QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

North Middlesex University Hospital NHS Trust

Emergency Medicine

Risk-based Review (on-site visit)

Quality Review report

5 February 2018

Final Report

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Quality Review details

Background to review	A number of reviews to the emergency department (ED) at North Middlesex University Hospital NHS Trust (NMUH) had previously been undertaken by Health Education England (HEE), the General Medical Council (GMC), and National Health Service Improvement (NHSI) since May 2015. The aim was to actively monitor the issues highlighted by the General Medical Council National Training Survey (GMC NTS), and in order to provide support in addressing these issues. Additionally, the Trust had been providing extensive reports and evidence packs on a weekly basis in order to demonstrate the work that had been put in place to improve the quality of training and learning experience provided in the department. The Risk-based Review (focus group) conducted on 1 December 2017 revealed some improvements in the training environment and experience of the trainees, but some issues still remained. These issues included: the quality of clinical supervision; rota arrangement to incorporate teaching sessions; lack of clarity regarding the role of the medical controller; focus on service delivery which had impacted on educational training, particularly in relation to the four-hour target in accident & emergency (A&E); and uncertain clinical leadership. Therefore, a Risk-based Review (on-site visit) was conducted in order to follow up on the progress the Trust had made since the last review.
Training programme / learner group reviewed	Emergency Medicine
Number of learners and educators from each training programme	The quality review team met with: • Foundation Year 2 (F2) trainees x 4 (rotated in ED in December 2017) • General Practice (GP) trainees x 4 • Higher trainees x 2 The quality review team also met with the Deputy Medical Director, Director of Medical Education, Medical Education Manager, Clinical Director for A&E, Chief Executive Officer, Director of Finance, Head of Quality for Postgraduate Medical Education (Royal Free Hospital).
Review summary and outcomes	The quality review team would like to thank the Trust for accommodating the review. A number of areas were identified as working well: • The quality review team was pleased to have heard that the department was meeting the GMC conditions. • All trainees reported noticeable improvement in their overall learning environment and experience. • The quality review team ascertained that the non-clinical managers no longer directly placed pressure on the trainees in regard to service demands and that information regarding service needs had been disseminated to the trainees through the appropriate avenues. No trainees reported issues in relation to bullying and undermining. • The quality review team heard that access to workplace-based assessments had improved. • All trainees reported that access to teaching had significantly improved. A number of areas that still required significant improvement were also identified:

	• The junior trainees reported that the Foundation and Core trainee rota still need to be improved and the quality review team encouraged trainee engagement to design a rota that would maximise learning and teaching opportunities. • The quality review team heard that although the pressure around the four-hour waiting time target in A&E had improved, there was one occasion where a trainee had been challenged by non-clinical staff about the recording of the time of discharge, which the trainee reported as being in contradiction to Good Medical Practice (GMC 2013). • The quality review team heard that the department was not using the clinical observation unit (COU) safety checklist correctly, which could potentially impact on patient and trainee safety. The quality review team heard that the trainees had reported this through the Datix system on multiple occasions. • Trainees reported concerns regarding the competency and availability of two middle grade doctors in the department.

Quality Review Team			
HEE Review Lead	Dr Chris Lacy, Head of the London Specialty School of Emergency Medicine	**HEE Representative**	Dr Gary Wares, Deputy Postgraduate Dean, Health Education England, North Central and East London
GMC Representative	Kevin Connor, Principle Education Quality Assurance Programme Manager, General Medical Council	**NHSI Representative**	Faizal Mangera, Head of Delivery and Improvement (NCE London)
External Clinician	Dr Keren Davies, Director of North East Thames Foundation School	**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 quality review team wanted to thank the Trust for accommodating the review and for the efforts made in facilitating the process.

The Director of Medical Education (DME) reported on the status of the emergency department (ED) at North Middlesex University Hospital (NMUH) since the last quality review. The DME stated that HEE, GMC and NHSI had supported the Trust in addressing the issues highlighted by the 2016 GMC NTS results, which had resulted in successful outcomes in emergency medicine (EM), as portrayed by the improved GMC NTS results in March 2017. However, the DME reported that the progress made since the 2016 visit had not been financially sustainable and in addition there were major upheavals in the department at consultant level. Consequently, a trainee survey conducted by HEE in September 2017 revealed dissatisfaction and concern raised by the trainees, particularly in the paediatric emergency and resuscitation unit which had resulted in further quality visits and close monitoring of action plans.

The DME further explained that the Trust had proactively implemented changes in EM and had ensured that regular trainee feedback had been collected locally through the Trust's "You Speak; We Listen" approach which had been part of the Friday morning teaching sessions. The DME stated that the Trust had recognised that one of the major concerns was the lack of supervision of trainee-led teaching. Furthermore, the DME explained that the Trust had produced reports and an extensive evidence pack that had been provided to the quality review team on a weekly basis, which, on the whole had demonstrated improvement.

