QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Barts Health NHS Trust (Whipps Cross University Hospital)

Acute medicine and emergency medicine

Risk-based Review (focus group)

Quality Review report

05 July 2017

Final Report

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Quality Review details

Background to review	Concerns relating to the education and training within emergency medicine and acute medicine at Whipps Cross University Hospital had been longstanding and were highlighted in the 2016 General Medical Council National Training Survey (GMC NTS). Following a meeting with the Trust's Education Team, the Trust Liaison Dean and the GP Head of School in February 2017, it was decided that the Trust would internally explore the issues within the training programmes and undertake an internal review (using a mock HEE focus group review style) to gain further feedback from the trainees in both specialties. Following the internal review, a meeting was arranged with key members of the Trust, Health Education England (HEE) and NHS Improvement in order to explore the findings of the internal review and what actions had been implemented to address the concerns raised. During this meeting, it was noted that the Trust appeared to be committed to improving the training environment in both acute medicine and emergency medicine. It was agreed that HEE would undertake a focus group with both cohorts of trainees in July 2017 to fully explore the improvements the Trust had made and to establish whether any further intervention was necessary in order to improve the learning and training environment.
Training programme / learner group reviewed	Acute medicine Emergency medicine
Quality review summary	Health Education England (HEE) would like to thank the Trust for accommodating the Risk-based Review (focus group). During the course of the review, the quality review team identified three areas of serious concern, for which immediate mandatory requirements were issued: - It appeared to the review team that the trainees in acute medicine were unclear about the patient pathway for patients with acute vascular conditions in the Ambulatory Assessment Unit (AAU) or on a medical ward and whether they should be transferred to the Royal London Hospital site immediately or whether they should be reviewed by the general surgery team at the Whipps Cross University Hospital first. The trainees reported that if they tried to obtain an assessment regarding a vascular issue from the general surgery team, they often refused to see and take responsibility for the patient, and believed that they should have been sent straight to the Royal London Hospital. The Trust was required to ensure a robust pathway for such patients was in place and that the policy was well-known and disseminated amongst all relevant staff. - The quality review team was informed that the handover system, in relation to patients moving from the AAU to other specialist wards in the hospital was insufficient and not formal nor robust. The trainees reported that there was often a nurse to nurse handover of patients, but that no formal handover between doctors in the AAU and the ward took place, which resulted in teams not being aware of patients that were under their directorate and who they were responsible for. The Trust was asked to ensure that a robust handover system was in place for patients moving from the AAU to other wards. - It appeared to the quality review team that the acute medicine trainees were unclear about and unaware of which consultant was providing cover for the AAU and who they should contact regarding patients on the AAU, from 3pm to 5pm. The Trust was asked to ensure there is a named

consultant who is responsible for all patients in the AAU at all times. A board handover meeting between the AAU consultant who leaves at 3pm and the consultant who is responsible for such patients after 3pm, with the junior trainees present, or an equivalent system or process must be introduced. The AAU junior staff must be aware of who the consultant they should escalate to is at all times.

The review team was further informed of a number of improvements that had been made, particularly in relation to the emergency department and a number of areas that were working well with regard to the education and training of acute medicine and emergency medicine trainees, as outlined below:

- Trainees at all levels in both acute medicine and emergency medicine were very positive regarding their educational and clinical supervisors, and felt they were approachable and accessible. The trainees reported that they were able to complete their work-place based assessments and relevant competencies for their Annual Review of Competence Progression (ARCP).
- The quality review team was informed of the new 'hot hub' radiology initiative that had been introduced. The emergency medicine trainees were extremely complimentary of the system and indicated that their requests were processed promptly.
- The emergency medicine trainees at all levels reported that they received good levels of support from staff in the intensive care unit, the medical higher trainees, and the admissions avoidance team, which was well integrated and worked well.
- All of the trainees the review team met with reported that they were able to secure study leave easily and could attend their relevant GP, foundation or core training sessions. The foundation trainees within emergency medicine reported that weekly departmental teaching had also taken place, which they found extremely useful.

