Health Education England

HEE Quality Interventions Review Report

Barking, Havering and Redbridge University Hospitals NHS Trust (Trust-wide)
Emergency medicine
Learner and educator review

London – North East London

Date of review: 08 November 2021

Date report issued to the Trust: 14 December 2021

Version 2

Review Overview

Background to the review:	This review was scheduled to explore the reasons for the results in the 2021 General Medical Council National Training Survey, where emergency medicine received a significant number of red outliers.
Subject of the review (e.g. programme, specialty, level of training, healthcare learner group)	Emergency medicine
Who we met with:	Director of Medical Education Head of Medical Education Deputy Manager of Medical Education Associate Director of Research & Chief Medical Officer's Services Medical Director Education Lead Director of Improvement Clinical Lead Guardian of Safe Working Hours Chief Medical Officer Seven foundation year two and general practitioner vocational training scheme trainees in emergency medicine Five higher trainees in emergency medicine 11 clinical and educational supervisors in emergency medicine
Evidence utilised:	Local Faculty Group minutes Most recent MEC minutes Summary of GoSWH Board report Rota including fill rate Breakdown of learner groups within the department Breakdown of educational and clinical supervisors within the department Evidence of organisation-wide and departmental induction feedback Evidence of teaching sessions and attendance lists Internal action plans

Review Panel

Role	Name / Job Title / Role
Quality Review Lead	Louise Schofield Deputy Postgraduate Dean Health Education England (North East London)
Specialty Expert	Firas Sa'adedin Deputy Head of London Specialty School of Emergency Medicine
Specialty Expert	Keren Davies Foundation School Director (North Central and East London)
Specialty Expert	Jyoti Sood Associate Director, HEE School for General Practice
Lay Representative	Saira Tamboo
Learner Representative	David Sims
HEE Quality Representative(s)	Chloe Snowdon Learning Environment Quality Coordinator Health Education England (North East London) Ummama Sheikh Quality, Patient Safety and Commissioning Officer Health Education England (London)

Executive summary

The review panel thanked the Trust for facilitating the review and ensuring good attendance at all sessions.

The review team were pleased to hear about the planned investment for enhancing the emergency department (ED) workforce. The review team also heard that trainees found consultants to be supportive, teaching time was rostered and protected, and new rest and computer facilities had been created for trainees. However, the review team heard that the department was an extremely busy, highly stressful environment which meant on the floor teaching was very difficult. The review team were also told that the trainees felt there was a blame culture (at Queen's Hospital in particular) which aggravated already convoluted processes, and relationships between the ED and other departments were fractious.

The review team asked the Trust to ensure that trainees knew how to exception report (following reports that this was not the case), increase the frequency of local faculty group meetings in line with Royal College of Emergency Medicine guidelines, ensure educational supervisors received 0.25 planned activities time per trainee, work to embed the internal professional standards document and provide evidence that previous Trust induction disruptions are avoided in the future.

Review findings

The findings detailed in the sections below should be referenced to the quality domains and standards set-out towards the end of this template. Specifically, mandatory requirements should be explicitly linked to quality standards. Not all of HEE's domains and standards have been included, only those that have a direct operational impact on the quality of the clinical learning environment, which a quality review will be most likely to identify (although this does not preclude other standards outlined in the Quality Framework being subject to review, comment and requirements where relevant).

Mandatory requirements

Mandatory requirements and Immediate Mandatory Requirements (IMRs) should be identified as set out below. IMRs are likely to require action prior to the draft Quality Review Report being created and forwarded to the placement provider. The report should identify how the IMR has been implemented in the short term and any longer termed plans. Any failure to meet these immediate requirements and the subsequent escalation of actions to be taken should also be recorded if there is a need to.

All mandatory requirements should be detailed in this section. The requirement reference should work chronologically throughout the report and link with the right-hand column in the 'Review Findings' section. Requirements identified should be succinct, SMART and not include the full narrative from the detailed report. Any Requirements should clearly relate to improved achievement of HEE Domain & Standards by the placement provider.

