QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

North Middlesex University Hospital NHS Trust

Emergency Department

Urgent Concern Review (on-site visit)

Quality Review report

23 October 2017

Final Report

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Quality Review details

Background to review	A number of reviews had previously been undertaken by Health Education England (HEE) and the General Medical Council (GMC) in regard to the emergency department (ED) at North Middlesex University Hospital NHS Trust since May 2015. HEE felt it was necessary to undertake a survey in September 2017 following the previous Urgent Concern Review to ED in June 2016. The survey highlighted a number of issues in relation to the clinical supervision provided within the department and the overall culture, especially in the paediatrics and resuscitation areas of the ED. Therefore, HEE felt it was necessary to undertake a further Urgent Concern Review (on-site visit) accompanied by the GMC and NHS Emergency Care Improvement Programme with the trainees, to gain further feedback and a greater understanding of whether the learning and training environment was suitable for trainees.
Training programme / learner group reviewed	Emergency Department
Number of learners and educators from each training programme	The quality review team met with the Deputy Chief Executive Officer (CEO), who was also the Trust Interim Medical Director. The quality review team also met with the Director of Medical Education (DME). The quality review team also met with the following trainees: • three foundation year 2 (F2) trainees • two GP trainees • one higher Emergency Medicine (EM) trainee • Two core EM trainees
Review summary and outcomes	During the course of the Urgent Concern Review (on-site visit), the quality review team acknowledged that the ED in North Middlesex University Hospital had the potential to provide a good environment for learning and high quality education, and offered a wide case mix and range of pathology. The quality review team acknowledged the work undertaken by the DME. The quality review team also recognised the significant work that the new CEO and interim MD had contributed to the department, who even after such a short period of time at the Trust seemed to be engaged and committed to improving the learning and educational environment for the trainees. A number of areas of improvement were highlighted as follows: • The quality review team was pleased to hear that all trainees had had both departmental and Trust-wide inductions, although some areas were identified which required improvement. • The trainees reported that a consistent handover meeting took place every morning, which had not been in place at previous reviews undertaken by HEE. However, it was acknowledged that the handover meetings could be improved for educational purposes. • The quality review team was pleased to hear that there had been no reports of overt bullying which the quality review team acknowledged as a huge improvement.

- The trainees were extremely complimentary of the paediatric emergency medicine consultants, and reported that good levels of support and supervision were provided when they were available within the department during the daytime hours.

Unfortunately, during the course of the visit, a number of areas of concern were reported and still remained from the previous reviews as outlined below:

Educational

- It was reported that the clinical supervision provided in department was poor. The quality of the clinical supervision provided in the paediatric emergency department and the resuscitation unit was reported to be absent or variable, especially out of hours. Trainees (including F2) reported that during the overnight shift, they were left in the department on their own, and had to physically leave the department to seek senior supervision or advice.
- Trainees were unable to access educational opportunities – foundation and GP trainees could not attend their specialty-specific training sessions. In regards to departmental training, the trainees reported they were asked to come in outside of their timetabled hours, for example, to come in earlier than their scheduled morning shift, or stay three hours after the 12-hour night shifts in order to attend.
- Rotas were reported as not being conducive to education – the quality review team learned that the teaching sessions were not incorporated in the trainees' rotas.
- The quality review team ascertained that ED needed an identified senior clinician who offered leadership to the department. Trainees acknowledged the flux and vulnerability of the department arising due to lack of leadership and reported that they did not know who to approach for advice on a day to day basis.
- The quality review team thought that the organisation's approach to learning from serious incidents (SIs) had made some progress. However, the opportunity to learn from SIs as an organisation seemed to remain lacking.

