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: 2 December 2016

Final Report

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Quality Review details

Background to review	The urgent concern review carried out on 2 December 2016 was one of a number of reviews, visits and meetings that had been undertaken by Health Education England (HEE) and the General Medical Council (GMC) with regards to the Trust's emergency department (ED) since May 2015. This report should therefore be considered alongside previous reports (from July 2015, March 2016, June 2016 and September 2016). HEE, accompanied by the GMC had previously 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. Following the July 2015 visit HEE and the GMC had 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 therefore 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. Further HEE-led visits with the GMC to the Trust had taken place in June and September 2016. A clinical commissioning group visit had also been undertaken on 21 November 2016 which had indicated that improvements had been made to the overall training environment. HEE and the GMC had originally planned to return to the Trust to undertake a follow-up visit in January 2017, but given the NHS England decision to lift the ambulance divert in November 2016, HEE and the GMC decided to return to the Trust earlier than anticipated to check if this decision had had any ramifications for the trainees in post at the time.
Specialties / grades reviewed	The quality review team met with trainees in emergency medicine at the following grades: • foundation year two (F2) • general practice specialty training year one and year two (ST1 and ST2) The quality review team also met with trainees in acute care common stem (ACCS) at the below grades: • specialty training year three (ST3)
Number of trainees from each specialty	The quality review team met with seven trainees in emergency medicine.
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 the improvements that had been made within the emergency department (ED) in the months since the March 2016 visit were clearly now well embedded in the department. The quality review team congratulated the Trust on the upward trajectory and urged the Trust to continue working with the department to ensure that the good progress was sustained. The review team highlighted the following areas that were working well: • The trainees reported that their level of clinical supervision was excellent; consultants were reported to be available, proactive and engaging, including out of hours;

- The trainees felt empowered to ask questions and felt valued by their educational and clinical supervisors;
- The trainees had seen no negative impact since the ambulance divert had been lifted and felt that the process had been managed successfully;
- The quality of the trainees' overall educational experience was to be commended; weekly teaching was appropriate and of a high quality although additional tweaks to the rota were required to ensure that the trainees could attend on a regular basis;
- There had been improvements in incident reporting with trainees confirming that they received feedback on incidents they had reported;
- The quality of triage had improved overall
- There were still some issues with referring patients to certain specialty departments after they were seen by the ED team;
- The standard of care policy being established across departments was found to be a positive tool which the review team felt needed to be embedded further across the Trust;
- It was clear to the review team that the culture of the department had changed for the better and that despite pre-conceptions about the Trust the trainees had been pleasantly surprised when they arrived at the Trust to find a cohesive, friendly team in the ED.

Various areas for improvement were also identified by the quality review team, detailed below:

- The quality review team noted that on-going issues regarding access to patients' medical notes or casualty cards still persisted;
- The virtual learning environment appeared to be under-utilised by the trainees although the review team acknowledged it had only just been launched; HEE expressed and offered its support for this valuable tool;
- The neutropenic sepsis pathway was found to be unclear and the review team felt that this could have a potential impact on patient care; the review team suggested it be reviewed to ensure clarity of the pathway for treating patients presenting in the ED with suspected neutropenic sepsis;
- The quality review team also heard that at times there were delays with patients (often children) having their observations checked. The trainees felt that the nurses at times were reluctant to re-do observations in a timely fashion and were concerned about the potential impact on delays in assessment;
- The trainees reported that at times there were still personality clashes between certain individuals which led to inappropriate public displays in front of patients; whilst trainees were clear that they were not involved in such incidences the quality team felt that this was not conducive to inspiring confidence in the Trust for patients or staff;
- Although the appointment of a flow coordinator had had a positive impact, there was still a need for this role to be more embedded so that all were clear about roles and responsibilities, especially the difference between the flow co-ordinator and nurse in charge roles.

The trainees interviewed all reported that their experience at the Trust had been much better than they had anticipated as they had had low expectations before they arrived at the Trust. Without exception, the trainees all agreed that they would recommend their post for training, particularly thanks to the level of clinical acuity and interesting pathology encountered. However, most admitted that they would still not recommend the Trust to their friends and family as a place to be treated. The quality review team emphasised to the Trust in the feedback session that there were significant elements to this that were beyond the Trust's control,

	given that it was due to concerns about the excessive wait time in the ED due to patient flow, and it should be noted therefore that the view of trainees reflected this rather than any particular concern about the emergency department itself. By the end of the review, the quality review team was confident that whilst certain issues remained, the Trust was fully engaged in improving the quality of patient care, and education and training in the ED. The review team stated that HEE would continue to work with the Trust to support this. No additional requirements were placed on the Trust following this review, and the requirements set in March 2016 were reviewed with a view to removing some requirements previously placed on the Trust. As a result, all the immediate mandatory requirements issued at the March 2016 visit were closed.