Immediate Mandatory Requirements **Completion of immediate requirements will be recorded below. Subsequent action to embed and sustain any changes may be required and should also be entered below with relevant timescales**		
Requirement Reference number	Review Findings	Required Action, timeline, evidence
	None	
Requirement Reference number	Progress on immediate actions	Required Action, timeline, evidence
	N/A	

Mandatory Requirements The Quality Review Panel will consider which individual or collective findings from the intervention will be added to the Quality Reporting Register, determining the relevant risk score, ISF rating and reflecting the accepted QRR narrative conventions.		
Requirement Reference number	**Review Findings**	**Required Action, timeline, evidence**
EM1.2	The review team heard that a programme of work was underway to address behaviours in the department (particularly in relation to sexism).	Provide evidence of the progress of the programme of work to address behaviours, including sexism, within the department, and provide trainee feedback that their experience has improved. To be completed by 01 March 2022.
EM1.6	The ESs and CSs said they were not aware of the new curriculum requirement that foundation trainees should receive feedback via a placement supervision group at least once each year and this should include members of the multi-professional team.	The department is required to ensure all educational supervisors understand the requirements for a placement supervision group and that relevant members of the multidisciplinary team have had training in the provision of feedback in this format. To be completed by 01 March 2022.
EM2.1a	The review team heard that the foundation and general practitioner vocational training scheme (GP VTS) trainees did not know how to exception report.	Provide evidence that rapid steps have been taken to ensure all trainees understand the process for exception reporting and are encouraged to do so, as well as evidence that this information will be included in Trust and local inductions going forwards. To be completed by 01 March 2022.
EM2.1c	The review team heard that the internal professional standards (IPS) document had not yet been fully embedded in the Trust.	Provide evidence of how Trust management plans to embed the IPS and monitor its progress. To be completed by 01 March 2022.
EM2.2a	The review team heard that the emergency department (EM) had quarterly local faculty group (LFG) meetings.	Work to increase the frequency of LFG meetings to monthly or bi-monthly. To be completed by 01 March 2022.
EM2.2b	The review team heard that LFG meetings were followed by a discussion for educational	Evidence that time is regularly (for example, monthly or bi-monthly) allocated for educational supervisors to discuss trainees

	supervisors who supervised higher trainees.	and to facilitate the completion of the Faculty Educational Governance (FEG) statement as per Royal College or Emergency Medicine guidance. To be completed by 01 March 2022.
EM3.4	The review team heard that the Trust induction had been offered online but there were a lot of technical difficulties which meant trainees who attended the induction remotely did not receive all of the necessary information. Additionally, many trainees started placements before they were sent their IT logins.	Provide evidence of trainee feedback from the next rotation demonstrating that they received a full Trust induction (whether they attended face to face or virtually) and details of their IT logins before their first shift. To be completed by 01 March 2022.
EM4.4	The review team heard that educational supervisors (ESs) did have some time in the job plans for supervision but that this was under review in the department, with the aim of producing a more robust job plan time allocation system.	Provide evidence that all ESs have the required 0.25 planned activities time per trainee in their job plan. To be completed by 01 March 2022.

Recommendations

Recommendations are not mandatory but intended to be helpful, and they would not be expected to be included within any requirements for the placement provider in terms of action plans or timeframe. It may however be useful to raise them at any future reviews or conversations with the placement provider in terms of evaluating whether they have resulted in any beneficial outcome.

Recommendation	
Related Domain(s) & Standard(s)	**Recommendation**
EM1.1	The review team recommends that the department reviews the clinical governance pathways and response times for feedback from serious incidents (SIs) and considers establishing a multidisciplinary teaching forum to share learning from SIs.
EM2.1b	The review team recommends that the Trust reviews how it is supporting trainees to get home when they finish work late at night.
EM5.1	The review team were told that funding for the Clinical Educator role had come to an end, but the department was considering reintroducing this, and the review panel strongly recommend that this is done. The review team suggest this could be done with a specified post or by giving planned activities time to consultants to do this.

Good practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that, in the view of the Quality Review Team, enable the standards within the Quality Framework to be more effectively delivered or help make a difference or improvement to the learning environment being reviewed. Examples of good practice may be worthy of wider dissemination

Learning environment / Prof. group / Dept. / Team	Good practice	Related Domain(s) & Standard(s)
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HEE Quality Standards and Domains for Quality Reviews

Domain 1 - Learning environment and culture
1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users. **1.2.** The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours. **1.3.** There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I). **1.4.** There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative. **1.5.** The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge. **1.6.** The learning environment promotes interprofessional learning opportunities.

