QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

North Middlesex University Hospital NHS Trust
Emergency Medicine
Urgent Concern Review (on-site visit)

Quality Review report

Date: 13 September 2016
Version: Final report

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Quality Review details

Background to review	The urgent concern review carried out on 13 September 2016 was one of a number of reviews, visits and meetings that have been undertaken by Health Education England (HEE) and the General Medical Council (GMC) in regard to the Trust's emergency department (ED) since May 2015. This report should therefore be considered alongside previous reports. HEE, accompanied by the GMC 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 meeting with trainees was organised for November 2015 where trainees interviewed appeared happier than they had previously been in July 2015, although problems persisted. Following the July 2015 visit HEE and the GMC conducted a full review of health education and training in the Trust's emergency department in March 2016. The March 2016 review uncovered a number of serious areas of concern and issued the Trust with three immediate mandatory requirements to address the following issues: • The review team heard instances of foundation year two (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 review 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. A number of further serious issues were also identified. This report should therefore be read in conjunction with the report from the March 2016 review of the Trust ED. Following the March 2016 review to the Trust significant work had taken place across the whole health economy in London, involving the Trust as well as commissioning and regulatory bodies. On 19 and 20 June 2016, HEE and the GMC met with F2 trainees working within emergency medicine, trainees in GP working within emergency medicine and higher emergency medicine trainees. The quality review team identified the following: • Trainees continued to report being unsupported when there was a consultant or middle grade in the department. This was most frequently reported to be within resuscitation and the paediatric emergency department. • Trainees also reported being left unsupported in the emergency department. Two examples were provided where neither middle grade nor senior on-site presence for between one and two hours. • F2s, ACCS and GP trainees were frequently left in the paediatric emergency department without direct access to competent senior support within the department, due to the unwillingness of middle grade doctors and consultants to provide support to the paediatric emergency department. Some trainees reported having had limited induction even before their first set of nights and then working in this department.

	However trainees did report that the new paediatric consultant was having a positive effect when on shift. • There was still an issue surrounding lack of available equipment within the ED, however this equipment was different to the original deficits identified.
Specialties / grades reviewed	The quality review team met with trainees in emergency medicine at the following grades: • foundation year two (F2), • general practice (GP), • specialty training year one (ST1), • specialty training year two (ST2). The quality review team also met with trainees in Acute Care Common Stem (ACCS) and higher trainees in EM, at the below grades: • specialty training year three (ST3), • specialty training year six (ST6).
Number of trainees from each specialty	The quality review team met with 11 trainees in emergency medicine. These trainees had commenced placement in August 2016.
Review summary and outcomes	The quality review team included individuals from both HEE and the GMC. The quality review team heard from the trainees in emergency medicine that improvements had been made within the emergency department (ED) since the Trust-wide review (TWR) in March 2016 as well as the urgent concern review in June 2016. Furthermore, at the urgent concern review on 13 September 2016 improvements were identified in the following areas: • The induction had improved significantly and was reported as being comprehensive although trainees noted that at times, they felt overloaded by information. • Clinical supervision during the day was reported to be good. • The trainees at all levels confirmed that the consultants were all approachable, supportive, happy to discuss patients and provide advice. • The Trust provided taxis to trainees when finishing shifts after 11pm. • Pastoral care of trainees was reported to have been much improved and following serious incidents, trainees received a comme il faut debriefing from senior colleagues. • The higher trainees advised the quality review team that the Trust was responsive to trainees' suggestions for improvements. • All of the trainees knew who the director of medical education (DME) and clinical director (CD) were and reported that they were visible within the ED. Various areas for improvement were also identified by the quality review team, which are detailed below: • It was reported that patients did not always receive a casualty card at the beginning of their journey within the ED and that these were not always kept with the patient's notes. As a result, trainees were not aware of investigations that may have been requested. At the time of the review, the Trust was aware of this issue and working toward a solution. • The trainees noted that relations between specialty teams were on occasion obstructive with neither team willing to take responsibility for certain patients. This was especially the case for medical and surgical teams and between obstetrics and gynaecology (O&G) and surgical

teams. The Trust confirmed that it was aware of these issues and was working on resolving them.

