Health Education England

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Quality and Regulation Team (London and South East)

North Middlesex University Hospital NHS Trust Emergency Department Review

Quality Visit Report

16 March 2016

Final Report

THE NHS CONSTITUTION

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Visit Details	
Trust	North Middlesex University Hospital NHS Trust
Date of visit	16 March 2016
Background to visit	The Care Quality Commission (CQC) carried out an inspection of services at the Trust on 3-6 June 2014 and 23 June 2014. The CQC found that the Barnet Enfield Haringey (BEH) strategy had affected the services provided by the Trust, increasing the workload and adding pressures to care for patients. The CQC found significant increases in patient numbers across the board from the Emergency Department (ED) through to the wards, to outpatients and within the end of life pathway, including the mortuary. The services were struggling with the additional workload and further work was required to ensure that the quality of service did not suffer as a result of the number of patients being treated. The CQC found that whilst the Trust had achieved much in absorbing increased numbers of patients, its infrastructure of staffing levels, training provision, complaints handling and governance had been stretched, and there had been an underestimate of the resources needed to maintain services at the current level. The Trust had failed to respond adequately to these issues. The Trust was required to: take action to improve its training – both mandatory and non-mandatory, and ensure that the lines of responsibility between ED and children's services over the responsibility for the paediatric ED were clear to staff during a period of change. Health Education England (HEE) conducted a conversation of concern at the Trust on 1 July 2015. Serious concerns were highlighted at the visit with regards to patient safety and the quality and delivery of education and training within emergency medicine. A subsequent informal visit was organised for November 2015 where trainees interviewed seemed happier than they had previously been in July 2015, although problems persisted. HEE shared the findings of the July 2015 conversation of concern with partner organisations. Due to the number and breadth of quality and safety concerns, the Risk Summit process was triggered by service commissioners in July 2015. Whilst there was agreement by system leaders that there was not an immediate risk to patient safety, an extended round table meeting was convened to review the challenges and agree actions required for sustainable improvement. In January 2016 the Risk Summit process was again triggered due to concerns about the protection of quality and safety in the emergency department (ED). The outcome of the Risk Summit included the production of an improvement plan and a quality and safety (Q&S) dashboard. Given that HEE was organising a multi-professional Trust-wide review of the Trust, it was decided to conduct a full pathway emergency department review to explore the following key lines of enquiry and to ascertain if any progress had been made since the earlier visits: • Review levels and quality of supervision in the emergency department, particularly out of hours • Review quality of educational and clinical supervision • Review the current departmental culture and ascertain whether the previous perception of bullying and undermining had been resolved • Explore whether pressure to meet four hour targets was impacting on training opportunities and quality of care • Review the provision, accessibility, quality and utility of clinical guidelines and protocols • Review the clinical governance arrangements within the department and in particular the arrangements for reporting and feeding back on clinical incidents • Review the management of paediatric cases within the ED

- Review the quality of formal and informal teaching for all training grades within the department

The Trust provided Health Education England with the following summary of approximate staffing levels (excluding trainees) in the ED on the day of the visit, 16 March 2016:

Staff group	WTE establishment	WTE in post
Consultant	14	9 (3) locums
Middle Grade (Trust Doctors)	11	7
Juniors (Trust Doctors)	12	10.5
Emergency Nurse Practitioner	14	9.9
Band 7 Nurses	7	5
Other Qualified Nurses	72.7	66.95
Healthcare Assistants	19.9	12.65

The visit team also heard that there were foundation doctors, general practice trainees, higher specialty emergency medicine trainees, and acute care common stem trainees working in the department.

Visit summary and outcomes

The visit team met with a number of staff members from the executive team and postgraduate medical education team, as well as two higher specialty training year four (ST4) trainees, 11 foundation year two trainees (F2s) who were working or had previously worked in the Emergency Department (ED), the college tutor for emergency medicine, two educational supervisors for emergency medicine, a healthcare support worker (currently undertaking the Care Certificate), three second year student nurses (adult nursing), a practice development nurse, the lead for resuscitation, a mentor and a matron.

The visit team heard from all levels of staff that the emergency department had the potential to be an excellent place to train, as a busy department with a wide range of clinical presentations.

Nursing and support staff were commended by doctors for their expertise, hard work and the support they provided to all colleagues.

Support from some senior staff members, particularly three consultants, was also reported to be excellent.

Nursing students/learners and educators noted a positive learning experience within the ED and good educational opportunities for postgraduate learning, particularly highlighting the preceptorship, emergency nurse practitioner and leadership programmes.

Student nurses reported an effective departmental induction and support from the practice development nurse.

Notwithstanding these positive findings, staff members at all levels felt that there was a lack of clinical leadership in the department. It was clear to the visit team that since the interim clinical director only worked 2 days per week, this was not sufficient to provide the appropriate level of clinical leadership that this department required. None of the medical trainees interviewed would recommend the ED for treatment to their family and friends and this was principally because they felt that the department was unsafe. The visit team heard from staff at all levels that there was a resistance to change within the department and that the sheer volume of workload seemed to be used as an excuse to avoid addressing any of the department's problems.

