QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Lewisham and Greenwich NHS Trust (Queen Elizabeth Hospital)

Paediatrics

Urgent Concern Review (Focus Group)

Quality Review report

Date: 24 August 2016
Version: Final Report

Developing people
for health and
healthcare

www.hee.nhs.uk

THE NHS
CONSTITUTION
the NHS belongs to us all

Quality Review details

Background to review	The urgent concern review in paediatrics at the Queen Elizabeth Hospital was organised following formal correspondence received by the Head of the Specialty School from one of the School's trainee representatives who was contacted by the trainees currently in post at the Trust. The trainees raised a number of safety issues but also expressed their concerns about the quality of paediatric clinical training at the Queen Elizabeth Hospital. The trainees also insisted on anonymity citing significant concerns regarding how they would be treated as a result of raising these concerns. In summary, the trainee representatives' report detailed a number of serious concerns within the department, namely: • Allegations of bullying and undermining, • Excessive workload and unfilled rota gaps, leading to trainees feeling regularly exhausted, • Significant near-misses and under-reporting of the same, • Trainees feeling significant pressure to avoid breeches, • A lack of regular consultant supervision available to trainees with some consultants seemingly unwilling to help during busy times despite requests for help, • Trainees' concerns regarding inadequate referral pathways and a lack of sign-posting to the same, • Service pressures inhibiting the trainees' ability to attend clinics. Although the School of Paediatrics Survey in 2016 had been more encouraging, there was a need to investigate the concerns raised by the trainees. Furthermore, the 2016 GMC National Training Survey (GMC NTS) only generated one red outlier within paediatrics which was for 'workload'. Similarly, within the paediatrics and child health foundation year 2 programme, a red outlier was generated for 'workload' as well as a pink outlier for 'feedback'.
Quality review team	Dr Camilla Kingdon, Head of London Specialty School of Paediatrics Dr Helen Massil, Trust Liaison Dean, Health Education England South London Ian Bateman, Head of Quality and Regulation Team, London and South East England Jane Gregory, Lay Representative Kate Neilson, Learning Environment Quality Coordinator (Scribe) Elizabeth Dailly, Learning Environment Quality Coordinator (Observer)
Specialties / grades reviewed (including number)	The quality review team met with two foundation and eight higher trainees in paediatrics based at the Queen Elizabeth Hospital site, at the following grades: • foundation year 2 (F2), • specialty training year 1 (ST1), • specialty training year 4 (ST4), • specialty training year 5 (ST5).
Summary of findings	The quality review team would like to thank the Trust for accommodating the urgent concern review, which was organised at short notice due to the nature of the concerns. During the course of the review, an area of serious concern was identified for which the Trust was issued with an immediate mandatory requirement (IMR), as follows: • It was not always clear where certain medicines were kept on the wards, including adrenalin and resuscitation drugs, so it was difficult to locate these in an emergency.

	Please see P1 below. In addition, there were a number of areas of concern raised by trainees which are outlined below: • It was reported that there was insufficient staff in all staff groups within the emergency department (ED) and paediatrics to support the workload required at the Trust, especially on Hippo Ward. • Serious incident (SI) reporting was not always completed despite numerous incidents and 'near misses'. Trainees noted that there were too many incidents to record. Some harrowing examples were provided by the trainees including a patient with a sub-arachnoid bleed waiting to be seen and being moved around between the ED and paediatric ward for over six hours. Please see P2 below. • Current processes in place for debriefing trainees (or other staff) after child deaths or other serious incident/notable clinical episodes at the Trust were not being effectively implemented resulting in trainees receiving insufficient support in these circumstances. Please see P3 below. • There was a lack of consultant presence in the Paediatric Assessment Unit (Hippo Ward) and within the ED. Furthermore the trainees reported that a minority of consultants were not supportive and would not respond to trainee requests for support. Some of these consultants would sit in their office and when support was requested, they would ask the higher trainee on the neonatal ward to provide support rather than leave their office. Please see P4 below. • The Trust often prioritised the ED to the detriment of the safe care of children. Paediatric flow was perceived to be for the benefit of the Trust's targets rather than the benefit of patients. This included the staffing of the paediatric rota with significant differentials in rates of pay for locums in different specialties (e.g. ED vs. paediatrics). Please see P5 below. • Trainees were working a disproportionate number of night and weekend shifts and their rotas were not European working time directive (EWTD) compliant. Please see P6 below. • Trainees were very heavily involved in rota coordination in and out of hours. Due to significant rota gaps, the consultants and trainees had met and decided that the night shifts needed to be prioritised over all other shifts. It was decided that, no matter what, two ST4+ trainees would always be present at night. This led to trainees working untenable shift patterns and hours and was to the detriment of their training, personal lives, and staffing during the day. Please see P7 below. • Patient flow converged on the PAU but there was not always a consultant present on the ward (especially in times of high acuity, such as during twilight hours). It was noted that there could be up to 24 families on the PAU at one time, although there were only six beds and one clinic review room (staffed by two nurses). The PAU saw a significant number of patients that could be treated in the ED or in outpatients. This resulted in trainees not being able to cover the neonatal unit adequately. Please see P8 below. • Trainees were not able to attend outpatient clinics due to workload so they were not gaining this experience. Most trainees reported attending one clinic despite being in post for nearly 12 months. The quality review team noted that attendance at clinics was a significant part of the higher curriculum. Please see P9 below.
Detailed findings	
Patient Safety	The quality review team heard from the trainees that there was potential for patients to get overlooked and 'fall between the cracks' due to the numbers presenting to the ED who were subsequently referred to the PAU. The paediatric team also reviewed sick patients within the resuscitation area in the ED. At the time of the review, the higher trainees in paediatrics had responsibility for reviewing all patients under the age of 17 rather than 16, as had previously been the case. It was the trainees'