- The F2 trainees advised the quality review team that on occasion they felt harassed by site managers' platitudes regarding breaches in ED waiting times, as they felt under pressure to justify their treatment of patients. These trainees suggested that this aspect of the site manager role could be aligned with the flow coordinator post in order to deal with patient flow and bed management within the ED. The Trust confirmed that at the time of the review, they were working on embedding the newly appointed flow coordinator role and clarifying the lines of responsibilities of this post.
- The trainees suggested that the flow of patients could have also been improved by consultants seeing some patients in the ED when it was very busy.
- Regarding security within the ED, trainees at all levels confirmed that whilst security guards were available, they would often turn up late when called to assist with a patient and were not as effective as they could be. The F2 trainees advised the quality review team that they sometimes felt vulnerable when psychiatric patients were in the ED. The Trust was aware of this issue, especially with regard to patients presenting with mental health concerns, and was working with the security team to address a training need.
- At the time of the review, the quality review team heard that whilst progress had been made with regard to middle grade and consultant supervision in and out of hours, there continued to be an issue with middle grade support at times. This was especially the case between the hours of 6am and 8am, when trainees reported it could be hard to obtain support.
- The F2 trainees advised the quality review team that they were often asked to interpret patients' electrocardiogram (ECG) results although they may not have had access to the patient's medical notes or casualty cards so this was potentially a clinical governance issue. However, the F2 trainees confirmed that they would check with a higher trainee if they had concerns around ECG results.
- The quality review team heard from the trainees that although the quality of the clinical assessment within triage had improved since the previous reviews, improvements were still required regarding training. It was noted that when a senior clinician worked in triage, it made a significant difference to trainee workload and patient flow. The Trust confirmed that the system of front door streaming and patient flow into triage was changed on 31 August 2016 to help improve the situation so subsequent changes may take time to embed.
- Regarding the information technology (IT) system, the higher trainees advised the quality review team that when patients had been discharged from the department, they were often discharged from the system in order that they would not breach the four hour waiting time. However, this in turn meant that trainees were not able to write GP letters which could have presented a patient safety concern. The Trust confirmed that they were liaising with the IT department to amend the system to implement a visible list of discharged patients awaiting completion of letters.
- The junior trainees confirmed that the rota they worked required them to work one in two weekends. HEE recommended that the Trust engage the trainees in revising the rota. The Trust noted that the current rota is improved in comparison to previous and that the current rota was designed in conjunction with the previous cohort of trainees.
- The quality review team heard from the F2 trainees and trainees in GP that it could be challenging to attend the teaching sessions due to rota design. The virtual learning sessions are available for trainees on the Trust intranet. HEE recommended that the rota is re-scheduled to allow

	trainees to attend training when they do not have rest or off-days. • The trainees advised the quality review team that they did not all receive individual cards for the arterial blood gas (ABG) machine as they had not completed the training prior to commencing placement. As a result, trainees often shared their ABG cards which posed a serious governance risk. HEE advised the trainees, and the Trust, that this should not be happening with a consensus agreement that this was not appropriate. • Whilst all of the trainees noted that the availability of medical equipment within the department had improved since the previous reviews, there was an issue with availability of auroscopes (especially end pieces) and ophthalmoscopes for adults. No additional requirements have been placed on the Trust following this review, and the requirements set in March 2016 remain extant. HEE are confident that whilst issues remain the Trust are fully engaged in improving the quality of patient care, and education and training in the ED, and will continue to work with the Trust to support this. However HEE remain of the view that the defrayal and diversion of blue light attendances should remain in place until the fragility of the ED improves, and until such a time as access to support out of hours is consistent.