It was reported that the medical directors had audited the competency of the newly recruited middle grades. The DME reported that five trainees had been placed on a development project to help develop their leadership skills. Additionally, it was reported that the Trust had made sure that the middle grade trainees were at ST4 level when providing clinical supervision to the junior trainees.

The Deputy Medical Director (DMD) stated the ED in NMUH was the second busiest in the country but had always been managed by a single team. Therefore, the Trust had been planning with their primary care partners to introduce a new system where the teams in ED would be divided into five zones. It was reported that the Trust believed that this new system would address many of the identified issues, as within each zone the allocated team would have all of the required skill sets, huddles would be conducted at regular intervals, and there would be clear expectations of supervisory role and local ownership. The DMD explained that the plans were also being discussed at executive staff meetings to ensure that ED would be a safer place that provided adequate training, as well as to ensure that services were sustainable during the out-of-hours shifts.

The Trust reported that 15 consultants were in post at the time of the review, including two paediatric consultants and one associate specialist. The number of educational supervisors (ES), and clinical supervisors (CS) in the department along with their trainer status was reported: four substantive consultants were an ES and CS (one of whom was on a secondment contract from Royal Free London Hospital), one locum consultant was an ES and CS, one substantive consultant was an ES and CS but was on maternity leave at the time of the review, one substantive part-time consultant was an ES and CS, three substantive consultants were in training, four locum consultants were in training, and one substantive part-time consultant had not been allocated a supervisory role.

The DME reported that although the teaching attendance had improved for the Friday generic EM teaching session, the Trust was still reviewing the teaching availability. For instance, it was reported that general practitioner (GP) teaching attendance was at 60% and, having reviewed the rota, the Trust recognised that the problem was around the Tuesday and Thursday teaching.

The DME explained that the GP trainees felt that they had missed out on some training opportunities due to the non-training middle grade doctor that had been allocated to Paediatric ED for further support. Therefore, the Trust had arranged a compromise so a GP trainee could be rostered in Paediatric ED with a manageable workload, provided that they were able to access senior clinical staff for advice where required.

The DME concluded that the Trust had now put in place more sustainable developments that had resulted in significant improvements, but also recognised that it would take time to achieve tangible and long-term changes.

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
ED1.1	**Appropriate level of clinical supervision** The foundation year two (F2) and GP trainees reported that overall the senior support provided in ED had been very good, and described both the consultants and middle grade doctors as supportive and fully engaged. However, it was reported that the quality of middle grade supervision at night was variable when workload intensity was high particularly if there were only one or two middle grade doctors available at night (the rota called for four middle grade trainees on a night shift). For instance, the junior trainees reported that during very busy periods, they were now always able to access clinical advice at night, but it was not necessarily educational as the middle grade doctor would not have time to discuss the patient query in detail. The trainees reported that there was a board in ED that informed all staff who the medical controller on duty was. The trainees stated that some medical controllers would make themselves known to the team, but some did not make themselves easily accessible. The F2 trainees reported that the medical controller had moved higher trainees from their allocated ED areas to a busier area where required. For example, if two higher trainees were allocated to be on shift in the department and the paediatric area needed support, one of the higher trainees was moved to paediatric emergency which had left only one higher trainee to cover the rest of the department. The trainees stated that they had observed this on some weekend shifts. However, the trainees recognised that in order to address the issue around supervision availability, the Trust had ensured that locums were placed in the department for additional support. The trainees stated that overall they felt that there were a sufficient number of senior clinicians available to meet the demands of the service, but there was still no overt focus on training. The GP trainees reported that compared to their experience in October 2017, their work in the paediatric emergency and resuscitation unit was now much better supported and they felt that consultants had been ready to help and keen to teach. The GP trainees also reported that there were now dedicated paediatric consultants in the ED at night and making it easier to access clinical advice. However, the GP trainees reported that the level of support provided needed to be balanced so that the trainees did not miss out on learning opportunities. For instance, it was heard that some trainees no longer took phone call queries as the senior clinicians answered these for them. During the previous visit in December 2017, the junior trainees identified some consultants and middle grade doctors that they intentionally avoided when they needed clinical advice. The trainees reported that these clinicians no longer worked at NMUH and that four new middle grade doctors had been appointed. The trainees reported a general feeling that the paediatric emergency unit was now better supervised, but also raised some concerns in relation to the competency and availability of two particular middle grade doctors. The higher trainees recognised that that there had always been an issue with balancing service provision and providing clinical supervision at NMUH due to high workload intensity in the ED. However, the higher trainees stated that clinical supervision had definitely improved since the last quality review. The higher trainees reported that current group of middle grade doctors was composed of 50% of the previous group, and had been supplemented by the additional four new middle grade doctors. The higher trainees reported that this had made a massive improvement to the availability of clinical supervision as they found that all four new middle grade doctors had good medical knowledge. However, the higher trainees indicated that part of the issue was due to resourcing middle grade doctors with appropriate skill sets. The higher trainees echoed the junior trainees' statement that not all of the middle grade doctors that had been recruited were competent to work in the resuscitation unit and not all were interested in working in the paediatric emergency unit. The higher trainees indicated that two of the new middle grade doctors seemed unapproachable when junior trainees needed clinical	