	perception that this change in process was a means of relieving the burden on the ED due to the shortage of staff in the department. As a result, increased referrals were being sent to specialty teams and it was felt by the trainees that this was impacting upon paediatrics in terms of increased workload more so than within other specialties. The trainees reported that of the 120 children who presented to the ED on a daily basis, approximately 60 of these were seen by the trainees in paediatrics, although in the winter months this figure could increase. The quality review team was informed by the higher trainees that it was not always clear where certain medicines were kept on the wards, including adrenalin and resuscitation drugs, so it was difficult to locate these in an emergency. They described an example of a patient developing signs of anaphylaxis after a dose of penicillin and no member of staff could find the adrenaline.	Yes. Please see P1 below.
Serious Incidents	The quality review team heard from the trainees that although they were encouraged to report serious incidents, SI reporting was not viewed as a mechanism for identifying themes in clinical incidents or as a lever for change in practice. The majority of them had not completed incident forms due to the fact that this would increase their already high workload as such incidents were a regular occurrence. It was noted that the main issue contributing to the incidents or 'near misses' was the shortage of staff within the Trust. The higher trainees reported that although they had never left a ventilated baby alone on the neonatal unit to attend the ED or PAU, instances of more than one emergency occurring simultaneously were common. In addition patients were often moved out of ED to the PAU in order to avoid breaching but then may not be reviewed in a timely fashion by the paediatric team due to their work pressure. The quality review team heard examples of incidents from trainees, including a patient with a sub-arachnoid bleed waiting to be seen and being moved around between the ED and paediatric ward for over six hours. The higher trainees informed the quality review team that there was not an effective process in place for debriefing trainees (or other staff) after patient deaths or other serious incident/notable clinical episodes at the Trust and they confirmed that such a meeting would be beneficial. However there was a Morbidity and Mortality (M&M) meeting within the department which was chaired by a consultant with the content compiled by trainees. It was noted that this meeting acted as a debriefing at times.	Yes. Please see P2 below. Yes. Please see P3 below.
Clinical Supervision	The quality review team heard that there was often a lack of consultant presence on the PAU and within the ED. Furthermore the trainees reported that a minority of consultants were not supportive and would not respond to trainee requests for support. Some of these consultants would sit in their office and when support was requested, they would ask the higher trainee on the neonatal ward to provide support rather than leave their office. The trainees recounted a case of a critically ill neonate who required stabilisation in ED and some difficulties were encountered by the paediatric and anaesthetic teams in securing the baby's airway. The paediatric consultant declined to stay to support the trainees, preferring instead to complete his/her ward round.	Yes. Please see P4 below.
Rotas	The quality review team was informed by all trainees that they believed that there was a shortage of both medical and nursing staff within the paediatric department and the ED to deal with the throughput of clinical cases and to fill the rotas. This shortage of staff meant that there were significant rota gaps which the higher trainees often had to fill themselves, often at short notice. There were reports of trainees arriving for a day shift only to be told to go home and return to cover the night shift instead. The quality review team heard from the higher trainees that they were working a disproportionate number of night shifts and their rotas were not EWTD	Yes. Please see P5 below. Yes. Please see P6 below.