Quality Review Team			
Lead Visitor	Professor Elizabeth Hughes, Director and Dean of Education and Quality, Health Education England London and South East	**GMC Representative**	Alexandra Blohm, Education Quality Assurance Programme Manager, General Medical Council
HEE Representative	Dr Sanjiv Ahluwalia, Postgraduate Dean, Health Education England, working across North Central and East London	**Scribe**	Kate Neilson, Learning Environment Quality Coordinator, Health Education England London and South East
Observer	Louise Fleming, NHS Improvement Representative		

Findings

GMC Theme 1) Learning environment and culture

Standards

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Ref	Findings	Action required? Requirement Reference Number
EM1.1	**Patient safety** The F2 trainees informed the quality review team that they had had some concerns around patient safety during their placement within the ED at the Trust. There had been one incident where a trainee felt unsupervised in an unsafe way overnight. On another occasion, it was reported that one of the staff/middle grade doctors advised an F2 trainee to steri-stip a wound on a child. However, one of the nurses subsequently advised that the wound was too deep to steri-strip. The F2 trainees noted that they felt that they could not always trust the advice from all of the staff/middle grade doctors. HEE notes that this particular example is without evidence or investigation, and that there are sometimes a number of treatment plans that can be used, however this statement is indicative of previous examples where this concern has been raised. Regarding support within the resuscitation area, the F2 trainees advised the quality review team that during the day supervision was sufficient. However, these trainees reported that there had been a "blue light" incident at 6am when senior support in the ED was unavailable, so the trainee had to put out a crash call in order to obtain higher trainee assistance.	
EM1.2	**Serious incidents and professional duty of candour** Although the majority of the trainees met by the quality review team had not submitted any Datix reports, the F2 trainee who had done so reported that they had requested further feedback as they were not satisfied with the initial feedback. This trainee was still awaiting further feedback at the time of the urgent concern review.	
EM1.3	**Appropriate level of clinical supervision** The F2 trainees advised the quality review team that all of the consultants within the ED were approachable, helpful and willing to discuss patients and provide advice. These trainees noted that there were consultants they would seek advice from rather than others but that they would approach any of the consultants, if required. It was reported by the F2 trainees that they trusted the advice provided by all consultants. Regarding out of hours supervision, the F2 trainees reported that it was not always clear who the designated higher trainee and staff/middle grade doctors were. Furthermore, it was often confusing who the locums working within the ED were. These trainees noted that there was one non-training middle grade doctor who was very good but otherwise they did not always trust the advice from the other middle grade doctors. The F2 trainees reported that all of the training grade trainees, including core and higher, were very good. The F2 trainees advised the quality review team that the higher trainee in paediatrics was always available to provide advice, including during out of hours. Whilst the paediatric consultant was not based within the ED, they would always respond to calls for support and review patients there or ask for them to be sent to the paediatrics department. It was noted by the F2 trainees that at the time of the urgent concern review, one of the consultants in paediatrics had been working in the ED which had eased the trainees' workload. The quality review team heard from the trainees in GP that supervision during the day was good and that consultants were approachable and that they trusted the advice given. However, these trainees reported that supervision out of hours was more difficult as consultants were not onsite. Regarding paediatric supervision out of hours, the trainees in GP noted that there could be a delay when requesting middle grade support from the middle grade doctors in the ED. The higher trainees confirmed that during the day, there were always consultants from whom to seek advice and were approachable whose advice they trusted. It was reported that the majority (but not all) of the consultants were locums. The trainees	