	The visit team uncovered a number of serious areas of concern and issued the Trust with three immediate mandatory requirements to address the following issues: • The visit team heard instances of F2 doctors, acute care common stem trainees (ACCS) and general practice (GP) trainees being left unsupported in the emergency department at night with neither middle grade nor senior on-site presence. • F2s, ACCS and GP trainees were frequently left in the paediatric emergency department with no competent senior support within the department, having had limited induction even before their first set of nights. • The visit team heard about items of equipment such as syringe drivers, infusion pumps, defibrillation pads, pulse oximeters, end-tidal CO2 monitors that were either unavailable or damaged and therefore not available for immediate use in the resuscitation area. Furthermore, the following areas for improvement were also highlighted to the Trust: • Handover (doctor to doctor) was reported to be of variable quality and on many occasions did not occur on the night shift before the consultant went home. • Concerns were raised over the availability of senior staff if the trainees and learners requested their assistance out of hours. • Issues were raised about the competency of some staff, specifically certain consultants and approximately 70% of the Trust middle grade doctors. As a result of this, there were concerns about patient safety – this was exacerbated by the high volume of patients coming through the department. The department was reported to be 'unsafe, unsupported and relentless'. • Concerns were raised about incident reporting – the visit team heard of at least one incident where a trainee was asked not to submit a Datix form and was instead advised that the issue would be dealt with internally. • There was no robust system in place to ensure that there was good learning from clinical incidents and trainees rarely received feedback on incidents they reported. • The visit team heard that staff members finishing work at 2am were left to make their own arrangements for travel home and they were not aware of parking permits to park at the hospital. • The nurses reported that it was difficult to persuade some doctors to attend multidisciplinary meetings/teaching sessions. • The nurses reported being regularly pulled from training opportunities (including ILS – immediate life support) to cover service responsibilities. Similarly, foundation doctors and higher trainees were unable to attend their dedicated teaching sessions due to service commitments. • Key staff with responsibility for patient safety seemed unaware of the recent introduction of a quality and safety dashboard (which had been introduced since the risk summit). It was clear to the visit team that there were a number of service-related issues that were in turn impacting on the quality of education and training provided in this department. The conclusion of the visit team, therefore, was that whilst there had been some improvements a great deal of work was still needed to bring the quality of education and training conducted in the ED to the required standard. The visit team suggested that options might include increasing the GP provision within the urgent care centre to 24 hours which would alleviate some of the workload pressure on the trainees and learners working within the ED. It was also apparent that strong clinical leadership was required to drive change in the department, which would hopefully lead to an improvement in

	morale across the department. The visit team was also keen to learn more about the external cultural review which had been commissioned at the Trust.

Visit team			
Lead Visitor	Dr Chris Lacy, Interim Head of London Specialty School of Emergency Medicine	**CCG Representative**	Jennie Williams, Executive Nurse and Director of Quality, Haringey Clinical Commissioning Group
Trust Liaison Dean	Dr Andrew Deaner, Trust Liaison Dean, Health Education North Central London	**GMC Representative**	Dr Russell Peek, Consultant Paediatrician, Gloucestershire Hospitals NHS Foundation Trust
Lay Member	Caroline Aldridge	**Lead Provider Representative**	Dr Emma Young, Consultant Emergency Medicine, UCLP Representative
Scribe	Jane MacPherson, Deputy Quality and Visits Manager	**Healthcare Professions Representative**	Louise Morton, Associate Dean for Healthcare Professions, Health Education England, North Central East London Office

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	Requirement / Recommendation
GMC Theme 1) Learning environment and culture			
ED1.1	**Patient safety** Trainees, trainers and learners at all levels of the organisation reported that they had serious concerns about patient safety within the emergency department (ED), particularly out of hours. None of the staff members interviewed felt that there were sufficient staff numbers (medical and nursing) for the volume of patients attending the ED. This was exacerbated by increased patient attendances following the Chase Farm closure and a local population, which was reluctant to access primary care services. The visit team heard numerous examples of patient safety potentially being compromised, as a result of a perceived dysfunctional department, the high volume of patients coming through the department, and inconsistent senior support. Furthermore, issues were raised about the competency of a significant number of senior medical staff. Trainees (at all levels) and nurses agreed that there were a number of consultants whose capability they had little confidence in, and this led to a difficult working environment, particularly out of hours.	The Trust must provide senior support to the paediatric emergency department, 24 hours, 7 days per week by doctors with appropriate paediatric competences.	Immediate Mandatory Requirement