	compliant. The higher trainees advised the quality review team that they completed the rota coordination for both the in and out-of-hours rotas. Furthermore trainees reported being very heavily involved in rota organisation with the higher rota coordinator estimated to have spent in excess of 200 hours organising the rota as well as working. This led to trainees working untenable shift patterns and hours so as to ensure that there was always a higher trainee on at night time. This however was to the detriment of their training, personal lives, and staffing during the day. This issue was exacerbated by the fact that it was extremely difficult to find locums who were willing to cover shifts within the paediatric department at the Trust. It was noted by the trainees that it was especially difficult to find external locums to cover the ED shifts due to previous negative experiences. Additionally, the department had been allocated locums who were not fit for the job due to sickness or part-time working patterns. The quality review team was informed that there were significant numbers of patients who were referred to the PAU who could have been treated in the ED, as they did not require paediatric support. It was noted by the trainees that there could be up to 24 families on the PAU at one time, although there were only six beds and one clinic review room (staffed by two nurses). These pressures on the PAU had an impact on the neonatal unit which meant that it could not be covered adequately as higher trainees were called to the PAU on a daily basis to review patients. The visit team was informed by the trainees that some nurses had left the PAU due to the high workload and pressured environment which had then impacted upon the workload of the trainees. It was noted by the trainees that at the time of the review, the referral criteria stated that all children under the age of one year were transferred directly from the ED onto the PAU. However the higher trainees had suggested that this be amended to six months to relieve some of the pressure on the PAU but that this suggestion was not accepted by the matron in the ED. The high workload on the PAU was exacerbated by a lack of consultant cover during twilight hours, which was the busiest time on the ward. The quality review team heard from the higher trainees that ensuring consultant cover until 8pm would ease the burden upon their workload. Furthermore, the trainees advised the quality review team that there were large numbers of GP referrals to the PAU, including referrals of babies with jaundice and it was suggested that the establishment of a dedicated jaundice clinic could relieve some of this burden. In addition, the quality review team heard that instead of the three times weekly consultant-led rapid access clinic (PRAC) taking place in the outpatient department, the PRAC patients were seen in PAU by the junior team, thereby further adding to the patient flow problem in PAU.	Yes. Please see P7 below. Yes. Please see P8 below.
Educational governance and leadership	The trainees that the quality review team met confirmed that they had not personally experienced any bullying or undermining from senior colleagues and that they would feel comfortable to raise concerns with paediatric consultants. However these trainees reported that there was one consultant who was particularly unsupportive and they had heard from other trainees and senior clinicians that they had experienced undermining behaviour from this consultant However these trainees noted that although they felt supported by consultants, they did not feel the same about the Trust's management. It was the perception of these trainees that there was no incentive from the management team to resolve the issues within the PAU, due to the fact that the situation helped to ease the issue of wait time breaches in the ED.	
Education and training	The quality review team was informed by the trainees that due to their high workload, they had not had the opportunity to attend outpatient clinics and that there was no dedicated list for higher trainees. As a result, these trainees (especially ST4 and above) reported difficulties with completing	Yes. Please see P9 below.

	their workplace-based assessments (WPBAs), especially the discussion of correspondence (DOC), which would cause problems with their annual review of competence progression (ARCP), as a key part of the curriculum. Regarding teaching, although higher trainees were meant to have protected teaching this did not happen in practice. The department had a comprehensive teaching programme which stated that trainees should have one hour's teaching three times a week; one session to be core trainee-led, one led by higher trainees and the third to be consultant-led. In practice, though, it was often difficult to find time for these teaching sessions. It was noted that GP and F2 trainees were released for teaching but that this was not the case for core and higher trainees. The quality review team heard from the trainees that there were no teaching ward rounds or bedside teaching. There was a ward round that took place between 9.30am-12.30pm but this was for the purpose of reviewing patients and not teaching. It was noted by trainees that they would not necessarily welcome an additional ward round due to workload pressures.	Yes. Please see P10 below.
Induction	The quality review team heard from the F2 trainees that they had received an adequate induction when they commenced post in August 2016 which included how to undertake baby checks and perform neonatal resuscitation. These trainees noted that there was always a senior trainee from whom to seek advice, if required and that they felt supported by both higher trainees and consultants. The higher trainees advised the quality review team that they ensured that F2 trainees were never on a shift on their own, which meant reorganising the rota themselves and covering extra shifts, in some circumstances.	

Next steps

Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
P1	It was not always clear where certain medicines were kept on the wards, including adrenalin and resuscitation drugs, so it was difficult to locate these in an emergency.	Adrenalin and all resus drugs need to be identified and clearly labelled in all clinical areas and communicated.	R1.1