	advice. It was noted that this had placed pressure on the higher trainees, as the junior trainees sometimes sought their advice and avoided these Trust grade doctors. The higher trainees complimented the department for significantly improving the overall quality and quantity of clinical supervision provided in ED, despite the increased workload experienced during the winter. The quality review team also heard that the higher trainees at ST4 level were always paired with a competent Trust middle grade doctor and therefore felt supported with providing supervision to the junior trainees. The higher trainees were highly complimentary of the Interim Medical Director/Deputy Chief Executive Officer, site managers and nurses for their persistence in ensuring that all trainees had a named clinical supervisor during every shift, particularly at night.	
ED1.2.	**Rotas** The higher trainees stated that they were satisfied with their rotas, but commented that the junior trainee rota for F2 and GP trainees could be improved. The junior trainees reported that they worked 13 hours per shift and felt that the rota design was not sustainable, negatively impacted their wellbeing and prevented them from attending teaching sessions. The quality review team heard that the night shift rota was scheduled from 22:00 until 11:00 to incorporate teaching after a night shift. The junior trainees stated that they found it very tiring and difficult to focus during teaching session in the morning if they came from a night shift. The junior trainees reported that they had not been involved with the design of their rota but suggested that the Trust needed to consider the productivity of the rota and to allow a good work-life balance.	Yes, please see ED1.2
ED1.3	**Handover** The higher trainees complimented the Interim Medical Director/Deputy Chief Executive Officer for proactively attending every morning handover, and indicated that this had significantly contributed to the quality improvements in ED. The higher trainees stated that the medical controller usually handed over to the consultant in charge at 10:00 in the morning. However, this varied and was dependent on the preference of the higher trainee. For instance, it was reported that some higher trainees preferred to do a walk-round handover in the department, whereas some preferred a sit-down handover in front of a computer with the nurse in charge and the medical controller from the night shift. Therefore, although there was not a formal handover, the higher trainees reported that they were aware when the consultants left at 23:00 and what tasks they needed to action during their shift when they took over.	
ED1.4	**Protected time for learning and organised educational sessions** The higher trainees reported that regional teaching time was protected, and that the Thursday morning teaching session for acute care common stem (ACCS), higher and middle grade trainees was now better. It was also reported that there had been a simulation teaching session that had been put in place. However, the higher trainees commented that the educational sessions were heavily dependent on the availability of the educational lead or college tutor, and on some occasions were cancelled if their lead was not physically present.	

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.**		
ED2.1	**Impact of service design on learners** The trainees commented that the overall service design had improved, but the four-hour waiting time target still had an impact on their training experience. The junior trainees reported that they had observed patients being moved out of the ED which they perceived to be an exercise to avoid breaching the target, as mentioned above. For instance, the quality review team heard of an occasion where a trainee begun seeing a patient after a three and a half hour wait and the patient was then transferred out of ED to another department although the trainee was still checking the patient's diagnostic results. The trainees stated that this had made them feel frustrated and suggested that it would be more beneficial for staff and their learning if patients that were sent to clinical observation unit (COU) in ED, came with a more specific plan from the team that referred them. The junior trainees reported that COU had been working well but the communication within the department needed to improve, and the trainees felt that COU was still being used inappropriately to avoid breaching the waiting time target. It was noted that a ward round in COU had been put in place by the consultants as part of quality improvement, but the trainees indicated that the safety checklist was not being filled in correctly, which had resulted in four Datix reports that were completed by the trainees. Additionally, the junior trainees indicated that one particular consultant had been repeatedly and inappropriately discharging patients home early in order to avoid breaching the Trust target. The trainees commented that although patient safety issues had been prevented, for example by calling the patients back following discharge, this meant that there was a potential risk to patient safety and training. On the other hand, the higher trainees stated that they had not felt pressure to move patients to COU. The higher trainees indicated that although patients were placed in COU to avoid breaching the target, this was also due to the lack of physical space to see patients. The higher trainees stated that it was understandable that nurses wanted to move patients from the resuscitation unit to make space for incoming patients. The higher trainees explained that the junior trainees were managing a high volume of patients and so had not been able to complete the patient notes sufficiently quickly, and this was an issue when handing patients over. However, the higher trainees stated that they had not found any unsafe patients in COU as a result.	Yes, please see ED2.1
ED2.2	**Organisation to ensure access to a named clinical supervisor** All trainees reported that they had been allocated a named clinical supervisor.	
ED2.3	**Organisation to ensure access to a named educational supervisor** The Foundation and GP trainees reported that they all had met their allocated educational supervisors (ES), who were all external to ED. It was heard that overall, the trainees had noticed an improvement with obtaining ES sign-off for their curriculum assessments. The higher trainees reported that due to the changes in the consultant body in ED, there were some uncertainties with who their allocated ES was. However, when they approached the ED educational lead/specialty tutor, they felt assured that their portfolios and curriculum assessments would be signed-off.	