	The higher trainees reported that although they rarely called their consultants overnight, when they did, the quality of advice given by consultants was variable; they added that at times some of their consultants had been reluctant to come into the hospital to assist. Most trainees reported having to deal with situations beyond their competence without appropriate supervision on a regular basis. The trainees stated that they often finished their shift and returned home full of anxiety that they had not been able to provide care at an appropriate level. The visit team heard examples of lengthy waits for treatment, for example, a patient having to wait an excessive amount of time for an electrocardiogram (ECG). The visit team heard that only 65% of patients who presented with chest pains obtained an ECG within 15 minutes, although this was supposed to be 100%. The visit team heard that foundation year two doctors (F2s), acute care common stem (ACCS) and GP trainees were frequently left in the paediatric emergency department with no competent senior support within the department, having had limited induction even on their first set of nights. The F2s reported that their induction to paediatric ED had focused on child protection and had only lasted for one hour; in general they felt ill-equipped to deal with paediatric patients. The visit team heard that the ED consultant on duty worked until approximately 11pm or midnight, and sometimes stayed until 2am. After the consultant had left, the F2s felt they were expected to call the paediatric higher trainee directly to request assistance but this trainee was located in the paediatric department, which was located in another part of the building and at times was unable to assist due to other workload pressures in the paediatric department. This was corroborated in the Trust Wide Review, which took place on the same day, 16 March 2016. The F2s reported that they regularly had to deal with complaints from patients (and family members) about the service that the Trust was providing. The visit team heard that foundation doctors (FDs) had been reduced to tears by the sheer volume of patients they had to deal with (for example 200 patients and a six hour wait) and they felt that they regularly had to send children home without having discussed their case with anyone senior. They corroborated the EM higher trainees' view that it was often difficult to access appropriate senior advice, particularly when at times they did not feel confident about the advice they received. Some FDs also added that they had lost confidence in their own ability as a result and were nervous about making incorrect decisions. The FDs praised the nurses for their support, however, and also commented that many of the paediatric consultants were good at providing feedback and offering assistance. The visit team heard that the paediatric higher trainee was previously based in the paediatric ED and therefore was more easily accessible in hours and out of hours (24/7). The visit team heard that a 'winter pressures' paediatric consultant was deployed to the paediatric ED in the afternoon / evening from 2pm to 10pm. This extra person had proved very useful.	The Trust should note that the subsequent conversations between HEE, the Trust and partner organisations emphasised that the Trust must provide resident competent 24/7 senior support and supervision to all trainees working within the emergency department at all times. Out of hours this can be provided by a competent Trust EM middle grade doctor or a higher EM trainee with a competent consultant on call. The Trust should note that the HEE & Royal College of Emergency Medicine (RCEM) definition of competent senior support is defined as a senior doctor with appropriate emergency medicine competences for the grade at which they are employed (see 'Medical & Practitioner Staffing in Emergency Departments' guidance - RCEM Feb 2015). There should be a minimum of one ST4 or competent equivalent present in the department at all times. The Trust is required to provide a clear escalation plan to advise trainees when to call the on-call emergency medicine consultant in the event of excessive waiting times and/or unsafe working conditions.	Immediate Mandatory Requirement Mandatory Requirement

	The visit team heard instances of F2 doctors, core medical trainees and general practice (GP) trainees being left unsupported in the emergency department at night with neither middle grade nor senior on-site presence. Both higher trainees and FDs reported that some Trust middle grade doctors avoided assisting them in the resuscitation area preferring to stay in the minors area. The visit team was also informed that on one occasion when there were no higher trainees or Trust middle grade doctors on duty at night; when a consultant was contacted to request assistance, the consultant had allegedly refused to come in to help. When the higher trainee had realised what had happened at handover the following morning, the higher trainee had proactively swapped her shifts so that she could work nights for the rest of the week so that this problem did not reoccur and in order to support the FDs on duty. The FDs and nurses all praised the higher trainees for their support, dedication and enthusiasm. The visit team heard that out of hours, when patients were breaching the waiting time target, the site manager called the on-call manager who in turn called the on-call executive or the on-call consultant directly. It was reported that although many consultants would remain in the hospital beyond their recognised hours it was rare for consultants to return to the hospital at night to help with the long waits. The higher trainees said that they felt there was no clear escalation plan for what should happen when waiting times became long during the night or the department became unsafe. On one occasion a higher trainee was told by a consultant only to call if "you are unable to off-load blue calls". Some of the nurses interviewed agreed that consultant cover at night was often poor and that there was variability in the consultants' skillset and enthusiasm for training; furthermore, it was reported that many of the better Trust middle grade doctors had left the Trust, which had resulted in a loss of enthusiastic and inspiring leadership within the department. The visit team also heard that a number of senior nurses had recently resigned and this was felt to be largely due to 'burn-out' as a result of the heavy workload at the Trust. There was a perception amongst the nursing staff interviewed that some nurses came to the Trust, with the intention of only staying for a short time before moving elsewhere. They considered this particularly the case amongst overseas nurses. The educational supervisors interviewed all felt that expanding the GP service overnight would help alleviate the workload. At the time of the visit the GP service was only available until midnight. The visit team heard about items of equipment such as syringe drivers, infusion pumps, defibrillation pads, pulse oximeters, end-tidal CO2 monitors that were either unavailable or damaged and therefore not available for immediate use in the resuscitation area. This caused delays and made working the ED very difficult. The visit team heard that this problem was because nobody had restocked the equipment in the resuscitation area.	Consider expanding the GP service to offer a 24 hour service. Ensure availability and serviceability of all emergency equipment including items mentioned to the left.	Recommendation Immediate Mandatory Requirement
ED1.2	**Serious incidents and professional duty of candour**		