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence
P2	The Trust is required to review and strengthen the serious incident process. The Trust should ensure that all trainees who submit Datix reports receive feedback, including details of how the issue has been dealt with.	Trust to undertake to use the Trust and departmental induction to emphasise the importance the Trust places on clinical incident reporting and to describe how the Trust uses Datix reports to identify problems, improve services etc. Please provide documentary evidence of this. Trust to provide a summary of departmental feedback to trainees via a log of Datix forms submitted by trainees over the next three months with relevant actions against each

		incident. Trust to ensure that the process of serious incident reporting is added as a standing item to the LFG meeting's agenda and relevant discussions minuted. Please provide LFG minutes.
P3	The Trust is required to review their current approach to debriefing and must instate formal debrief meetings following patient deaths or other serious incidents in order that trainees are fully supported at these times and can use such incidents as learning opportunities.	The Trust is required to review their current policy and provide a standard operating procedure which states the process in place for debriefing trainees following patient deaths or other serious incidents. The Trust is required to evidence adherence and delivery of their reviewed policy and procedure and compliance with this action should be monitored through LFG meetings and minuted. Please provide LFG minutes.
P4	The Trust is required to review the level of clinical supervision provided for all trainees at all times. Particular focus must be placed on the supervision provided in the PAU across all the opening hours. The evenings are a particularly pressurised time and the trust is required to review consultant cover then. The Trust is required to formulate a standard protocol that outlines the expected levels of clinical supervision the consultants will provide and that this is then adhered to by all, to eliminate inconsistency amongst the consultant body.	The Trust is required to review consultant job plans in order to identify adequate DCCs to safely cover the PAU with dedicated consultant presence until it closes in the evening. The trust is expected to provide a report outlining the outcome of this review with an action plan describing how any shortfall in DCCs will be addressed by the trust. The trust is required to submit the protocol which describes expected levels of consultant presence to -deliver clinical supervision. Minutes from LFG meetings should be provided to document feedback from the trainee representatives about levels of supervision in and out of hours (OOH) over a three month period and the ability to access local formal teaching opportunities.
P5	The Trust is required to review the rota gaps within the Paediatric rotas and ensure that there is a Human Resources (HR) policy in place around recruiting to vacant posts.	The Trust to submit copies of the new rota as well as evidence that this had been sent to trainees. Please also provide the HR policy. Compliance with this action should be monitored through LFG meetings.
P6	The Trust is required to review the work hours of the trainees in paediatrics to monitor EWTD compliance. This should include all shifts undertaken by the junior Paediatric doctors in the trust – whether rostered to work or whether undertaken as a locum shift to cover gaps.	The Trust to carry out a diary carding exercise on trainees and submit the results to Health Education England. Compliance with this action should be monitored through LFG meetings.
P7	The Trust is required to review the management of all rotas in the department which include trainees. Such a review must involve trainees and should result in an approach to rota management which involves trainees but does not require significant management of the rota by trainees in the future.	The Trust must provide evidence of the review, and a clear plan for the management of the rota in the future. The Trust must provide evidence of adherence and compliance with the agreed approach to rota management on an on-going and sustainable basis.
P8	The Trust is required to review the guidelines and referral criteria for referring patients into the PAU both urgently and semi-urgently. In particular this	The Trust is required to undertake an urgent review of the clinical supervision of Paediatric trainees working in the Paediatric

	should include: 1. Referrals from ED, 2. Urgent referrals from GPs, 3. Referrals from the UCC (Urgent Care Centre) which currently go directly to the Paediatric registrar, 4. Referrals to the consultant-led Paediatric Rapid Access Clinic, 5. Referrals of babies with prolonged jaundice, 6. Any other plans for future services. All these patient referrals currently go to the PAU significantly contributing to the high intensity of work there. This not only places unacceptable levels of responsibility on the trainees allocated to work in PAU and ED, but also requires trainees to leave other clinical areas, including outpatients and the neonatal intensive care unit (NICU), which impacts patient safety as well as trainee ability to adequately cover the curriculum.	Assessment Unit. This should include supervision over the full time the PAU is open and should include all referral pathways into the PAU. Please provide a report from this review and subsequent actions.
P9	The Trust is required to review rotas to ensure that trainees at level ST4 and above have the opportunity to attend regular outpatient clinics, including time to dictate letters following these clinics.	The Trust is required to submit the revised rotas which states who is responsible for covering the wards (and providing clinical supervision) when higher trainees are attending outpatient clinics. Compliance with this action should be monitored through LFG meetings with trainee representation. Please provide minutes to evidence that higher trainees have access to these requirements.
P10	The Trust is required to ensure that core and higher trainees are able to attend the departmental teaching sessions, which are held three times a week. The Trust must ensure that there is appropriate cover on the ward so that the trainees can attend teaching sessions, which should be bleep-free.	The Trust is required to submit copies of communications sent to trainees which states who is responsible for covering the wards as well as holding the bleep, when core and higher trainees are attending the protected teaching sessions. Minutes from LFG meetings, over a three month period, must be submitted that demonstrate that core and higher trainees are able to attend the departmental teaching sessions.

Recommendations

Req. Ref No.	Recommendation	Recommended Actions / Evidence
	N/A	

Other Actions (including actions to be taken by Health Education England)

Requirement	Responsibility
N/A	

Signed	
By the Lead Reviewer on behalf of the Review Team:	Dr Camilla Kingdon Head of London Specialty School of Paediatrics and Child Health
Date:	20 September 2016