QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Lewisham and Greenwich NHS Trust
(Queen Elizabeth Hospital)
Emergency Medicine
Urgent Concern Review (on-site visit)

Quality Review report

19 October 2016

Final report

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Quality Review details

Background to review	The GMC NTS results over the previous three years for acute care common stem (ACCS) had been poor and shown lack of improvement. In the GMC NTS 2016 there were four red outliers and three pink outliers in comparison to four red outliers and five pink outliers in 2015. The GMC NTS results over the previous three years for emergency medicine F2 had shown improvement from four red outliers in 2015 to one red outlier and one green outlier in 2016. The GMC NTS results over the previous three years for GP programme - emergency medicine had shown improvement from two red outliers and two pink outliers in 2015 to one red outlier in 2016 although this was a triple red outlier. The Trust had been visited twice in the previous two years. The last visit to emergency medicine and ACCS had been on 31 March 2015 and before that there was a conversation of concern to emergency medicine on 15 October 2014. There was only one item still open from the 15 October 2014 conversation of concern on the Trust action plan but there were multiple actions still open from the visit on 31 March 2015.
Training programme / specialty reviewed	Emergency Medicine (foundation, general practice, ACCS and higher) including ACCS – Acute Medicine
Number and grade of trainees and trainers interviewed	The quality review team initially met the chief executive officer, deputy medical director, associate medical director, director of medical education, medical education manager, clinical director for critical care, divisional director for acute and emergency medicine, college tutor for emergency medicine, clinical lead for emergency medicine, college tutor for anaesthetics, clinical director for critical care, education lead for anaesthetics and intensive care medicine, cross-site intensive care medicine tutor and pastoral lead for trainees. The quality review team then met with three foundation year two trainees, one general practice trainee, one acute care common stem trainee and three higher emergency medicine trainees.
Review summary and outcomes	The quality review team thanked the Trust for the time everybody gave to the review. The quality review team found no areas of serious concern within emergency medicine. The quality review team found the following areas that were working well: • All emergency medicine trainees reported that they had access to good clinical supervision throughout the day and night. • All trainees reported that the emergency department provided a supportive and positive team atmosphere. Trainees felt they were able to raise issues with staff. • The trainees reported that the emergency department and acute medicine morning handover was robust and worked well. • The quality review team was impressed with the whole academic ethos that the emergency department provided the higher emergency medicine trainees with, such as an academic day once a month and consultants assigned to complete workplace-based assessments.

- The higher emergency medicine trainees reported they had access to proactive training; the trainees were able to meet their curriculum requirements.
- There was a sense of real significant improvement in the emergency department.

The quality review team found the following areas for improvement:

- The Hospital at Night service required further improvement with regards to team working. The SBAR tool did not seem to be utilised efficiently by the night time ward cover. The critical outreach team did not seem to be working as clearly as it should be, and the review team felt that there needed to be a clear policy stating who provided night time cover, an escalation policy and clear details regarding how this operated.
- The review team heard that there was a lack of clarity regarding the process via which emergency medicine trainees should refer patients to the medical teams. The review team suggested that the Trust needed to implement a consistent process as to whether this was face to face or via another format.
- The review team was informed that the interface between the trainees within the emergency department and radiology required further work. There needed to be a clear and set process which was clarified with all staff in these departments.
- The review team heard that there was no robust feedback process following the reporting of incidents via Datix.
- The review team required the Trust to ensure that all trainees were able to obtain ID badges on the day of their induction in a timely manner.
- The review team also recommended that the Trust should review which induction session the ACCS-AM trainee attended.
- The quality review team was informed by trainees of bullying and undermining behaviour and this was passed onto the DME and Trust Board representative.

Educational overview and progress since last visit/review – summary of meeting with Trust Senior Management Team

The Trust commented that they hoped to resolve the issues raised at the visit in a timely and practical way and also added that they supported the raising of concerns by trainees; they intended to ensure that they were dealt with appropriately.