Systemic

- There appeared to be an overt focus for all staff, including the trainees, on the delivery of the service, especially meeting the 4-hour wait target. The quality review team heard of one occasion when a trainee saw patients one after the other without making records on the patient notes. The trainee further reported that only until at the end of the shift, after all 10 patients were seen did they have the opportunity to write and update the patients' records. The quality review team stated that this was unacceptable practice and compromised patient safety.
- Numerous episodes of harassment were reported by the trainees and they indicated that they felt harassed by various staff members including nurses in charge, site managers, and by the service manager associated with four-hour wait resulting in patients being transferred to the observation ward or discharged when their presentation may require a more considered management plan in the ED. They expressed the view that achieving the four-hour target took precedence over patient safety and that this harassment was equally levelled at the consultants who appeared unable to support the trainees when concern about safety arose.
- It was reported that the observation ward was used as breach avoidance process. The quality review team heard that patients were moved to the observation ward even when not clinically appropriate and that often when the patients arrived, the ward was not ready to accept them. Trainees reported that notes were often not completed before patients were transferred to clinical decision unit (CDU) necessitating trainees on CDU

	to unnecessarily fully reassess patients. However, the quality review team acknowledged that the new consultant allocated to this ward was keen to change the ward into a positive environment for the patients and the trainees. • The quality review team was informed that the departmental culture in ED did not create one of people feeling valued, and therefore the morale was low amongst the trainees as well as the consultants. The quality review team was further informed that this had a negative impact on the standard of care patients received. • The quality review team heard that there were concerns relating to the competence, workload and attitude of some of the Trust grade doctors and locum consultants. The quality review team stated that it was unclear if these concerns were being actively managed. The Trust acknowledged and agreed with the aforementioned points and reported that they had proactively reflected on the areas of concerns raised, and therefore needed to think on the best steps to take to ensure they had been addressed and resolved. The Postgraduate Dean stated that the quality review team was keen to return to the Trust in the near future to meet with the trainees again, including foundation year and GP trainees to ascertain that the learning and training environment had significantly improved.

Quality Review Team			
HEE Review Lead	Dr Chris Lacy, Head of the London Specialty School of Emergency Medicine	**HEE Representative**	Dr Sanjiv Ahluwalia, Postgraduate Dean, Health Education England, North Central and East London
HEE Representative	Ian Bateman, Head of Quality and Regulation, health Education England London and South East	**GMC Representative**	Jane McPherson, Education Quality Assurance Programme Manager, General Medical Council
GMC Representative	Kevin Connor, Education Quality Assurance Programme Manager, General Medical Council	**NHSI Representative**	Professor Matthew Cooke, Emergency Care Improvement Expert, NHS Emergency Care Improvement Programme
Foundation Representative	Dr Keren Davies, Director of North East Thames Foundation School	**Lay Representative**	Jane Chapman, Lay Member
Observer	Elizabeth Dailly, Deputy Quality and Reviews Manager, Quality and Regulation Team (London and the South East)	**Scribe**	Adora Depasupil, Learning Environment Quality Coordinator, Health Education England London and the South East

Educational overview and progress since last visit – summary of Trust presentation

The review team thanked the Trust for accommodating the review and for the efforts made in facilitating the process.

The quality review team acknowledged the significant work that had been put in place to support training and patient care and the positive outcomes as demonstrated by the 2017 GMC NTS results. However, the trainee

survey undertaken in September 2017 highlighted that there remained some issues in regards to the quality of care and learning environment within the department, specifically in the paediatrics and resuscitation unit. The Trust reported that there had been structural changes within the last four to five months prior to the urgent concern review (on-site visit) on 23 October 2017. The Trust explained that these changes had a significant impact on the morale of the consultant body within emergency department (ED), and also affected how the consultants reacted with the trainees. The Trust further explained that the trainees were sensitive to these changes and believed that the survey taken managed to capture this. The quality review team heard that the workload in the ED at the Trust was highly intense and therefore could be a challenging department for a foundation year trainee.

The Trust reported that there was a general feeling of poor morale across the board and to address this, the Trust reported conducting regular local faculty group meetings (LFG) to allow discussions with the trainers and the trainees. The DME reported anonymous surveys often produced better response rate and the trainees were reluctant to address their concerns with the DME directly. The DME further explained that they had spoken to the consultants and encouraged them to be more proactive with meeting and talking with the trainees. The quality review team was informed that the department now had regular ED teaching every Friday. The interim medical director (MD) reported that they had spent 45 minutes with trainees in a forum and found that the trainees indeed had been finding the focus on meeting the 4-hour target relentless and had been actively attending the morning handover meetings with the trainees and consultants to observe. Additionally, the MD reported that the trainees had stated that they had not been happy with the limited help available to them in the paediatric ED at night. Therefore, the MD reported that emphasis had been placed on the importance of senior clinician presence in the paediatric department and that trainees would no longer be based there alone. The quality review team was informed that the MD himself had made himself visible to the trainees, so the trainees would be able to approach them in order to raise any concerns. Furthermore, the MD planned to carry out a survey each day that asks “Did you have a good/bad day today?” in order to gain constant feedback from the trainees.