Quality Review Team			
Lead Visitor	Dr Sanjiv Ahluwalia, Postgraduate Dean, Health Education England, working across North Central and East London	**GMC Representative**	Alexandra Blohm, Education Quality Assurance Programme Manager, General Medical Council
HEE Representative	Ian Bateman, Head of Quality and Regulation, Health Education England London and South East	**Scribe**	Jane MacPherson, Deputy Quality and Reviews Manager, Health Education England London and South East

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services.

1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.

Ref	Findings	Action required? Requirement

		Reference Number
EM1.1	**Patient safety** The quality review team heard that the decision to lift the ambulance divert had not led to any negative repercussions for the trainees. The trainees all stated that the number of 'blue calls' and subsequent intensity of workload varied significantly depending on the night in question but the trainees all felt that this had been successfully managed and that they received appropriate supervision out of hours. The quality review team heard that a core-level doctor had been allocated to the resuscitation area and that this had had a positive impact on the trainees' workload in the emergency department (ED). Unlike at other earlier visits, none of the trainees reported serious issues with faulty equipment although it was highlighted that some of the otoscopes were broken at the time of the review. The quality review heard that the system of streaming and patient flow into adult triage had improved since the earlier visits, albeit with the occasional problem. For example, the neutropenic sepsis pathway appeared to be an issue: the quality review team heard that the ED saw the cancer patients first before they moved through to oncology but at times it was not clear whether or not blood tests had been taken due to stickers not being printed for the tubes. Trainees also reported a regular long wait for these patients, which was not in line with national guidelines for the treatment of suspected neutropenic sepsis. Notwithstanding this, the main issue with regard to this pathway appeared to be a lack of clarity about how it should work and therefore the Trust was asked and agreed to review this. The senior management team informed the quality review team that the Trust was implementing a new requesting system for laboratory tests. The trainees also highlighted other reasons for the slow flow of patients, including delays in test results returning from the laboratory, as well as radiology delays, and a delay in discharging paediatric cases from the paediatric ED due to observations not being re-completed by some nursing staff.	
EM1.2	**Serious incidents and professional duty of candour** Although the majority of the trainees interviewed by the quality review team had not submitted any Datix reports, those that had confirmed that they had received feedback on incidents they had raised. This was in stark contrast to previous visits when serious concerns had been raised regarding incident reporting. The quality review team was pleased to note the improvement in this area. At the previous visit in September 2016 it had been 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 patients' notes. As a result, trainees were not aware of investigations that may have been requested. The quality review team was disappointed to note that on-going issues regarding access to patients' medical notes or casualty cards still persisted at the subsequent review in December 2016. Trainees stated that at times they had to sift through a large number of ECGs to try and find the correct patient and also reported that casualty cards were still going missing, which sometimes led to patients being issued with two cards. The trainees noted that this presented a potential prescribing risk as it was not always clear what drugs had already been administered and recorded on the lost casualty card. The trainees informed the review team that a project was on-going at the Trust to try and address this problem. The trainees suggested that installing a functioning printer in the rapid assessment area would go a long way to alleviating this issue. During the feedback session the Clinical Director advised the review team that steps were being taken to resolve this matter and that the Trust had a self-enforced deadline of the week commencing 5 December 2016 to remedy this issue – this included the purchasing of a new printer as suggested by trainees. The quality review team was however pleased to hear that previous concerns regarding the timeliness of patients having electrocardiograms (ECGs) appeared to	