Additionally, areas for improvement were highlighted as follows:

- The quality review team heard that the departmental teaching that rotated around different Bart's sites teaching that was previously provided once a month for the core and higher trainees in the emergency department (ED) had not been provided for two months prior to the review. The trainees indicated that they had previously found the teaching sessions useful.
- The emergency medicine trainees indicated that although there was a adequate clinical supervision and support provided during the day, out of hours this was variable. The review team was informed that there was a lack of permanent core or higher-grade trainees on the out of hours rota, and that these posts were predominantly filled by locums who provided variable levels of clinical supervision and support. However, it should be noted that all trainees reported that they had never had to make decisions or act beyond their level of competence and could always access someone more senior when necessary.
- When discussing how patients were referred from the ED to the AAU, the acute medicine trainees reported that the ED staff would make the referral directly to the medical higher trainee. However, the trainees stated that this was not always communicated to the team in the AAU and that no formal handover was in place, meaning at times it could be unclear who was responsible for a particular patient, especially if the patient remained in the ED department whilst awaiting transfer to a medical bed.

Quality Review Team

HEE Review Lead	Dr Catherine Bryant Deputy Head of School for Medicine and Medical Specialties	**HEE Review Lead**	Dr Jamal Mortazavi Deputy Head of the London Specialty School of Emergency Medicine
Trust Liaison Dean	Dr Indranil Chakravorty Trust Liaison Dean, Health Education England North East London	**External Clinician**	Dr Kevin O'Kane Training Programme Director for acute medicine, South London
External Clinician	Dr Gillian Park London Northwest Healthcare NHS Trust	**Scribe**	Elizabeth Dailly Deputy Quality and Reviews Manager Health Education England London and the South East
Lay Member	Ryan Jeffs Lay representative		

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
AM&EM 1.1	**Patient safety** It appeared to the review team that the trainees in acute medicine were unclear about the patient pathway for patients with acute vascular conditions in the Ambulatory Assessment Unit (AAU) or on a medical ward and whether they should be transferred to the Royal London Hospital site immediately or whether they should be reviewed by the general surgery team at the Whipps Cross University Hospital first. The trainees reported that when they attempted to send such patients to the Royal London Hospital they were informed by the vascular team that as it was not an emergency, the patient needed to be reviewed by the general surgery team at Whipps Cross University Hospital.	Yes, please see AM&EM1.1 below

	However, the trainees indicated that when they tried to then obtain an assessment regarding a vascular issue from the general surgery team based at Whipps Cross Hospital, they often refused to see and take responsibility for the patient, and believed that they should have been sent straight to the Royal London Hospital. It should be noted that the trainees within emergency medicine reported that any vascular patient transfers to the Royal London Hospital they had been involved in had run smoothly and that the pathway from the Emergency Department (ED) functioned effectively.	
AM&EM 1.2	**Serious incidents and professional duty of candour** All of the trainees, in both acute medicine and emergency medicine confirmed that they were aware of how to report serious incidents through the Datix system. However, some of the acute medicine trainees indicated that although they were often encouraged to complete Datix reports, they felt that they often underreported and that there were a lot of missed opportunities for reporting in the Acute Assessment Unit (AAU). This was primarily due to how busy the unit was and the length of time it took to complete the relevant form, which acted as a deterrent and meant the trainees often were not able to complete them in real time and during their working hours. Furthermore, the review team heard that although trainees received initial feedback when they submitted a report, informing them of who was investigating the incident, some felt the final feedback they then received was insufficient and did not provide a full root cause analysis of the problem.	
AM&EM 1.3	**Appropriate level of clinical supervision** The acute medicine (AM) trainees reported that generally they received good clinical supervision during the day when working in the AAU and that they could access a good level of senior supervision from the higher trainees in the unit from 9am-5pm. Nonetheless, the trainees appeared to be less clear regarding the arrangements for consultant cover in the AAU. They reported that there was a designated consultant covering the unit in the morning until 3pm and then another consultant responsible for the unit from 5pm, but that they were often unsure as to which consultant they should escalate to and contact from 3pm till 5pm. However, it should be noted, that the trainees reported that they had never had to act outside their competence during these periods and that they were always able to contact the higher trainee if necessary. The quality review team was also informed that the clinical supervision and support provided in the evenings was inconsistent and variable. The review team heard that at the time of the review, a locum Trust grade doctor undertook a 12-hour shift Monday-Thursday, providing additional senior review until 9pm, which the trainees found extremely useful when undertaking out of hour shifts. However, the trainees reported that the individual in particular was due to embark upon a training post in August 2017 and that they were unsure who would then provide this additional clinical supervision for more junior trainees. The AM trainees further stated that the out of hours' arrangements, which consisted of one junior trainee based on the AAU, two junior trainees covering the take, two junior trainees covering the wards and one higher trainee with overall responsibility who they could contact, worked well when they were fully staffed and there were no rota gaps. However, the trainees indicated that often, there were only four junior trainees covering all three areas, due to rota gaps. Therefore, often there would just be one junior trainee covering all the wards, as the AAU needed to be manned at all times. When discussing the clinical supervision provided in the ED, the emergency medicine trainees reported that overall they felt well supported and that they were especially well supervised during the day, as there was a consultant in the department until 10pm, and multiple higher trainees they could access. However,	Yes, please see AM&EM1.3a below