In regard to reporting through Datix, the DME informed the quality review team that they had not been made aware of the 12 serious incidents (SIs) related to ED. However, the DME confirmed that all trainees had been shown and all knew how to report incidents through Datix and reassured the quality review team that a meeting with the staff in charge of Datix was conducted to discuss the SIs reported for feedback and learning, and that the postgraduate dean was welcome to attend if any trainees were involved. The quality review team heard that the Trust now had a daily bulletin board of all SIs in the seminar room which was accessible to all trainees.

The Trust reported that they had anticipated to be a full member of the Royal Free Group by April 2019 which the Trust hoped would improve the learning environment and opportunities for the trainees, including sharing the simulation equipment and a better model of teaching.

The quality review team heard that although the Trust had not seen an overt friction in the working relationship between the doctors and nurses in ED, the two groups of staff seemed to work separately. The Trust recognised that although the nursing staff attended the handover meetings, the meeting did not feel like a multidisciplinary team meeting. Therefore, the Trust reported that the senior and medical leadership had been encouraged to lead in ensuring that all staff members worked together as a team in the department. The Trust assured the quality review team that recruitment to the vacant clinical director post was underway, and that three new consultants had been appointed in the ED, who had some good ideas that the Trust had been supporting to ensure improvement to the learning and training environment of the trainees.

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	**Serious incidents and professional duty of candour** The quality review team learned that the junior trainees often relied on other staff members such as nurses to complete Datix forms to log serious incidents (SIs), although the trainees reported that they knew how to use the reporting system. The quality review team heard that the trainees were able to read information relating to SIs during handover meetings as these had been posted on a noticeboard in the seminar room. However, the trainees reported that there had been no regular opportunity to discuss SIs, nor had they been offered a wider explanation of why errors had been made and how to avoid them, and therefore they did not significantly contribute to their learning. Furthermore, the core & higher trainees reported that they had not been made aware of morbidity and mortality (M&M) meeting schedules, or if feedback had been shared. The quality review team was informed that feedback to trainees on the SIs they had reported had not been constantly provided.	Yes, please see EM1.1 below
EM1.2	**Appropriate level of clinical supervision** The quality review team heard that there was a good level of supervision during the core hours of nine in the morning to five in the afternoon, when the trainees felt that they were able to approach various consultants for advice and discussion about patient cases. However, the trainees reported that they felt there was a noticeable lack of supervision from five in the afternoon onwards, especially after 11pm when the consultant left the department and the higher trainee left to supervise could be a substantive member of staff, or a locum cover. The quality review team was informed by the foundation and GP trainees that there were occasions when there had been no middle grade or higher trainee to assist them in the paediatric department out-of-hours, and so they felt that they were on their own to manage the patients. The quality review team also heard that when trainees needed senior advice, they had to physically leave the paediatric department to seek guidance, which could be difficult to obtain as the middle grade or higher trainee on duty had a heavy workload covering the whole department. In regard to the resuscitation unit, similar issues were reported and the trainees reported that they were left alone in the department out of hours, with no dedicated supervisor present within the unit. Similar to the paediatric department, the quality review team heard that the trainees had to look for the middle grade or higher trainees if they needed support. The foundation and GP trainees recognised that the middle grade and higher trainees often struggled to provide adequate clinical supervision out of hours due to their onerous workload, but also stated that the department recognised this burden and had arranged for two middle grade or higher trainees to be rostered at night. The quality review team was informed that the trainees were happy with the standard of supervision provided to them by the higher trainees when they were available, and also that the higher trainees understood how they worked and their capability levels. However, the trainees reported that they had some issues with the consistency of supervision provided especially when they were on a shift with locum doctors. When	Yes, please see EM1.2a Yes, please see EM1.2b below