	have been resolved. The trainees reported that anyone who booked into the main reception with non-traumatic chest pain received an ECG within 15 minutes, and were then managed as a cohort within the ED. At the previous visit, the trainees had advised the quality review team that they had not all received individual cards for the arterial blood gas (ABG) machine. This issue appeared to have been largely resolved by December 2016 with the exception of one trainee who had not attended the required training course. The trainees interviewed expressed frustration about the lack of private space in which to take patients' history and the paucity of cubicles available. The trainees reported that at times they had to take patients' history in the corridor. Although some trainees reported that they had been given guidance on 'taking history in an open environment' as part of mandatory training, others had not and in general the trainees felt (particularly at times when the department was extremely busy due to the high number of patients attending the department) that they had no alternative but to carry out these consultations in a less-than-private area.	
EM1.3	**Appropriate level of clinical supervision** The foundation, GP and ACCS trainees all stated that they received appropriate supervision, both during the day and at night, and they confirmed that the level of supervision was appropriate during the previously difficult period of 6am to 8am. The trainees commended their supervisors for their proactivity, visibility (particularly during the day) and enthusiasm to teach. Some trainees commented that the clinical supervision that they had been receiving since September 2016 was much better than at other Trusts. The trainees also enthused about the locum consultants who had been recruited recently and who they felt had had a positive impact on their training experience. All the trainees interviewed confirmed that they felt comfortable approaching their consultants and that support was readily available. The foundation, GP and ACCS trainees agreed that their out-of-hours experience was largely dependent on which middle grade trainee or Trust grade doctor was on duty with them at night but they were grateful that the rota coordinator was clearly making an effort to ensure that each night-shift was staffed with an appropriate skill mix across the middle grade rota. The trainees confirmed that they knew who in the department was a middle grade and who was a consultant by the uniform they wore. The quality review team heard that the trainees' experience in the paediatric ED had been improved by the presence of a consultant who covered the twilight period; the trainees agreed that when this doctor was not on duty, accessing support was more difficult. Some of the trainees commented that they felt uncomfortable working in the paediatric ED particularly at night, as they felt more isolated. They agreed though that appropriate support was available if they needed it, both within the ED, and from the paediatric higher trainee covering on call duty.	
EM1.4	**Responsibilities for patient care appropriate for stage of education and training** The quality review team heard that there was some tension between some of the nurses in the paediatric area of the ED and the junior doctors and it seemed as though this was largely down to a lack of communication regarding roles and responsibilities; the review team suggested that the nurses perhaps needed further guidance and clarification on the role of the junior doctor. The quality review team also heard that at times there were delays with patients (often children) having their observations checked. The trainees felt that the nurses at times were reluctant to re-do observations in a timely fashion and were concerned about the potential impact on patient safety, as well as the delay this caused in terms of discharging those fit to go home. The quality review team heard that there was some confusion regarding the roles and responsibilities of both the flow coordinator and the nurse in charge positions. Some of the trainees suggested that these people did not see all the wider issues of the department and concentrated more on bed and cubicle management. Similar to the recommendation at the September 2016 visit, the quality review team recommended	

	that the Trust should clarify the lines of responsibility of both these posts. Trainees reported no issues in acting above or below their level of competence. They commented that at times they acted down and were happy to do so whereas other times they acted up but felt comfortable doing so as a consultant was always available if needed.	
EM1.5	**Protected time for learning and organised educational sessions** The trainees reported that the quality of the Wednesday morning teaching session was good, but similar to the previous visit the trainees stated that that it could be challenging to attend the teaching sessions due to rota design. Although the trainees were aware of the virtual learning sessions available on the Trust intranet, none had taken advantage of this resource. The review team recommended that the Trust should record the Wednesday teaching sessions so that the trainees could watch this invaluable teaching in their own time, and HEE confirmed to the Trust its willingness to fund audio-visual equipment for this purpose. Some of the trainees had heard that the Trust was planning to re-schedule the Wednesday session in any case so they hoped that they would be able to attend more sessions in future. The GP trainees were not able to attend as many of the half-day release sessions as they would have liked, again due to rota constraints.	
EM1.6	**Adequate time and resources to complete assessments required by the curriculum** All of the trainees interviewed confirmed that they had met with their educational supervisor and clinical supervisor and were able to complete workplace-based assessments.	

3. Supporting and empowering learners

HEE Quality Standards

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.

3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.

EM3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** Regarding security within the ED which had previously been raised as an issue at earlier visits, trainees at all levels confirmed that this was no longer a concern, although they did concede that some of the security guards were not as effective or attentive as they should have been.	
EM3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The quality review was pleased to note that none of the trainees interviewed had been subject to bullying and undermining behaviour. Some trainees commented, however, that they had witnessed episodes of inappropriate behaviour displayed by particular staff members in front of patients; typically these were arguments about patient care which the trainees felt should have been conducted privately. Appropriate more detailed information to enable this to be addressed was shared with the senior management team at the end of the visit. At the September 2016 visit, the quality review team had heard that relations between specialty teams were on occasion obstructive with neither team willing to take responsibility for certain patients. This had especially been the case for medical and surgical teams and between obstetrics and gynaecology (O&G) and surgical teams. At the time of the December 2016 review, it appeared that these issues had largely been resolved, although this was still a work in progress for certain areas (namely, the medical and orthopaedic teams). The trainees reported that they found	

	the new ‘standard of care’ document useful as it outlined the correct pathway and which department each patient should belong to. The senior management team reported that they were keen to use the ‘standard of care’ policy in a practical way and that there were plans to audit the usage of this document in the future.	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.

5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.

5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.

5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.

EM5.1	**Regular, useful meetings with clinical and educational supervisors** See EM1.8.	

Signed

By the HEE Review Lead on behalf of the Quality Review Team:	Sanjiv Ahluwalia
Date:	14 December 2016