HEE Standard	HEE Quality Domain 1 - Learning Environment & Culture	Requirement Reference Number
1.1	**Serious incidents and professional duty of candour** The foundation and general practitioner vocational training scheme (GP VTS) trainees felt that the long waiting times, which were compounded by a lack of staff and a lack of space, potentially posed a risk to patient safety. The review team heard that category two patients could experience waits in the waiting room of five to six hours. The foundation and GP VTS trainees said they would not be happy for their friends and family to be treated in the emergency department (ED) because they thought patient care was compromised by the lack of a triage system and waiting times. The foundation and GP VTS trainees gave the review team examples of when patients who were very unwell and had been admitted to a ward during one shift, were still in the Trust's ED waiting to be taken to the ward when they came onto their next shift many hours later. The foundation and GP VTS trainees said that they often left shifts feeling deflated or upset because they felt patients were not given the time and care they wanted to be able to provide. The higher trainees said that night shifts were particularly challenging but all shifts were unsatisfying and left them feeling as if they were not able to do the best for their patients. The higher trainees highlighted to the review panel that they believed at times the ED was unsafe, especially when there were wait times of 40 hours for patients to get a bed which meant patients were between the care of the ED and the relevant specialty. The higher trainees said that sometimes there were as many patients being seen in resus from within the ED as from the community because people were not seen quickly enough when they arrived and then became sicker while waiting to be seen. The higher trainees said they would not want their friends and family treated in Queen's Hospital ED. The higher trainees said that great patient care was given in the department, but too often a lack of staff and space, and the complicated IT systems and other processes meant that this was not the case. The higher trainees also told the review team they would not be happy for their friends and family to be treated by some of the specialities in the hospital either.	

	The higher trainees reported to the review panel that they thought there was a blame culture at Queen's Hospital and when incidents occurred, rather than learning from mistakes and taking steps to ensure they did not occur again, people were blamed and the processes were drastically changed. The higher trainees provided the example that fixed rate insulin infusions were no longer given in line with national guidance because of an incident which had occurred. The higher trainees described the way the Trust dealt with patient safety incidents as "putting a plaster on a huge wound" and said that people worked really hard but often did not fix the real problem and this created further work. The higher trainees told the review team that there was a backlog of serious incidents (SIs) and incidents which occurred over a year ago were only just being reviewed. The higher trainees said that when SIs were reviewed and changes implemented, these were not disseminated or embedded properly and therefore did not result in real change. The higher trainees said the Quality and Safety Manager wanted to streamline the SI process. The higher trainees thought that the culture of blame was often the reason why specialties did not want to accept referrals until a patient had been fully worked up with various tests. The higher trainees said they thought it was because the specialty doctors were worried to admit a patient that they were not able to look after (for example, surgeons admitting medical patients). The trainees highlighted how difficult this was for them as it meant patients stayed under their care for extended periods of time. The educational supervisors (ESs) and clinical supervisors (CSs) said that patient safety was paramount and junior doctors should not hesitate to escalate when they felt that behaviours of specialities could impact on this.	EM1.1
1.2	**Bullying and undermining** The foundation and GP VTS trainees said that they had seen occasions where locum consultants had been dismissive of trainees when they had asked for advice on patient care. The foundation and GP VTS trainees said there had been a few times when consultants had shouted at trainees in front of other staff. The foundation and GP VTS trainees said that relations between the doctors and nursing staff were sometimes fractious and the trainees thought this was because of the level of pressure all staff were under. The foundation and GP VTS trainees highlighted that they knew working in an ED would be difficult but thought that it could be a positive experience if there was a sense of camaraderie among the staff, but they did not feel this was the case at Barking, Havering and Redbridge University Hospitals NHS Trust. The higher trainees said that it was difficult sometimes to say which behaviours were bullying and undermining because all staff at Queen's Hospital were stressed and worked hard in a difficult enviornment. The higher trainees said the staff in the specialties could be rude and that they were aware that consultants in the specialties were critical of their juniors which made juniors hesitant of taking referrals. The higher trainees highlighted that there was a sexist culture at Queen's Hospital and said that female trainees in ED had a harder time than male trainees. The higher trainees said that this came mostly in the form of patronisation and was experienced by female ED trainees from doctors in the specialties.	