	discussing the observation ward, the trainees explained that due to the quick turnaround of locum cover, the locum doctors were often not aware of the processes in place for patients to be transferred to the observation ward and that sufficient management plans were not created for patients. Therefore, the trainees reported that often they found that they had to duplicate work, or had to assess the patients again. One of the core trainees that the quality review team met with reported that due to their level of experience in the emergency department (ED), they felt less reliant on supervision but understood that the foundation trainees needed more supervision and that the ED could be an intense and challenging environment to work in. The quality review team was also informed that some of the consultants did not engage with supervising the trainees and that there was a lack of clarification regarding who led the clinical and educational supervision in the department. It was further reported that the general feeling was that the morale was poor in the department: the consultants were unhappy, there was no clear clinical leadership on the shop floor and these factors consequently affected the level of clinical supervision provided to the trainees. Some of the EM trainees reported they no longer had career aspirations in the department.	Yes, please see EM1.2c
EM1.3	**Induction** The quality review team was pleased to learn that all trainees had received both Trust and departmental inductions. However, the trainees also reported that the induction could have been improved by including other useful information such as IT training guidance and information regarding the taxi-ride allowance that was offered to staff who worked out-of-hours.	
EM1.4	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** All of the trainees the review team met with reported that the department presented a wide range of training opportunities due to the diverse case mix and pathology. The quality review team was informed that at the time of the review, one of the core trainees was on the higher trainees' rota, despite not having reached this level of training.	Yes, please see EM1.4 below
EM1.5	**Protected time for learning and organised educational sessions** The quality review team was informed that the local departmental teaching sessions had been scheduled every Friday morning. However, the trainees reported that the teaching sessions had not been incorporated in their rota, therefore not everyone had been able to attend. In order to attend the teaching sessions, the trainees reported that they often had to come in early, or stayed later after a 12-hour night shift in order to make the local teaching session. One of the trainees reported that they had only been able to attend two of the teaching sessions at the time of the review, due to rota arrangements. The review team was further informed that the trainees were unable to attend their specific foundation and GP teaching sessions. Furthermore, the quality review team was informed that the department had fixed dates of study leave available to the trainees, therefore if the specific course was not scheduled to be on one of those days, the trainees struggled to attend. The higher trainees reported that although teaching for the senior trainees was supposed to take place on Thursdays, often it did not occur. Instead, the core and higher trainees indicated that they would often approach a consultant and choose a topic to discuss on an ad hoc basis.	Yes, please see EM1.5 below
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.

EM2.1	**Effective, transparent and clearly understood educational governance systems and processes** The higher and core trainees reported that none of them had attended a local faculty group (LFG) meeting and they were not aware if there was a trainee representative that they could approach.	Yes, please see EM2.1 below
EM2.2	**Impact of service design on learners** The quality review team heard that there appeared to be an undue pressure placed on the trainees by various members of the department, in relation to achieving the four hour waiting target in the ED. The review team was informed that this had led to instances which compromised patient care and safety. Firstly, the review team was informed that patients were often referred to the observation ward when it was clinically inappropriate to do so, in order to avoid breaching the target. Furthermore, trainees indicated that in order to meet the target, often they felt they did not have time to document in the patients' case notes and had to wait until the end of a shift in order to complete all the patients' records. The trainees reported that patients were often allocated to them and put under their name, even when they were still with a previous patient, in order to avoid breaching the target. The quality review team was also informed that due to the four-hour target, some trainees often were not able to take a proper break during their shift. The quality review team heard that although it had not been the norm to go through a whole shift with no break, the foundation year trainees had often worked through approximately five hours and then took a 20-minute break. The quality review team also heard that some core and higher trainees felt that they had not been able to take their breaks properly and stayed on the shop floor to ensure they were visible to the foundation year trainees to ensure adequate support was provided.	