	suggested that the flow of patients could have been improved by consultants seeing some patients in the ED when it was very busy. Paediatrics and out of hours supervision was reported by the higher trainees to be good.	
EM1.4	**Responsibilities for patient care appropriate for stage of education and training** The trainees in GP informed the quality review team that there were occasions where it was difficult to find a nurse allocated to the patients in the "corridor" area. This meant that there was no one monitoring the patients within the "corridor" and that the trainees in GP often completed patient observations themselves. The Trust subsequently confirmed that they completed weekly audits of hourly rounding and observations, which found that compliance was high. These trainees reported that it was sometimes difficult to find patients within the ED due to the issues with the flow and the fact that there were 22 bays and the waiting area. It was reported by the trainees in GP that patients did not always receive a casualty card at the beginning of their journey within the ED or that these were not kept with the patient's notes. As a result, trainees were not aware of investigations that may have been requested. This then created additional work for trainees, including printing the casualty cards. The F2 trainees informed the quality review team that they were asked to interpret patients' ECG results by the nursing staff within the ED but that they did not always have access to the patients' notes. The higher trainees suggested this posed a clinical governance issue. However, the F2 trainees confirmed that they would check with a higher trainee if they had concerns around ECG results.	
EM1.5	**Rotas** The F2 trainees and higher trainees confirmed that as they had commenced placement in August 2016, the workload had been manageable so far. It was noted that this may have been due to the fact that ED attendances were reduced due to the fact that some of the local population went abroad during the summer school holiday period. However the trainees advised the quality review team that during the few days prior to the urgent concern review, ED attendances had started to increase which may have been due to the schools in the area commencing back after the school holidays. The quality review team heard from all of the trainees that patient flow in the ED was chaotic and that bed management was an issue. The F2 trainees reported that on occasion they felt harassed by the site managers regarding patients who breached the four hour ED waiting times. Furthermore, these trainees advised the quality review team of an incident when the flow coordinator (the nurse who managed patient flow in the ED) felt pressured by the site manager to move a patient from the ED to the surgical assessment unit (SAU) despite a bed not being available there, which then delayed the patient being seen by the surgeon. The higher trainees in ACCS confirmed that some worked on the core trainee rota which was a rolling rota and meant that certain trainees worked every other weekend. There were occasions where trainees had worked nine late shifts in a row from 5pm-2am (weekdays) or 3pm-2am (weekends). The Trust subsequently provided information on the trainee rota which showed it to be much improved in comparison to the previous rota. The Trust also confirmed that the rota did not require trainees to work more than seven late shifts in a row, with breaks.	
EM1.6	**Induction** The quality review team heard from the F2 trainees and trainees in GP that they had all received a one day Trust induction and a separate full day ED induction, prior to commencing the placement. In addition, some protocols were emailed to the trainees by one consultant prior to starting. The ED induction covered elements of paediatrics pathways (including child protection) as well as ACCS, and stroke pathways for which trainees received hard copies. It was felt by all trainees that the induction provided a lot of information and at times they felt overloaded by this. The F2 trainees and trainees in GP advised the quality review team that they would have appreciated more time within the induction programme on the IT systems at the	

	Trust. Additionally, these trainees noted that the tour of the ED could have been improved. The orientation was carried out by one consultant with 17 trainees (including trainees at all levels) so those at the back of the group found it difficult to hear the consultant. These trainees noted that it would have been helpful to stagger the orientation and condense the induction. The quality review team felt that the Trust should obtain feedback from the trainees regarding how the induction could be improved. Additionally, the trainees in GP advised the quality review team that they had not received the training for the ABG machine prior to commencing placement so they had not received an ABG card. As a result, trainees reported borrowing each other's cards which the quality review team confirmed was a serious governance risk as the responsibility for the results sat with the trainee whose card had been used. HEE advised the trainees, and the Trust, that this should not be happening with a consensus agreement that this was not appropriate.	
EM1.7	**Protected time for learning and organised educational sessions** The F2 trainees advised the quality review team that the weekly teaching sessions were held on a Wednesday between 8am-11am. These trainees reported that they found it hard to stay awake during the sessions following a night shift and that it would have been better to have this teaching in the afternoon over two days, rather than on one morning. It was noted that the quality of the teaching was good and that they could access the teaching slides on the intranet. The trainees in GP also attended the Wednesday 8am-11am teaching sessions, as well as GP specific teaching on a Thursday. However as the rota meant that trainees in GP usually had a Thursday off, this teaching clashed with the trainees' zero days. It was reported by the higher trainees that they were released from the department to attend the regional teaching. However ACCS trainees attended the local teaching sessions with the core trainees (Wednesday 2pm-4pm), which they felt was not relevant to their level and the quality was variable. It was noted that the Trust was working to resolve this.	
EM1.8	**Adequate time and resources to complete assessments required by the curriculum** The quality review team heard from the F2 trainees that they were able to complete their workplace-based assessments (WPBAs).	