	The director of nursing informed the visit team that there were weekly ED meetings which members of the executive team attended to discuss any incidents and encourage open and honest communication. He informed the visit team about the recently developed quality and safety dashboard. However, none of the ED staff members interviewed appeared to be aware of this dashboard. The interim director of education informed the visit team that the Trust was keen to further develop the serious incident reporting process and improve the feedback loop. The director of nursing reported that when Datix forms were completed, the reporter received an automated email response. If the incident related to medicine, it would be sent to the relevant clinical director and if it related to nursing, it would be sent to the relevant matron. If an investigation were required, a neutral investigating officer would be appointed. He added that a new system had been introduced whereby the reporter would receive a copy of the serious incident report and outcome. The interim director of education informed the visit team that incident reports were discussed at local governance committees and local faculty group meetings, and that trainee representatives were expected to feedback to their colleagues. The director of medical education stated that if trainees were involved in serious incidents, he arranged to meet with them and to offer appropriate pastoral support. The director of nursing also reiterated that administrative, debriefing and pastoral support was provided and that the educational supervisors were also involved in this area. The visit team heard that a student nurse forum took place every few weeks, led by the assistant director for multi-professional education and her team, which the director of nursing or his deputy intended to attend more regularly in future. The higher trainees interviewed felt that if they raised issues they were not escalated but rather were met with resignation. They highlighted that they had completed Datix forms several times per week regarding poor equipment, for example, but rarely had any issues been resolved and they did not routinely receive feedback about what actions had been taken in response to the concerns raised. The visit team was informed of an occasion when a Trust middle grade doctor had allegedly not provided appropriate advice regarding a patient with a cocaine overdose and abdominal pain. The patient was discharged home but subsequently returned with an acute abdomen that required emergency surgery. When this issue was raised with the trainee's senior colleagues, the trainee was allegedly asked not to submit a Datix report and advised that the matter would be dealt with internally. The trainees were aware that previous issues had been raised about the competency of the particular Trust middle grade doctor. The pre-registration nurses and healthcare support worker were aware of the Datix process although none had completed any forms.	Conduct an audit of the new Datix feedback system to ensure that trainees and learners are receiving appropriate feedback reports on the issues that they have raised. (See action TWR Ref 1.2 on action plan). The Trust should review their processes for dealing with near misses involving medical staff.	Mandatory Requirement Mandatory Requirement

	The college tutor and governance lead reported that she discussed any serious incidents with a risk coordinator on a weekly basis. She informed the visit team that she conducted audits and subsequent re-audits to see if the issue reported had improved or worsened. The visit team heard that any learning from serious incidents was discussed at departmental mortality and morbidity (M&M) meetings. Unfortunately the trainees interviewed were rarely able to attend these meetings due to their service responsibilities. In general, staff members at all levels did not feel that they received good feedback on the issues and incidents they had reported. However, the visit team heard from nurses of one positive attempt to tackle timekeeping problems after this had been raised as an issue at a multidisciplinary meeting, and this had been largely successful.	Ensure that trainees are released to attend M&M meetings so that they can take advantage of this important learning opportunity.	Mandatory Requirement
ED1.3	**Appropriate level of clinical supervision** The visit team heard that the higher trainees' night rota started at 10pm and finished at 8am; a Trust middle grade doctor started at 11pm and another at midnight. The higher trainees reported that they were on a one in six rota and that when they were working night shifts they were supernumerary. The higher trainees reported that they knew who to contact for advice but that in hours it was unclear which area a consultant was responsible for. Out of hours they often felt uncomfortable running the ED, particularly given the volume of patients in the department and the paucity of relevant training they had received. The trainees reported that board rounds did not routinely take place at night unless the higher trainees proactively instigated them. The matron interviewed reported that she felt that student nurses were well supported by their mentors at night, as particular effort was made to ensure that students on night duty were allocated to work alongside an experienced mentor. None of the student nurses interviewed had yet undertaken night duty. The trainees reported that they only had confidence in approximately 30% of the Trust middle grade doctors. They reported that many Trust middle grade doctors were unfamiliar with resuscitation procedures and higher trainees gave examples of inappropriate, unsafe sedation practices by Trust grade doctors. The visit team heard that a significant number of the Trust middle grade doctors were not advanced life support (ALS), advanced paediatric life support (APLS) or advanced trauma life support (ATLS) trained. This issue had actually been placed on the risk register. It was reported that the Trust management had been proactive about offering support and funding to put on courses, but that some of the Trust middle grade doctors had refused to attend the courses. The visit team did hear that two consultants and two Trust middle grade doctors had undertaken a	The Trust to ensure an educational board round process is implemented at appropriate shift change over times. Ensure that all Trust middle grade doctors are up to date in at least two of the three life support courses (ALS, ATLS & APLS) and are performing at a level suited to their level of responsibility in the department. These senior clinicians should be able to supervise a department alone with remote support and	Mandatory Requirement Mandatory Requirement

