak to an A&E SHO (or middle grade if no SHO was available). Each doctor interviewed had to have been in post for at least 2 months. The telephone survey was performed by a single interviewer and was informal in manner, but used a written protocol, and semi-structured questionnaire (available on request).

Results

In all but one of the 19 A&E departments in the Anglia and Oxford region, an A&E SHO was interviewed. At one hospital, the first A&E SHO contacted had only just taken up the post so another was interviewed; at another, an SHO was not available and so the interview was with a staff grade.

Out-patient referrals

Regular case-specific communication or feedback was provided by 5 out of 106 specialties (4.7%) receiving out-patient referrals, spread over 5 of the 19 hospitals (Table 1) 'Out-patient referrals' were defined as cases booked directly to a speciality clinic at the direction of an A&E SHO without consultation with a specialist.

Each of the 5 specialties giving feedback sent a letter to the referring A&E SHO. However, for one specialty, feedback was received from only one consultant firm out of several, and for another, the 'regular feedback' was actually sporadic letters of criticism.

Table 1 Proportion of hospital specialties giving regular case-specific feedback to A&E SHOs on their referrals to out-patients

	Specialties at		Total
	Base hospital	Non-base hospital	
Feedback	5	0	5 (4.7%)
No feedback	85	16	101 (95.3%)
Total	90	16	106

Base hospital – hospital in which A&E department is situated.

Non-base hospital – hospital away from site of A&E department.

Table 2 Proportion of hospital specialties giving regular case-specific feedback to A&E SHOs on their in-patient referrals

	Specialties at		Total
	Base hospital	Non-base hospital	
Feedback	3	0	3 (1.3%)
No feedback	166	68	234 (98.7%)
Total	169	68	237

Base hospital – hospital in which A&E department is situated.

Non-base hospital – hospital away from site of A&E department.

In-patient referrals

Regular case-specific communication or feedback was provided by 3 out of 237 (1.3%) specialties receiving in-patient referrals, spread over 3 of the 19 hospitals (Table 2) 'In-patient referrals' were defined as cases referred for immediate assessment or admission even if the patient was then discharged the same day or booked into a clinic by the specialist.

Two of the 3 specialties sent a letter to the referring A&E SHO and one wrote to the A&E consultant who, in turn, gave verbal feedback to the SHO. For one specialty, the 'regular feedback' was actually sporadic letters of criticism.

The A&E doctors at 18 of the 19 hospitals (95%) felt regular case-specific feedback would be useful; 13 (72%) would prefer written feedback, of whom 5 (38%) would prefer a copy of the discharge summary or GP clinic letter, 6 (46%) a letter written specifically to the A&E SHO, 1 a letter to be sent via the A&E consultant, and 1 wished for 'any written feedback'.

The A&E SHOs suggested that feedback would be most useful from at least one of the specialties of general medicine, paediatrics, trauma and orthopaedics and general surgery. A few, particularly those with definite non-A&E career intentions, felt feedback from their chosen career specialty would be most useful. Others preferred feedback from specialties of which they had little experience, to enhance their knowledge.

Discussion

The data confirm that A&E SHOs in the Anglia and Oxford region receive virtually no regular communication or feedback on specific cases they refer to specialist out-patient and in-patient teams. However, they would welcome it, preferably in written form.

A letter from the specialist could be sent via the A&E consultant to the A&E SHO. It could either be a brief note, or a copy of the letter to the patient's GP with an additional note to the A&E SHO if appropriate. The letters could be studied by the trainee and selected ones discussed, if necessary, with the trainer.

'Trainees are hungry for regular constructive feedback',⁹ and continuing professional development should meet the needs of the individual as well as the wider needs of the service.¹⁰ Not only would regular case-specific feedback reinforce good patient service, it would help to discourage poor practice. It would encourage adult-type learning which is 'based on and builds on previous experience', and 'involves cycles of action and reflection'. Indeed, the British Association for Accident and Emergency Medicine (BAEM) now recommends that SHOs should be sent discharge summaries concerning patients they have seen.¹²

A&E is important in training doctors in several branches of medical practice. The quality of their training is in the interests of many training bodies, including the respective Royal Colleges of Surgeons, Physicians, and General Practitioners. The surgical Royal Colleges have proposed competency-based assessment for higher surgical training.¹³ The Chief Medical Officer proposes to monitor all NHS doctors' practice by clinical audit and annual appraisal of their performance. This information may be used for re-validation.¹⁴ In addition, hospital Trusts 'are accountable for continuously improving the quality of the services and safe-guarding high standards of care, with accountability to the NHS Trust Board', and the Commission for Health Improvement is to inspect Trusts' clinical governance arrangements.¹⁰

We suggest that trainees, trainers and hospital Trusts should insist on the completion of this crucial part of the

training loop so that patient outcome can become more important in the continuous appraisal of a trainee's clinical performance.

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