The quality review team was informed by the Trust that they considered the challenges for acute care common stem (ACCS) and emergency medicine to be recruitment, retention, unpredictable and relentless issues and that despite the whistleblowing case being addressed positively the Trust felt the trainees did not approach them in the first instance to raise concerns.

The postgraduate dean reported that Health Education England South London (HEE SL) would work with the trainees to be clear on the lines of reporting and how to raise issues locally first before escalating to the Head of School or HEE SL.

The Trust reported that the frailty pathway had had a significant impact on patient flow. The older people's assessment liaison (OPAL) model was slower to start due to lack of consultant supervision but the Trust now had a consultant in place. The work with community partners on Home First was going well and all these models were helping reduce waiting time for beds across the Trust.

The quality review team heard that the Trust had increased the night time cover for acute medicine to one higher trainee and two core trainees admitting patients, one core trainee covering the ward and now an additional core

trainee to support. There was a hospital at night team that would support trainees when required but the Trust recognised this required further work. The critical outreach team were reported to be visible and accessible when required across the Trust. The medical handover at night was attended by the critical outreach team.

The senior management team stated that currently there were no gaps within the ICU rota. The Trust had introduced the shadowing for all trainees starting in the ICU for the first seven nights. The trainees shadowed a previous ICU trainee and the trainee and consultants then had to say they felt competent to be unsupervised at night on the ICU. The quality review team thought this was an area of good practice.

The Trust reported that the current staffing on the ICU was good but the Trust was planning ahead looking at where there could be gaps in the rota and was looking at the medical training initiative (MTI) programme. The Trust was worried that they would not be able to get the number of MTI doctors they would require. The postgraduate dean commented that he would raise this with the HEE SL commissioning team about supporting the Trust with this.

The Trust informed the quality review team that they informed trainees at induction how to raise concerns and how to report incidents.

Quality Review Team			
HEE Review Lead	Dr Andrew Frankel, Postgraduate Dean, Health Education England South London	**Head of School**	Dr Chris Lacy, Head of London Specialty School of Emergency Medicine
Royal College of Emergency Medicine Representative	Dr Julia Harris, Chair of Training Standards Committee, Royal College of Emergency Medicine	**Trainee Representative**	Sophie Mitchinson, Trainee Representative
Quality and Regulation Representative (foundation, GP and ACCS session)	Ian Bateman, Head of Quality and Regulation Team (London and South East)	**Lay Member**	Caroline Turnbull, Lay Representative
Observer (foundation, GP and ACCS session)	Fran Davies, Deputy Director Clinical Quality, NHS Improvement	**Scribe**	Vicky Farrimond, Learning Environment Quality Coordinator

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
EM 1.1	**Serious incidents and professional duty of candour** The trainees reported that if they recognised an incident as a serious incident they would raise this formally to a senior consultant and would submit a Datix form. For most incidents trainees would talk to a consultant about what had happened. The higher trainees reported that they were all encouraged to report incidents. The quality review team heard that feedback was not provided following the submission of Datix forms.	Yes, see EM1.1 below
EM 1.2	**Appropriate level of clinical supervision** The quality review team was informed that despite the emergency department being very busy the foundation and core trainees always felt they were able to access consultant or higher trainee support day and night. The quality review team heard that the acute medicine trainees had good supervision throughout the day but at night supervision was not easily accessible as there was only one higher medicine trainee covering the hospital. The nursing support in the green area of the emergency department (ED) still appeared to be lacking, the trainees reported that the one nurse was overworked and suggested an additional member of staff (even at HCA level) would help reduce the nurses' workload. The higher emergency medicine trainees stated that they could easily access consultant supervision throughout the day as there was one consultant based at the nurses' station and there would usually be another consultant on the shop floor that could be easily accessed. The quality review team was informed that the higher trainees took the lead in the resuscitation area and that if trainees required support consultants were happy to assist. The consultants would always attend resuscitation for paediatrics cases and cardiac arrests. The trainees reported that the consultants covered the shop floor until 10pm. After 10pm the higher trainee covering the night had a handover from the consultant on-call and there was another higher trainee working in the ED until 10pm or midnight. The contact number for all the consultants was easily accessible in the department should support be required out of hours and consultants were reported to be responsive to requests from trainees for assistance overnight.	Yes, see EM1.2 below
EM 1.3	**Responsibilities for patient care appropriate for stage of education and training** The foundation trainees commented they sometimes carried out nursing duties but this was not frequent and the trainees did not feel it impacted on their day to day activity. The higher trainees reported that they were able to input into the care of patients within resuscitation as they took on the role of team leader and looked not only at the treatment of the patient but also the wider organisation of the patient's care and involvement of other teams. The foundation and core emergency medicine trainees reported that they all worked within the resuscitation area. The core trainees reported that there was always a higher trainee based within resuscitation and they would sometimes take the handover from the paramedic and suggest what they felt would be suitable treatment. The higher trainees felt they all had autonomy to carry out activities appropriate to their training level within resuscitation and they could always escalate to a higher trainee or consultant if they had concerns.	