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	**Behaviour that undermines professional confidence, performance or self-esteem** The quality review team was informed that the paediatric ED had competent staff but that it was not organised very well. The trainees reported that various nurses constantly approached them and they had been asked to sign medication for patients whom they had not had a chance to check the medical history for. The quality review team also heard that some nursing staff had argued with the trainees in relation to the plan the trainees had given to them which had been based on the department's protocol. The quality review team heard that some trainees felt that in paediatrics, the nurses' decision had been taken as more important which had had a negative impact on their confidence. The close layout of the paediatric ED meant that many of these conversations were held within earshot of the patients and relatives in the waiting room. The quality review team was informed of numerous occasions when the trainees felt undermined both by non-medical staff and medical staff. For instance, the quality review team was informed of a non-medical staff who had approached the trainees and had asked them what they had been doing the whole day. The trainees also reported an occasion where a consultant had told a trainee that the examination the trainee had undertaken had been wrong, and that this happened in front of other medical students. The quality review team also heard of some incidences when a trainee had been discussing patient cases during a handover, and a consultant had commented that they needed to see more patients – the trainee reported that they had felt demoralised after working a 12-hour shift. Furthermore, the quality review team was informed of an instance when one of the service managers (SM) had felt that a trainee had not engaged with them when discussing the patients within the department and whether they would breach the four-hour target and therefore had approached one of the consultants within the department and asked them to speak to the trainee in question. Similarly, the quality review team also heard of an instance where a SM had told one of the consultants during a morning handover to encourage the trainee doctors to work harder despite having just finished a 10-hour shift. When asked about the team atmosphere, the trainees reported that they did not often feel like they were working in a team but rather they felt like they were there purely for service provision. The trainees further reported that the atmosphere in the department varied based on the consultants and higher trainee present. For instance, the trainees reported that if they had worked on a shift with a familiar consultant or higher trainee, they felt that they had been able to work better as the senior clinicians knew their name and had been aware of their competencies, and had been able to provide support where necessary. The trainees were extremely complimentary of one of the consultants within the department, who had assumed a lot of the educational roles and responsibilities. The trainees reported that the individual was extremely supportive and approachable, and had always made an effort to ask the trainees at the end of the shift or a meeting how they had been feeling and coping in the department.	Yes, please see EM3.1 below

4. Supporting and empowering educators

HEE Quality Standards

4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.

4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.

	N/A	

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** The quality review team heard that when the educational supervisor was on leave, no cover had been provided, and therefore the trainee had some delays in obtaining their leave request approval. However, the quality review team heard that the higher trainees had informal opportunities to meet with their educational supervisors to discuss patient cases.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
N/A			

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	N/A		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
EM1.5	The Trust is required to review the rotas of the trainees and ensure that educational activities are embedded.	The Trust to submit the rotas to HEE, demonstrating allocated time for educational activities.	R1.12
EM1.2a	The Trust is required to ensure that adequate clinical supervision is provided for all trainees, especially in regard to the paediatric emergency department and the resuscitation unit.	The Trust to confirm this is now the place, and provide a rota demonstrating which member of staff is providing cover to the junior trainees in the paediatric ED and resuscitation unit.	R1.8

		The Trust to provide trainee feedback demonstrating that this issue has been adequately addressed. This can be through local faculty group (LFG) meeting minutes.	
EM1.2b	The Trust to ensure that all foundation and GP trainees have been allocated an educational supervisor from outside of the emergency department.	The Trust to confirm this has taken place and submit a list of the educational supervisors and which department they are from.	R1.8
EM1.1	The Trust to ensure that feedback is received from Datix forms and that lessons learnt from such serious incidents (SIs) are disseminated across the department.	The Trust to review the learning opportunities available from Sis and confirm that Sis are discussed and that trainees are invited to and attend the morbidity and mortality meetings.	R1.4
EM2.1	The Trust to ensure a regular Local Faculty Group takes place, with trainee representative.	The Trust to confirm the names of the trainee representatives and submit the LFG minutes.	R1.5
EM1.2c	The Trust to appoint an educational lead within the department.	The Trust to confirm who the educational lead is.	R2.15
EM1.4	The Trust to ensure that all trainees are on the correct rota for their clinical competence. No core EM trainees should appear on the higher trainee rota.	The Trust to submit copies of the rotas	R1.9

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
EM3.1	The Trust to participate in the HEE project on improving professional behaviours and interactions in EM and O&G	Review project outcomes in July 2018	R3.3

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
N/A	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Chris Lacy, Head of the London Specialty School of Emergency Medicine
Date:	6 November 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.