	course recently, but there was still clearly a lot of work to be undertaken. Higher trainees reported that on occasions at night there were no ATLS qualified staff on duty in the Trust to lead trauma calls and that trauma calls may be led by FDs. The educational supervisors suggested that since the workload was so arduous, perhaps some of the Trust middle grade doctors were reluctant to use up their free time to attend courses. They corroborated the trainees' opinion that some of the middle grade doctors were not sufficiently trained and were reluctant to assist in the resuscitation area, and that this impacted hugely on everyone else's workload and morale. It was clear to the visit team that many of the doctors were given middle grade responsibility despite lacking competence or capability to work to this level. The appraisal process for the Trust middle grade doctors was unclear.	possess some extended skills (see RCEM Feb 2015). The Trust is encouraged to work with HEE NCEL to devise an appropriate training programme for Trust EM middle grades to improve the competences of current middle grades, and to enable successful recruitment to rota vacancies to ensure that there are sufficient middle grades to supervise FD and core trainees out of hours when there is no consultant present. The Trust is required to ensure that all staff supervising trainees, including Trust middle grades, undergo a robust appraisal process.	Recommendation Mandatory Requirement
ED1.4	**Responsibilities for patient care appropriate for stage of education and training** The two higher trainees reported that the environment was busy and stressful and that whereas they had been closely supervised at their previous Trust, they had had to quickly learn how to run the ED when they arrived at the Trust. The FDs all reported that they had felt very anxious when they had first started working at the Trust and remained so while attached to the ED. One FD reported the ED was "beyond stressful" and often cried when back at home after a shift. None of the nursing learners felt that they had been asked to work beyond their competence. They all agreed that working in the ED had been overwhelming at the start particularly if they had to work in the resuscitation area on their first day but they reported that staff members were on the whole supportive. They felt that there was a good friendly atmosphere in the department. They also reported that the matron was very hands-on.	The Trust is required to provide details of the support plan in place that ensures all trainees and learners have access to appropriate timely psychological and mentoring support during this difficult period of Trust recovery.	Mandatory Requirement
ED1.5	**Rotas** During the meeting with the senior executive team, the director of nursing's presentation highlighted a workstream which had commenced to review the hospital at night system. He reported that there was ED consultant cover from 8am to 11pm and ED matron / band seven presence on a 24 hour / seven day a week basis. The visit team heard that the critical care outreach team (CCOT) service had expanded to 24/7 since December 2015 and that on the whole feedback regarding CCOT had been positive. The exception to this was regarding the interaction with the critical care outreach and ITU teams. This		

	had been issued as an immediate mandatory requirement on day one of the visit, 15 March 2016. The visit team also heard that the nursing presence overnight included band seven nurse practitioners. Safe staffing levels were reportedly maintained at 1:4 in the ED and 1:8 across the Trust. The higher trainees and FDs informed the visit team that they regularly worked beyond their hours and rarely took breaks. The FDs reported that it was not unusual on nights to work in paediatrics or the resuscitation area all night without a break, due to the constant pressure of urgent cases waiting to be seen. Some commented that they had worked three out of four weekends, with the fourth weekend being counted as annual leave or a post-nights weekend. Other trainees reported working shift patterns that only had one day off per week in a four week period. None of the trainees interviewed had completed a diary card exercise. They reported being unable to access the monitoring system. The visit team heard that at times trainees were not given sufficient time off between their shifts, as required by European Working Time Directive (EWTD). Some trainees reported that they were not given any time back in lieu of the bank holidays they had worked until a solicitor friend had emailed the medical director to complain. In addition they said that their study leave was allocated to fixed days in their rota and so they were unable to use it constructively as it did not coincide with their learning needs. They reported that study leave was often rostered for days immediately after twilight shifts rather than being set as rest or days off. The educational supervisors informed the visit team that the ED saw 181,000 patients in the year ending April 2015 and was the biggest single receiving Trust of ambulances in the London area. It was reported that on average the Trust received 120 ambulances per day. The educational supervisors stated that the number of consultants was insufficient. The Trust had funding for 14 but at the time of the visit there were only six substantive and three locum consultants (of whom eight worked as supervisors). The visit team also heard that there were three or four gaps in the middle grade rota which the department had been unable to fill. The process for filling gaps in the rota was reportedly ad hoc and often left to the last minute. The visit team heard that the department did not have sufficient clinical staff to handle the significant number of patients who presented at the ED. Initial assessment of patients attending by ambulance was done by nurses (with little to no medical input) and was of variable quality. The trainees stated that the nurses were in no way to blame for this problem, which was due to the large number of ambulances arriving, which inevitably meant that the nurses needed to triage patients more quickly than they would have liked. The pre-registration nurses interviewed confirmed that if patients came in by ambulance, they were taken to the rapid assessment unit where the paramedics handed them over to the nurses. The student nurses explained the categorisation process to the visit team regarding how patients	The Trust to conduct a robust diary card exercise for all trainees of all grades (F2, GP, ACCS, EM higher) working in the ED. Trainees should be encouraged and enabled to participate. The Trust to ensure that all trainees receive appropriate adequate breaks, especially on night shifts. The Trust to provide to HEE NCEL the Emergency Department Foundation, ACCS and ST4+ higher trainee rotas from August 2015 - May 2016. The Trust should continue to work with partner organisations to formalise the consultant recruitment process to ensure a robust strategy to recruit to the 14 funded posts in a timely fashion. (In setting this requirement HEE NCEL notes the attempts made by the Trust to fill consultant vacancies previously, and also notes the national context of recruitment challenges to consultant emergency medicine posts. However, it must be noted that the current consultant numbers are well below the RCEM Feb 2015 recommendations of a minimum of 16	Mandatory Requirement Mandatory Requirement Recommendation