	The quality review team was informed that the ACCS acute medicine trainees had not felt that they had been given sufficient autonomy in relation to the management of the acutely deteriorating patient. The quality review team was informed that managing the deteriorating patient within medicine wards at night was difficult. The trainees reported that when they would put out a peri-arrest call in these situations and the ICU outreach team would come and provide support. During the day, the trainees were able to escalate a patient to the consultants.	Yes, see EM1.3 below
EM 1.4	**Rotas** The quality review team was informed that the ED secretary managed the ED rota; the trainees felt this was managed well and had no concerns regarding the rota. The higher trainees reported that they had no issues attending regional training days as the ED secretary ensured they were all able to attend or swap their shifts to enable the trainees to attend.	
EM 1.5	**Induction** The foundation and general practice trainees reported that the ED departmental induction was good and found the lectures on areas to look out for, scenario training and how the ED worked beneficial. The trainees did report issues with having timely access to ID badges. The trainees reported that on the day of their induction the office was only open 10am till 2pm and they had no free availability to obtain their ID badges prior to starting on nights so had to miss some of the Trust induction lectures to acquire these. All the trainees stated that they were asked for feedback on the ED departmental induction. The ACCS – AM trainees' induction did not appear to have been as well planned as the inductions for other trainees. The quality review team heard that the trainee was not provided with induction information and was simply expected to join the core medical trainees' induction. The higher trainees stated that the ED departmental induction was good and gave the trainees an insight into how the ED worked and the layout of the ED.	Yes, see EM1.5a below Yes, see EM1.5b below
EM 1.6	**Handover** The 8am morning handover within the emergency department was well attended, robust and worked well. The core trainees reported that throughout the rest of the day due to shift overlapping they would hand over to the trainee taking over from them and inform the higher trainee that they had done this prior to leaving. The 8am morning handover within acute medicine was reported to work well and all patients were discussed within this timeframe. However, there were concerns about the handover of patients who had deteriorated on the wards over night as the night time trainee on call for the wards needed to individually liaise with up to five different teams who were often already on ward rounds before they were able to leave.	Yes, see EM1.6 below
EM 1.7	**Adequate time and resources to complete assessments required by the curriculum** The higher trainees reported that the consultants were good at being proactive and contacting them to complete workplace-based assessments. They were also good at signposting to the trainees who to approach to complete their extended supervised learning events (ESLEs). The trainees reported that they had opportunities to complete ultrasound training with consultant support. The higher trainees commented that they had an academic day built into the rota once	

	every three to four weeks which was for the trainees to utilise for their personal development such as quality improvement projects, audits, teaching medical students and attending clinics. This time was not taken out of the trainees' study leave allocation and the quality review team felt this was an item of good practice.	

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.