	the trainees stated that this high standard of supervision did not extend out of hours, as there was a lack of permanent higher grade trainees on the out of hours' rota, and these posts were predominantly filled by locums who provided variable levels of clinical supervision and support. The trainees stated that often the most senior doctor in the ED, who was a permanent member of staff was Specialty Training Year 1 or 2 (ST1 or 2). When asked about the supervision provided by the locums, the trainees reported that this varied and depended on the individual in question. The EM trainees stated that some of the locums were extremely difficult to get hold of during the out of hours shifts for senior advice, meaning predominantly the shop floor was covered by just the core trainee and the junior trainees. Furthermore, as the out of hours' team covered three different areas within the ED (paediatric ED, the resuscitation unit and majors), the trainees reported that they could feel 'stretched'; especially if the higher trainee or locum Trust grade doctor were with a sick patient in the resuscitation unit and they needed their advice or senior review. However, it should be noted that all trainees reported that they had never had to make decisions or act beyond their level of competence and had always been able to access someone more senior, often by phone, when necessary. Furthermore, the trainees reported that they were also able to access support from the Intensive Care Unit (ITU) and anaesthetic consultants if necessary. The emergency medicine trainees were extremely complimentary of the services provided by the Admissions Avoidance Team (AAT) and reported that they saw patients quickly and provided additional support.	Yes, please see AM&EM1.3b below
AM&EM 1.4	**Induction** Trainees in both specialties at all levels confirmed that they had received both Trust and departmental inductions. However, the AM trainees indicated that although they did receive a booklet with some information regarding the systems and patient pathways in place in the AAU, this was not detailed and robust enough and that they had had to learn such processes 'on the job'.	Yes, please see AM&EM1.4 below
AM&EM 1.5	**Handover** When discussing the patient pathways in place for patients who were treated in the AAU, the AM trainees indicated that there was no overarching and formal Standard Operating Procedure (SOP) or process in place which covered all of the relevant systems and pathways. The quality review team was informed by the AM trainees that two handover meetings took place in the AAU daily. The first in the morning was led by the consultant and all relevant members of staff attended to discuss patient plans for that day. A further meeting took place in at 2pm, which focused on upcoming patient discharges. The AM trainees indicated that when patients arrived in the AAU from the Emergency Department (ED), how thoroughly they had been triaged could greatly vary, depending on how busy the ED was. When discussing how patients were referred from the ED to the AAU, the trainees reported that the ED staff would make the referral directly to the medical higher trainee, who then accepted the patient. However, the trainees stated that this was not always efficiently communicated to the team in the AAU and that no formal handover or appropriate and robust 'flagging' system was in place, meaning at times it could be unclear which team was responsible for a particular patient in the AAU, as the unit was also used for patients under the care of other specialties When discussing how patients were then transferred from the AAU to the relevant medical wards in the hospital, the quality review team was informed that although a nurse to nurse handover always occurred and that the trainees often tried to contact the ward team to personally handover the patient, there was no sufficient and robust handover system in place between the relevant doctors in the AAU and the ward. The quality review team heard that this on occasion led to instances in which the teams on the ward were unaware of patients who were under their	Yes, please see AM&EM1.5a below Yes, please see AM&EM1.5b Yes, please see AM&EM1.5c below