GMC Theme 2) Educational governance and leadership

Standards

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

EM2.1	**Impact of service design on learners** The F2 trainees advised the quality review team that there had been occasions where they had felt threatened by patients within the ED, especially psychiatric patients, and that the security team did not intervene on these occasions. It was noted that sometimes psychiatric patients were placed in the same room as other psychiatric patients which could cause problems. Furthermore, this room was located next to the computers used by these trainees so they found it hard to concentrate due to the noise. Lack of space within the ED was reported by the F2 trainees to be the main issue. It was noted that the psychiatric liaison team would attend when required but that they were busy so there would often be a delay. The Trust was aware of this issue, especially with regard to patients presenting with mental health concerns, and	

	was working with the security team to address a training need. The quality review team was informed by trainees at all levels that the issues regarding availability of equipment, such as peak flow meters and tendon hammers, that was reported at the urgent concern review on 19 and 20 June 2016 had been resolved. However, trainees noted that there were not sufficient supplies of auroscopes (especially end pieces) and ophthalmoscopes for adults. The higher trainees confirmed that when they had reported issues with missing or broken equipment, the Trust had listened to their concerns and responded as appropriate. This included a problem with a broken Lucas CPR machine which was resolved by the CD. It was reported by the trainees that they would be reluctant for their family to be treated within the department when it was busy and that it would be dependent upon which higher trainee was on shift at the time.	
EM2.2	**Organisation to ensure access to a named educational supervisor** All of the trainees advised the quality review team that they had been allocated an educational supervisor, all of whom were out of the department, and that they kept in contact with the trainees.	
GMC Theme 3) Supporting learners		
Standards **S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.**		
EM3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The quality review team heard from trainees at all levels that they received good pastoral support from the department and other trainees. The DME and CD were visible within the department, were approachable and supportive of trainees. Trainees at all levels reported that the Trust provided taxis to trainees when they finished shifts after 11pm. It was noted that this was an improvement upon the previous arrangement. Regarding access to the car park and trainee safety at night, the trainees advised the quality review team that they were able to ask a security guard to accompany them to their car. However, none of the trainees had needed to do so.	
GMC Theme 5) Developing and implementing curricula and assessments		
Standards **S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.** **S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good Medical Practice and to achieve the learning outcomes required by their curriculum.**		
EM5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** See EM1.8 above.	
EM5.2	**Opportunities for interprofessional multidisciplinary working** The quality review team was informed by the F2 and higher trainees that relations between specialty teams were on occasion obstructive with neither team willing to take responsibility for certain patients. This was especially the case between medical and surgical teams as well as obstetrics and gynaecology (O&G) and surgical teams. The Trust confirmed that it was aware of these issues and was working on resolving	

	them.	
EM5.3	**Regular, useful meetings with clinical and educational supervisors** See EM2.2 above.	

Good Practice and Requirements

Next steps	Responsibility
It was agreed that HEE and the GMC would carry out a further review of EM education and training at the Trust in January 2017.	Ian Bateman, Head of Quality and Regulation, HEE London and the South East

Signed	
By the Lead Visitor on behalf of the Visiting Team:	Professor Elizabeth Hughes, Director and Dean of Education and Quality, Health Education England London and South East
Date:	10 October 2016