	The DME said that a programme of work had started to address behaviours in the department, particularly in relation to sexism and all consultants in the ED were engaged with this. The DME said the next phase of the work would engage middle grade doctors.	EM1.2
1.3	**Quality Improvement** The ESs and CSs told the review team that they tell trainees to make the most of a busy department and get involved in quality improvement projects and audits.	
1.4	**Appropriate levels of Clinical Supervision** The review team heard that at King George Hospital, there were generally two consultants (although occasionally one) who worked 08:00 until 16:00, one who worked 14:00 to 21:00 and one who worked the night shift until 02:00. The Clinical Lead informed that at Queen's Hospital, there were five consultants during the day, two who worked the late shift and one night consultant until 02:00. The Clinical Lead said there was a consultant on call after 02:00. The review team heard that at weekends, Queen's Hospital had three day consultants, two on the late shift and one on the night shift. The Clinical Lead said that at King George Hospital, there was one day consultant, two on the late shift and one on the night shift. The review team heard that a paediatrics ED consultant was on site seven days a week until 22:00, at which point the ED consultant provided cover. The ESs and CSs said that the more junior trainees did not work in paediatrics past 22:00 either. The GP VTS trainees said that they were mostly able to find a consultant and if the consultant was busy, they would direct them to a higher trainee for help. Some of the GP VTS trainees said they felt the permanent consultants were great at both hospital sites but the locum doctors provided less good supervision. The GP VTS trainees explained that at times, they asked the specialty doctors (outside of the department) for advice instead of the locums in ED because they knew their support would be more helpful. The foundation trainees said that a lot of the time they could find a more senior doctor to speak to but sometimes it was hard to find a consultant, especially at King George Hospital where there was no DECT phone. The foundation trainees highlighted that they were supposed to discuss every patient with a senior doctor but that there had been occasions at night where the seniors were too busy to discuss patient management. The foundation and GP VTS trainees said that there had been times when working in the paediatrics section of ED that they had had to ask the paediatrics higher trainee on call questions because there was no one else around to ask. The foundation and GP VTS trainees said it was frustrating when they were unable to find a senior to ask questions because it meant patients had to wait longer while they tried to find someone. The foundation and GP VTS trainees explained that when they did find someone to ask for help, they were only able to discuss the next steps for that patient and then they had to move on to the next patient, and this meant there was no time to use these discussions for learning. The review team asked the foundation and GP VTS trainees if there was a difference in clinical supervision levels during the week and the weekend and the trainees said that the ED was always busy and this meant that the	

	ability of consultants and higher trainees to supervise was always impacted. The foundation and GP VTS trainees said that there was generally a consultant onsite in each area of the ED and so it was clear who to go to for clinical supervision but that it was sometimes confusing when there were a few middle grade doctors on shift. The ESs and CSs said that as a general rule, foundation trainees discussed all cases with a consultant and foundation trainees did not do step down handovers (they were not handed over patients from doctors of a higher grade than them). The higher trainees said consultants in the ED were generally supportive and nice. The higher trainees said they were able to find the consultant allocated to the specific area to seek advice when needed.	
1.4	**Appropriate levels of Educational Supervision** The Education Lead said the department was ensuring all trainees had formal meetings with their ESs. The Clinical Lead informed the review team that about 75% of the consultant body in the ED were trained ESs. The foundation and GP VTS trainees the review team met with confirmed that their ESs were outside of the department.	
1.6	**Multi-professional learning** The ESs and CSs said they were not aware of the new curriculum requirement that foundation trainees should receive feedback via a placement supervision group at least once each year and this should include members of the multi-professional team.	EM1.6

Domain 2 – Educational governance and leadership
2.1. The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met. **2.2.** The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training. **2.3.** The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership. **2.4.** Education and training opportunities are based on principles of equality and diversity. **2.5.** There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.

HEE Standard	HEE Quality Domain 2 – Educational Governance and Leadership	Requirement Reference Number
2.1	**Effective, transparent and clearly understood educational governance systems and processes** The foundation and GP VTS trainees said they did not know how to exception report but were often finishing late. The review team heard that the trainees had asked how to exception report and were told they would be shown but they had not yet received this information. The foundation and GP VTS trainees explained that they had a sign in sheet where they	EM2.1a