	directorate and who they were responsible for. Furthermore, the acute medicine trainees reported that they felt this could lead to a delay in patient care and often meant that certain jobs were not picked up and missed. The trainees were also concerned that the lack of formal system in place could lead to potential patient safety issues, if the patient who had been transferred became unwell on the ward, as the ward team were not necessarily fully aware of the patient's condition and what interventions had already been undertaken. The quality review team was also informed that it was unclear as to who was required to provide direct care and was responsible for patients who had been accepted by the medical higher trainee and was due to move to the AAU, but who due to bed capacity issues had to remain in the ED. The acute medicine trainees were unsure whether they should attend the ED themselves to carry out jobs for the patient, or whether such tasks were undertaken by the ED staff. However, it should be noted that the review team was informed that quality improvement projects were being undertaken at the time of the review, to address both of the handover systems and ensure more robust processes and patient pathways were introduced. When discussing the handover system in the Emergency Department, the trainees reported that it worked well. They stated that four separate handover meetings and board rounds took place throughout the day, that they were consultant led and at which attendance was compulsory. The review team heard that the handover meetings sometimes provided teaching opportunities, depending on which consultant was leading them.	Yes, please see AM&EM1.5d below
AM&EM 1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The trainees in both acute medicine and emergency medicine commented that they were exposed to a wide range of pathologies and cases throughout their placements.	
AM&EM 1.7	**Protected time for learning and organised educational sessions** All of the trainees within acute medicine and emergency medicine confirmed that they were released for and able to attend their specific core, foundation and GP teaching sessions. However, the review team was informed that the weekly foundation teaching that had been provided had been stopped once the trainees had undertaken their Annual Review of Competency Progression (ARCP). The review team was informed that although efforts had been made to attempt to organise departmental teaching for the junior and core AM trainees; this had been unsuccessful and no formal teaching was incorporated into their rotas. The foundation trainees within emergency medicine stated that departmental teaching sessions were provided weekly and that they were also exposed to ad hoc teaching opportunities on the shop floor. However, the review team was informed that although teaching had previously been provided on a monthly basis for core and higher trainees, which was of a high standard, had consultant presence and included teaching from other specialties, this had not been run for the two months prior to the review. The trainees indicated that there had been plans to provide a 'catch up day but that no formal plans or date had been communicated to the trainees.	Yes, please see AM&EM1.7a below Yes, please see AM&EM1.7b below
AM&EM 1.8	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** All of the AM trainees the review team met with confirmed that they had been allocated an educational and clinical supervisor during their induction and that they were able to meet with and access them easily, in order to complete their relevant work-based place assessments (WBPAs). This was reiterated by all the trainees in	

	emergency medicine, who confirmed that they had been able to meet with both their educational and clinical supervisors easily throughout the placement.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity.

2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.

2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.

AM&EM 2.1	**Effective, transparent and clearly understood educational governance systems and processes** The acute medicine trainees reported that there were opportunities for them to be involved in governance and quality improvement projects, but that no regular morbidity and mortality or audit meetings took place within the department. Moreover, some trainees the review team met with felt that they sometimes faced hurdles and barriers when they attempted to implement small and simple changes in the department, that may improve processes and patient flow.	
AM&EM 2.2	**Impact of service design on learners** The emergency medicine trainees informed the review team of a new 'hot hub' system that had been introduced to improve the radiology service. The trainees were extremely complimentary of the system and reported that until 5pm, their requests were processed within half an hour.	

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.

AM&EM 3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** All of the trainees the review team met with, in both specialties confirmed that if they had any issues or concerns, they were aware of who they should raise them with and felt comfortable doing so.	
AM&EM 3.2	**Access to study leave**	

	All of the AM trainees the review team met with reported that they had been able to secure study leave with the rota coordinator. Similarly, trainees in emergency medicine reported that they were able to attend their relevant regional teaching sessions.	

Good Practice and Requirements

Good Practice
The emergency medicine trainees informed the review team of a new 'hot hub' system that had been introduced to improve the radiology service. The trainees were extremely complimentary of the system and reported that until 5pm, their requests were processed within half an hour.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
AM&EM 1.1	The Trust must ensure there is a robust patient pathway in place regarding patients with acute vascular conditions in the Acute Assessment Unit (AAU) or on the medical wards and that this policy is well known and disseminated amongst staff.	The Trust to submit the policy and evidence that the policy has been disseminated amongst the relevant members of staff, i.e. by submitting copies of the email or communication that was sent.	R1.2
AM&EM 1.3a	The Trust must ensure that there is a named consultant who is responsible for all patients in the AAU at all times. A board handover between the AAU consultant who leaves at 3pm and the consultant who is taking over responsibility for such patients at 3pm with the junior trainees present, so they are aware of who to escalate to during this period, or an equivalent system or process must be introduced. The AAU junior staff must be aware of who the consultant they should escalate to is at all times.	The Trust to confirm that the board handover at 3pm with the junior trainees, or an equivalent system has been introduced.	R1.8
AM&EM 1.5c	The Trust must ensure that a robust handover system is in place, for patients moving from the AAU to other wards.	The Trust to confirm that a more robust handover system is in place for patients moving from the AAU to other wards, and provide details of the new system in place.	R1.14