	were prioritised.	consultants to provide cover until at least 10pm seven days per week).	
ED1.6	**Induction** The higher trainees reported that they felt welcomed and valued when they arrived at the Trust. They were given an induction initially, however, which was more suited to FDs. None of the trainees had received any guidance on 'how to be a middle grade' and the guidelines and pathways they received were out of date. The nursing learners were positive about their induction to the department, reporting that they received an introductory booklet on their first day and had a morning-long induction which included a tour and explanations about who their mentors were and what they would be doing for the next five weeks. The learners reported that they were given a list of their three mentors for each of their subsequent posts. The healthcare support worker also reported that he was given an appropriate induction. He had also been allocated a dedicated mentor prior to arriving at the Trust. However, all the student nurses reported a delay of up to two weeks (in a five week placement) with their initial interview i.e. receiving their initial interview almost at the point when they should have been having their mid-placement meeting. None had a date planned for their midway interview. The student nurses reported that they had requested their initial interview from mentors but that it did not happen until they escalated their request to the placement coordinator. The practice development nurse had instigated regular meetings with the students to ensure that their assessment requirements were being met. The student nurses all felt that the quality of supervision/feedback they received depended on who was on duty but all noted that they had not been left unsupervised.	All trainees should receive an appropriate induction suited to their level of training. Guidelines and pathways should be reviewed and updated where they are found to be out of date. The Trust should take steps, in conjunction with the relevant university, to ensure that all students meet with mentors in a timely manner.	Mandatory Requirement Mandatory Requirement Recommendation
ED1.7	**Handover** The student nurses confirmed that they had a general handover every morning followed by a smaller nurse-to-nurse handover in each area. The medical team and senior nurses had a separate handover. Nursing staff started at 7.30am whereas medical staff started at 8am. The quality of handover was reported to be variable out of hours. The visit team heard that at times patients were handed over three times in one shift without medical input. The practice development nurse informed the visit team that she had hoped to introduce a handover which was attended by both medics and nurses but the biggest stumbling block was trying to persuade the medical staff of its potential benefits. The visit team was told that whilst senior nurses attended the medical handover there was no	Ensure that the quality of handover out of hours is improved, so that patients are not being handed over on numerous occasions without clinical review. The Trust to ensure that a robust, recorded, structured and safe consultant-led handover occurs with the middle grade or higher trainee every evening before the evening consultant goes home.	Mandatory Requirement

	whole team handover in the department. Concerns were raised by the higher trainees that there was no system to ensure safe clinical handover of the department from the consultant to the Trust middle grade doctor / ST4 when the consultant left the department in the late evening.	Consider introducing a multidisciplinary handover that both medics and nurses attend.	Recommendation
ED1.8	**Protected time for learning and organised educational sessions** The higher trainees reported that they were rarely able to attend their formal teaching on a Wednesday afternoon due to their busy workload. The F2s informed the visit team that they were rarely able to attend any teaching sessions (including the ED teaching session) and had in fact been informed during their induction that they would not be able to attend the dedicated Trust F2 teaching. They reported that when they had on occasion been able to attend the three hour session on a Wednesday morning, the quality of teaching had been good. Please note that the visit team was not able to meet any ACCS trainees. Nursing staff reported all grades of staff being regularly pulled from training opportunities (including ILS) to cover service responsibilities.	FDs should be released to attend trust-wide F2 bleep-free teaching when they are on shift. They should also be released to attend departmental teaching. The combination should ensure that they attend 70% of teaching as recommended by the Foundation School. Ensure that all ACCS and higher trainees are released to attend their dedicated departmental teaching sessions and that their workload is covered in their absence. The teaching sessions should be clearly indicated on their timetables.	Mandatory Requirement Mandatory Requirement
GMC Theme 2) Educational governance and leadership			
ED2.1	**Effective, transparent and clearly understood educational governance systems and processes** The director of nursing included in his presentation details regarding enhanced ED governance, as follows: • Daily assessment of hourly rounding • Daily assessment of patient experience • Daily (Monday to Friday) walkabouts by director of nursing and medical director • Internal reporting and assurance • External reporting and assurance • Daily silver meetings It was reported that the head of nursing made sure that hourly rounding took place and that daily breach analyses were conducted.		
ED2.2	**Appropriate system for raising concerns about education and training within the organisation**		