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.

ED3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees stated that they no longer felt harassed by non-clinical staff in ED in relation to the four-hour wait target, and noticed that service managers no longer directly gave them instructions about the ED patients. However, the trainees reported that they still felt pressured to see and move patients quickly by the nurse in charge before they had had a chance to complete the patients' discharge summaries or history notes. The trainees indicated that they were aware of the pressure that had been placed on the consultants and nurses in ED by service management especially after bed meetings, to discharge or admit patients in order to meet the four-hour target. All trainees also reported that communications about patient treatment and service plans were now disseminated by service management, through consultants and nurses in charge and then onto the trainees. The quality review team also heard that trainees had been asked by clinical staff to "click on" patients – which meant that patients had been allocated to them to see - even when the trainees were not in a position to see these patients yet. For instance, during the trainee's lunch break, just so these patients would not breach the waiting time target without being seen. The trainees also reported that they had been asked to put their name against a patient's record before surgery even when the trainees had not had a chance to see the patient. The trainees reported that they were not challenged back when they had refused to click on patients inappropriately. Furthermore, the quality review team heard of one occasion where a trainee had been challenged by non-clinical staff about the recording of the time of discharge which the trainee reported as being in contradiction to Good Medical Practice (GMC 2013). However, the trainees reported that they felt confident challenging this behaviour and had not felt bullied or harassed and understood the pressures of the service.	Yes, please see ED3.1 below
ED3.2	**Academic opportunities** The higher trainees reported that they had been provided with opportunities to teach the medical students, and sometimes to teach the F2 trainees.	

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.

ED4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The quality review team heard that seven EM substantive and locum consultants were in training to obtain accreditation for supervisory roles at the time of the quality review.	

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.

ED5.1	**Appropriate balance between providing services and accessing educational and training opportunities** All trainees stated that ED in NMUH offered a good range of training and learning opportunities, especially as the patient demographic offered different backgrounds of pathology. All trainees commented that although there were still occasions when support had not been fully provided due to the workload intensity, all trainees had observed that training opportunities were being more utilised with supervision. The higher trainees recognised that the quality reviews had contributed significantly to quality improvement. The higher trainees stated that teaching around providing clinical advice was not sufficient, and that all the trainees would benefit more if there was an emphasis on bedside teaching by the consultants in order to optimise every teaching opportunity. The higher trainees described that two consultants in ED were very good as formal educators, and the rest were very good at bedside teaching, and that the Trust needed to find a way to balance the service demands with the teaching and learning opportunities provided to the trainees.	

6. Developing a sustainable workforce

HEE Quality Standards

6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.

6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.

6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.

6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.

6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

ED6.1	**Learner retention** During the previous quality review, none of the trainees reported that they would consider working in the ED at NMUH as a consultant in the future, and stated that they did not want to recommend NMUH as a learning placement. However, since the learning quality improvements, the higher trainees reported that they would now consider a career in the NMUH ED as they believed that the service overall, as well as the learning environment and experience, were noticeably better.	

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	N/A	N/A	N/A

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

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
ED1.2	The Trust is strongly encouraged to work with the foundation trainees to construct a rota that supports training and educational attendance as well as addressing work-life balance.	The Trust to confirm that meetings have taken place with the foundation trainees to review the rota and provide minutes of the meetings. The Trust to submit the revised rotas.	R1.12
ED2.1	The Trust to review the use of the observation unit with a focus of learning and training.	The Trust to confirm the outcome of the review and detail how learning and training was being provided to trainees when based upon the observation unit.	R1.15
ED3.1	The Trust is encouraged that no trainee is being asked to “click on” patients to avoid breaching of quality targets.	The Trust to confirm that this no longer takes place and provide trainee feedback, through local faculty group meeting minutes, confirming that trainees are not being asked to ‘click on’ patients to avoid breaching of quality targets.	R2.3

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
N/A	N/A
Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Chris Lacy
Date:	1 March 2018

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.