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
AM&EM 1.3b	The Trust to provide additional training and support to any locum doctors undertaking out of hours shifts in the emergency	The Trust to detail what training and additional measures have been taken to ensure that the locum staff providing clinical	R1.8

	department, to ensure that they are able to provide sufficient clinical supervision to the junior and core trainees on the rota.	supervision to junior and core trainees out of hours are competent and able to do so. Compliance with this action should be monitored through Local Faculty Group (LFG) meetings. The Trust to submit minutes from LFG meetings and a register of attendance, where the clinical supervision provided by locum staff out of hours is discussed over a three-month period.	
AM&EM 1.5b	The Trust to review the handover and flagging system in place for patients moving from the emergency department (ED) to the acute assessment unit (AAU). The Trust to ensure that all patients are appropriately flagged for each specialty team when they arrive in the AAU.	The Trust to provide the outcome of the review and evidence what changes have been implemented regarding the appropriate flagging of patients moving to the AAU. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings and a register of attendance, where the handover and flagging of patients moving from the ED to the AAU is discussed over a three-month period.	R1.14
AM&EM 1.5d	The Trust to clarify whether patients who have been accepted by the medical higher trainee to move to the AAU, but due to bed capacity issues remain in the ED, are under the direct care and responsibility of the trainees within the AAU or the ED. The Trust to ensure that this policy is well known and disseminated amongst all relevant members of staff.	The Trust to confirm the policy with HEE and provide evidence that this has been communicated with all relevant members of staff.	R1.6
AM&EM 1.7a	The Trust is required to ensure that acute medicine trainees have access to protected departmental teaching sessions that are relevant to their level of training. The Trust should liaise with the trainees in order to garner their opinion on the introduction of a programme of teaching sessions, and when would be the most suitable time to hold them.	The Trust to submit the following items: - copies of the communications sent trainees around introducing weekly teaching sessions relevant to their level of training, - confirmation of when these sessions will be held (day and time), - programme of teaching sessions which includes details of topics to be covered. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes and a register of attendance from LFG meetings over a three-month period, where teaching sessions for acute medicine trainees is discussed.	R1.16
AM&EM 1.7b	The Trust is required to ensure that core and higher emergency medicine trainees have access to protected departmental teaching sessions that are relevant to their level of training. The Trust should liaise with the trainees in order to garner their opinion on the	The Trust to submit the following items: - copies of the communications sent trainees around introducing weekly teaching sessions relevant to their level of training, - confirmation of when these sessions will be held (day and time),	R1.16

	introduction of a programme of teaching sessions, and when would be the most suitable time to hold them.	- programme of teaching sessions which includes details of topics to be covered. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes and a register of attendance from LFG meetings over a three-month period, where teaching sessions for core and higher emergency medicine trainees is discussed.	

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
AM&EM 1.4	The Trust to review the information booklet provided for acute medicine trainees regarding the patient pathways in place in the Acute Assessment Unit.	The Trust to confirm the outcome of the review and what changes have been made to the induction booklet provided to trainees. The Trust to submit the booklet trainees receive.	R1.13
AM&EM 1.5a	The Trust to review the whole patient care pathway in acute medicine. HEE recommends that the Trust works with NHS Improvement to undertake this review, and implement changes to ensure the pathways are robust and suitable.	The Trust to confirm that such a review has taken place and detail the subsequent changes that have been made to the patient care pathway in place.	R1.2

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
Whipps Cross has the potential to offer excellent acute medical experience for CMT trainees. CMT quality criteria published by the JRCPTB state that trainees should spend a minimum of two-thirds of placements (usually 16 months) contributing to the acute medical take, including the acute medical unit. During the transition of CMT to the new Internal Medicine 3Y programme, the Training Programme Director for CMT in NE London and London School of Medicine should review the current distribution of trainees across the Barts HealthTrust to ensure that all trainees have training programmes that are compliant with CMT quality criteria and matched to the learning opportunities available across the 4 sites.	TPD and London School of Medicine

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Catherine Byant
Date:	11 July 2017

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.