	The interim director of education informed the visit team that local faculty groups (LFG) needed further development and that they were in varying stages of maturity. It was reported that two LFG meetings had taken place in the ED in 2016 thus far. Although trainee representatives reportedly attended these meetings, there was no evidence that trainees had attended in the ED LFG minutes provided. It was unclear to the visit team what if any actions were taken from these meetings, and if outcomes from these meetings were escalated within the Trust's educational governance structures. The trainees reported that they regularly escalated issues, but felt that their consultants were powerless or reluctant to deal with them. The matron, on the other hand, informed the visit team that when she had raised issues regarding stock of consumables and equipment to the director of nursing he had recently authorised her to order what was needed.	Create terms of reference for the LFG and ensure that there is a robust governance and accountability process. It should be possible to clearly evidence to the trainees that issues raised in the LFG meetings are subsequently addressed. The visit team did not have an opportunity to talk with the ACCS trainees - please ensure that there is an appropriately constituted trust-wide ACCS LFG with trainee representation from all ACCS stems.	Mandatory Requirement Mandatory Requirement
GMC Theme 3) Supporting learners			
ED3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** Trainees reported that they were not given parking permits to park at the Trust nor were they reimbursed for transportation costs when they had to travel home after their shift in the middle of the night. The visit team was concerned about the safety of trainees travelling home (often by bicycle) at 2am.	Trust to allocate parking permits to staff members who work out of hours or consider alternative arrangements to promote staff members' safety when they leave the Trust in the early hours.	Recommendation
ED3.2	**Behaviour that undermines professional confidence, performance or self-esteem** Trainees at all levels reported that at times the atmosphere in the department was not conducive to a supportive working environment. Trainees gave examples of recent instances when they had felt bullied, when consultants had shouted in public areas and when doctors and nurses had been undermined and demoralised. Trainees reported having been shouted at in front of patients, medical and nursing colleagues; they also commented that feedback from consultants was not always constructive. Trainees confirmed that there were three consultants who were the alleged main culprits of the bullying behaviour, the details of which will be passed to the Trust Medical Director in confidence by HEE. One trainee reported an incident when a consultant arriving late for a handover had bellowed at colleagues in front of patients and other staff members. The visit team was told that this incident was escalated to seniors Relationships between one consultant and the higher trainees had disintegrated so much that the	The Trust to ensure that a robust reporting procedure is in place to record continued instances of bullying and undermining behaviour. Trainees to be appropriately supported and encouraged to report witnessed unprofessional behaviour. Trust to undertake a survey all EM trainees (FD, ACCS, GPVTS & Higher EM) in June 2016 to monitor for Trust effectiveness in stopping undermining & bullying behaviour. Trust to ensure that a mandatory training programme is provided for all ED staff outlining acceptable and unacceptable professional	Mandatory Requirement Mandatory Requirement

	higher trainees tried to avoid working with the consultant for fear of being admonished in public. All of these issues had been raised with senior staff at the Trust (and in earlier visits). The trainees were aware that a new clinical director was due to be appointed who they hoped would be able to bring about change in the department. They also confirmed that they had been allocated a neutral mentor from another Trust who was very supportive. The FDs stated that when uncertain about the standard of clinical advice given by a consultant or by a Trust middle grade doctor, they would speak to the on-call medical higher trainee or the emergency medicine (EM) higher specialty trainee, if on duty. The visit team was informed about one incident when an FD, who had recently completed ALS, had not agreed with the management advice given to her by one consultant, but her suggestion for alternative treatment had been ignored and belittled. Trainees at all levels confirmed that they had learned who to approach for advice and who to avoid. However, they commented that they felt at times ethically challenged since they had to choose between following advice that they perceived to be potentially inappropriate from a senior clinician or follow their own clinical plan. The F2s all felt that when they had suggested alternative treatment to some of the consultants, their suggestions had met with a strong, negative response. They often feared that they were learning the incorrect method of dealing with patients. The FDs all stated that the ST4 emergency medicine trainees were much more supportive than the Trust middle grade doctors and went above and beyond their normal duties and working hours to support them and the department. The nurses also agreed that some of the senior clinicians and Trust middle grade doctors were more approachable and capable than others. The nurse learners and healthcare support worker felt that in general staff members were friendly despite the work pressures. The matron felt that some of the previously raised issues with regards to bullying and undermining had been tackled as at least one of the alleged culprits was leaving or had left the Trust. She conceded that at times behaviour from some of the senior colleagues was less than professional.	standards and highlighting Trust Bullying & Harassment policies and reporting procedures. Medical Director to provide confidential report to HEE London on the investigation and action taken following these disturbing disclosures.	Mandatory Requirement
ED3.3	**Mentorship** The visit team heard that many nurses in the department wanted to undertake the mentorship course and therefore a competitive entry process had been introduced which included an interview where a candidate had the opportunity to demonstrate that they had the requisite attributes to be a good mentor. The visit team heard that there were 20 mentors in post with an additional 10 undertaking the mentorship programme which would finish in April 2016. The mentorship programme was funded by the Trust. The nursing mentors informed the visit team that they were ‘playing catch up’ in regard to annual		