EM 2.1	**Impact of service design on learners** The quality review team was informed that when the ACCS medical trainee on call for the wards was working at night the 975 bleep would go off constantly. Sometimes this resulted in trainees having to prioritise which patient to see first, the trainees felt that it was not always possible to see all patients. The hospital at night team did provide support where possible although they were also very busy and so this did not always assist in alleviating the trainees' workload. The situation, background, assessment, recommendation (SBAR) tool did not appear to be effectively utilised by ward cover staff overnight as they would often bleep trainees instead; the review team felt that this should be reviewed. It did not appear that the addition of the F1 doctor on the on call rota at night (Monday to Friday) had sufficiently alleviated the pressure of work and there did not appear to be sufficient evidence of the Hospital at Night team working as a robust multi-professional team. The quality review team heard that referrals from the ED to the surgical teams and obstetrics and gynaecology worked well and there were no issues with referring patients. The trainees commented that referrals to these services were often to core trainees. The quality review team was informed that referral process from the ED to the medical team was variable. The medical higher trainee in the ED took referrals face to face but when the medical higher trainee was reviewing patients or not in the ED the trainees were unsure if they should bleep the medical trainee to refer a patient or wait till the trainee was back in the department for this to be face to face. Furthermore, there was a significant discrepancy in relation to the ability of ED staff to refer patients to the medical team in the 20 minutes before the handover meeting with one consultant forbidding this and the others allowing this. This created difficulties for the EM staff. At night, the variability of referrals seemed to be intensified as there was only one medical higher trainee covering the hospital and the ED trainees could be waiting up to two hours to refer a patient. The trainees reported that if referrals were prolonged they had to wait till the medical higher trainee was available as they were unaware of an escalation policy; the trainees reported that once the medical higher trainee had allowed the ED to make referrals directly to the core medical trainees overnight. The quality review team was told that the medical higher trainee would take the referrals from ED and then create a patient roster and distribute the patients amongst the medical core trainees. These patients would then be seen according to who came in first and the seriousness of the case. Due to the medical higher trainees' high workload as well as taking referrals this could create a bottleneck for them. The higher trainees reported that the net effect of the backlog often resulted in 25	Yes, see EM2.1a below Yes, see EM2.1b below

	patients waiting overnight to be admitted in the morning and consequently patients having to wait in corridors. The trainees suggested a protocol should be introduced for busy periods at night to ease the medical higher trainee's workload.	
EM 2.2	**Systems to manage learners' progression** All the trainees the quality review team interviewed reported that they would recommend their current post.	

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.

EM 3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** All the trainees working within the ED reported that there was a supportive team atmosphere. The trainees reported that the ED worked as a cohesive unit and this resulted in trainees feeling valued and able to ask for support and advice when necessary. The acute medicine department did not appear to the trainees to have as supportive environment as that within ED. This was due to the trainees working with different consultants each day on a busy acute take and there was not much opportunity for one to one time with consultants. The trainees did report that they were able to escalate concerns and were supported with patient care by the higher trainees and consultants during the day.	
EM 3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The quality review team was informed by the trainees of behavior that undermined professional confidence, performance or self-esteem. The quality review team heard that trainees often felt intimidated and undermined when they attempted to refer patients to the medical team in particular between 7.40 am and 8.30 am. This behaviour was mainly only shown by one individual and was not reciprocated by the rest of the medical team. The quality review team heard that the relationships with radiology were still strained. The trainees reported that the on-call service was better than the face to face service throughout the day. The quality review team heard that when trainees referred patients for scans the radiology trainees would rank them as not urgent and push scans back to the next day when they were needed that day and the higher trainee would have to go back and support the foundation and core trainees' referral. The quality review team was informed that there were two consultants in particular that made the conversations difficult and would not take a referral over the phone. Therefore, the trainees had to leave the patient (some of whom were in resuscitation), exit the ED and go to radiology to refer patients. The review team felt that these behaviours were not conducive to a supportive learning environment and were not in keeping with the GMC's standards of good medical care and professional behaviours. The quality review team heard about the Trust anti-bullying campaign and how trainees who had been bullied or undermined were volunteering for this service which they were very positive about and seemed to be a good initiative.	Yes, see EM3.2a below Yes, see EM3.2b below

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The higher trainees had an academic day built into the rota once every three to four weeks which was for the trainees to utilise for their personal development such as quality improvement projects, audits, teaching medical students and attending clinics.			
The Trust's anti-bullying campaign and using trainees as volunteers to support this campaign			
Proactive approach from the ED consultants towards supporting trainees to complete WPBAs. Higher trainees reported that named consultants sought out trainees to complete WPBAs and that they supported trainees to achieve the curriculum requirements.			