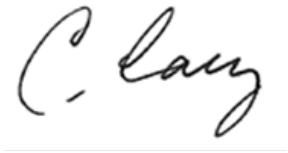
	mentorship update compliance. They considered this was related to workload and that some mentors would not have realised that their update was overdue. They felt that staff understood the requirement for annual update. The department had arranged a series of update sessions up to June 2016 and there were mentors booked onto these. It was less clear what the arrangements were in the department and Trust for triennial review. The nursing team was unclear as to whether all mentors understood the requirement for triennial review. The visit team heard that student nurses received their off-duty rota on their first day in post but had the opportunity to contact the practice development nurse prior to their arrival to request particular days off or alternatively they could change their off-duty days on day one of their placement at the Trust. Once agreed, there was a fixed rota for five weeks. Student nurses considered that they did work with their mentor for at least 40% of the time (in accordance with Nursing and Midwifery Council standards). The visit team heard that at times it was difficult to find the time to carry out the role of a mentor particularly in the resuscitation area. The practice development nurse commented that she often released the mentor and learner so that they could leave the ED to fulfil their mentorship requirements. The practice development nurse was the only nurse in the ED who had undertaken the sign-off mentor course. However the department had not been allocated a sign off placement student recently. Another mentor is due to undertake sign-off mentor training in April 2016.		
ED3.4	**Access to study leave** Trainees at all levels reported that study leave was rostered into their rota. Some F2s had had study leave fixed during the second week of the rota and as a result had had no time to plan any courses, as they had only received the rota one week prior to starting in post. Some F2s reported that they had to take study leave days instead of rest days after their night shifts. Some F2s reported having requested study leave days prior to starting in post in order to take an exam, but had not been granted sufficient days.	All trainees and learners should be able to request study leave at their chosen leave time so that they can undertake courses that are relevant to their training.	Recommendation
GMC Theme 4) Supporting educators			
ED4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The matron informed the visit team that, in her opinion, the learning and development opportunities available at the Trust exceeded opportunities offered at other Trusts. She reported that she was impressed by the large number of people who were supported to undertake		

	mentorship courses. The nursing staff welcomed the introduction of the trust-wide preceptorship programme, access to leadership courses and the number of staff supported to train as emergency nurse practitioners. The visit team heard that the Trust wanted to limit the number of newly qualified nurses employed into ED in order to ensure they were appropriately supported, given the challenges of working in the ED for a newly registered nurse. The matron commented that when six newly qualified nurses had joined as a group and had undertaken the preceptorship programme, they had fared better than a newly qualified nurse starting on their own, as they benefited from the peer support and the 'time out' for reflection provided within the programme. The visit team heard that some consultants had not completed recent ALS, ATLS and APLS training and, as a result, were not up-to-date with their mandatory requirements. The visit team heard that at least one had refused to undertake the courses.	Ensure that all consultants working in the ED are up-to-date with their mandatory ALS/APLS/ATLS training and that a robust appraisal occurs annually to ensure required competences are maintained.	Mandatory Requirement
ED4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The college tutor reported that she did not receive any extra supporting professional activity (SPA) time for her role. The educational supervisors confirmed that they were also clinical supervisors, and were responsible for both trainees and non-training grade doctors. Considering the number of junior and Trust middle grade doctors in the department this meant that many consultants were supervising five or more doctors each. The educational supervisors all felt that they were too few in number to look after all their supervisees properly.	Trust to ensure the college tutor role is appropriately supported with an allocated SPA in the job plan. Trust to work with the HEE NCEL to ensure that all educational and clinical supervisors undergo appropriate faculty training in e-portfolio use, new workplace-based assessment (WPBA) tools, recent RCEM curriculum & exam changes, and annual review of competence progression (ARCP) requirements.	Mandatory Requirement Recommendation
GMC Theme 5) Developing and implementing curricula and assessments			
ED5.1	**Opportunities for inter-professional multidisciplinary working** The visit team heard that some funding had been received from Middlesex University which had allowed the department to introduce team multi-disciplinary days. The resuscitation lead felt that these would help improve morale; he commented that staff members were actively requesting this kind of training. The resuscitation team were currently setting up a multi-professional simulation course focussing on care of patients in the ED which was being supported by paediatric and anaesthetic faculty within the Trust. The healthcare support worker reported that he appreciated the interdisciplinary teaching days that he had attended.	The Trust should promote inter-professional learning across the board. (See ref TWR1.6 on action plan for further details)	Recommendation

	The nurse learner reported that there was a dedicated teaching session for student nurses every other Friday in the Trust, but that they did not attend any other teaching with other professionals. The visit team heard that in general doctors and nurses were still working in silos with little inter-professional learning.		
ED5.2	**Regular, useful meetings with clinical and educational supervisors** The higher trainees all praised their educational supervisors for their support and understanding. They commented that their educational supervisors encouraged them to undertake work that was curriculum-based and also encouraged them to attend audit meetings. They said that without them their experience would have been very different.		

Good Practice	**Contact**	**Brief for Sharing**	**Date**

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
HEE to provide details of alleged undermining and bullying behaviour to the Trust Medical Director in confidence.	Ian Bateman (Head of Quality and Regulation)
HEE to provide details of concerns with regards to competences of Trust grade and consultant staff to the Trust Medical Director in confidence.	Ian Bateman (Head of Quality and Regulation)

Signed	
By the Lead Visitor on behalf of the Visiting Team:	 Dr Chris Lacy, Interim Head of School of Emergency Medicine
Date:	12 April 2016