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
EM 1.1	The Trust is to review the process for feeding back on incidents reported via Datix and ensure that trainees are informed of the progress and outcome of their reported incident.	The Trust is to provide copies of the Trust policy for feeding back from serious incidents and details of M&M meetings which trainees can attend to learn from serious incidents. The Trust is to devise and carry out an audit of Datix feedback to trainees over a four week period to demonstrate that this is taking place.	
EM 1.3	The Trust is to review the out of hours support available to the medicine teams at night to manage the deteriorating patient, escalating concerns and use of the SBAR tool.	The Trust is to provide a clear policy on the escalation of medical problems that occur in inpatients overnight. This policy must encompass all parts of the system including ward staff and ICU staff. The Trust must assure HEE SL that this policy is clearly communicated to all staff working at night. The Trust must ensure that its Hospital at Night team works as a coherent team and should review the process at another Trust (whose Hospital at Night team works well) (HEE SL to recommend a Trust)	

EM 1.5a	The Trust is to review the opening hours of the ID badge office on the days of induction to ensure that all trainees are able to receive their ID badges on the day of induction, especially all trainees who are starting straight on nights.	The Trust is to confirm the arrangements for the provision of ID badges at the next induction which is agreed by all departments involved in this process. They are to provide evidence that at the next induction all trainees receive their badges in a timely manner.	
EM 1.5b	The Trust is to ensure that those trainees working in AM ACCS posts are informed in advance of their induction arrangements.	The Trust is to confirm that ACCS AM trainees receive sufficient notice of where to attend for their induction. This could be in the form of the letter from the DME.	
EM1. 6	The Trust is to review the medicine morning handover to ensure that it is robust and all patients are handed over in a timely fashion.	The Trust is to review the medicine morning handover so that the on-call trainees do not have to attend multiple handovers prior to leaving the Trust. The Trust is to submit the outcome of this review, including any details of plans to address deficiencies in this area. The Trust is to ensure that all patients are handed over to the oncoming team.	
EM2. 1a	Ensure that there is appropriate support available to ACCS trainees at night. Ensure that the SBAR tool is utilised effectively. Review the hospital at night system and remind staff that the SBAR tool is to be used.	Provide outcome of review including plans to address deficiencies in the area of hospital at night, including ensuring appropriate support for trainees.	
EM 2.1b, EM3. 2b	The Trust is to review the referral policy from ED to medicine to ensure the policy is clear and is agreed by all stakeholders. The policy should include details on escalating referrals in times of increased workload.	The Trust is to provide evidence of the ED to medicine referrals policy; the policy should clearly state how to escalate referrals after waiting for prolonged periods of time to refer. The policy should also be clear on how to refer around handover. This policy should be agreed by the Clinical Directors of the ED and AM and disseminated to all staff members and referrals should take place as stated in the policy.	
EM 3.2a	The Trust is to review the bullying and undermining behaviours described within this report. The Trust must ensure that inappropriate behaviour ceases as it is not conducive to a supportive learning environment and is not in keeping with the GMC's standards of good medical care and professional behaviours.	The Trust is to review any reported incidents of bullying and undermining behaviour and within this report and provide evidence of the steps taken following this review. The Trust is required to encourage professional behaviours within the workplace and communication from the Trust that this has occurred. The Trust with HEE SL to ensure that trainees are not bullied and undermined. The Trust should ensure that all trainees are aware of the pastoral support available to them within the Trust.	

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
EM 1.2	The Trust is to review the staffing levels in the green area within the emergency department.	Please provide an outcome of the review and any actions which the Trust has implemented.	

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
HEE to write to the Trust to provide details on specific instances of behaviour that that undermines professional confidence, performance or self-esteem.	Ian Bateman, Head of Quality and Regulation Team

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	*Dr Andrew Frankel*
Date:	*16 November 2016*