	filled in their hours but no one had raised it with them when they had repeatedly noted that they were working over their hours. The review team heard that people often filled in their start and finish times for the week in advance so did not record their actual finish times. The foundation and GP VTS trainees said some consultants encouraged them not to pick up new patients when they were coming to the end of their shift but at other times, they felt pressured to see new patients and this meant they had to stay late. The foundation and GP VTS trainees said that some consultants did not like it if patients who just needed to be referred were handed over so this meant trainees finished late getting referrals done. The foundation and GP VTS trainees confirmed that the Trust did not provide taxis or money towards transport if trainees finished late at night.	EM2.1b
2.1	**Impact of service design on users** The Trust representatives informed the review team that a significant piece of work was ongoing in the Trust looking at staffing levels in the ED. The Director of Improvement explained that they had been seconded from Barts Health NHS Trust to lead on this work. The Director of Improvement said that the ED at Barking, Havering and Redbridge University Hospitals NHS Trust had been operating with below optimal staffing levels and this had been reflected in trainee feedback surveys. The Director of Improvement informed the review team that the Trust was showing a strong commitment to improving the situation and a business case for £2 million in investment had already been signed off. The Director of Improvement explained that two further stages of the business case were being prepared which, if approved, would mean a total of £5 million in investment in staffing (medical and nursing) for the ED. The Director of Improvement said that this would constitute £2.5 million of new money and £2.5 million of reinvestment (money which was currently being spent on locum and bank staff). The Director of Improvement explained that the investment would see the consultant body grow from 18 to 38 whole time equivalent doctors in 18 months to three years time. The review team heard that there would also be an increase in the number of clinical fellows, physician associates (PAs) and advanced clinical practitioners (ACPs). The review team heard that the ED currently only had PA students but were looking to employ qualified PAs too. The review team heard that recruitment of the additional consultants would be challenging for the Trust but it was hoped that in the next three to six months, five to eight new consultants would have been recruited. The Director of Improvement informed the review team that the Trust hoped to see a boost in consultant numbers at the end of each Certificate of Completion of Training (CCT) cycle. The Director of Improvement highlighted that as the Trust was on the border of Essex and London, they hoped to have a wider pool of newly qualified consultants to draw from. The Director of Improvement said the Trust was also looking to recruit consultants from overseas, particularly Australia. The Director of Improvement told the review team that the initial part of the plan when new recruits started was to implement an appropriate triage system at the front door to the ED so that people arriving to the ED would be screened according to need, and initial treatment would be started. The Director of Improvement said that the Trust had a workshop with Barts Health NHS Trust planned to work through the challenges posed by winter pressures.	

	The Education Lead said the ED's weekend staffing compliance was controlled by workforce numbers but that many trainees picked up extra shifts. The Trust representatives said that getting more middle grade doctors to work in the ED was a challenge but doctors were recruited from overseas to fill gaps. The Trust representatives said that these doctors were given enhanced support and training and the department helped them to progress through such programmes as the Certificate of Eligibility for Specialist Registration (CESR) and the Royal College of Emergency Medicine (RCEM) ACP programme. The ESs and CSs told the review team that they tried not to differentiate between non-training doctors and trainees in terms of support and teaching, encouraging non-training doctors to do their RCEM portfolios and take part in CESR. The ESs and CSs said the department had been very successful in helping people complete the CESR process. The ESs and CSs said the department was practised in supporting doctors from overseas. The Director of Medical Education (DME) told the review team that the Trust was aware that the red outlier for reporting systems in the General Medical Council's (GMC) National Training Survey (NTS) results for 2021 were likely due to ongoing issues with the IR1 process and how trainees received feedback from this. The DME said that there was an ongoing piece of work on this which aimed to provide an education package to junior doctors describing the process and to improve the feedback people received. The Education Lead informed the review team that the department hoped that the red outliers reported in the 2021 GMC NTS results had improved since the time the survey was conducted. The Education Lead described the infrastructure changes which had been undertaken in winter 2020/2021 which had since been completed. The Education Lead said that trainees now had access to a good rest area and computer space, as well as breakout rooms, which was a considerable improvement. The Education Lead said the ED had altered the rotas to remove 12-hour shifts for trainees so that since August 2021, the longest shifts were 10 hours. The Education lead said that good trainee feedback had been received on the new rota in the last local faculty group (LFG) meeting and shorter shifts were benefitting the learning experience for trainees. The review team asked the Trust representatives if they had considered allowing middle grade doctors to self-roster and heard that the Trust would like to move towards this and did already include them in the rostering process, but that the number of middle grade doctors needed to increase first. The review team heard that higher trainees did not work at King George Hospital at present (following a past agreement with Health Education England) but that the Trust wanted to open both sites to higher trainees in the future. The Trust representatives said that the foundation trainees and GP VTS trainees worked equitably across the two hospital sites, although only worked in ED paediatrics at Queen's Hospital as there was more consultant support there. The foundation and GP VTS trainees told the review team that the delays in the system and the logistics of the job were very challenging. The	

	foundation and GP VTS trainees said the department was extremely understaffed and this caused staff significant stress. The review team heard that every day a list of empty shifts at both hospital sites was sent around. The review team asked if these gaps were filled and the foundation and GP VTS trainees said they thought some were. The foundation and GP VTS trainees explained that when there were rota gaps, although it was not voiced as such, there was more pressure to see more patients, especially when patients were waiting in the corridors. The review team heard that even when the ED had enough staff, space was still an issue and so patients experienced delays while doctors waited for a space to see them in. The foundation and GP VTS trainees said that their breaks had shifted from two half an hour breaks to a one-hour break after they provided feedback that they were never able to take their second half hour. The foundation and GP VTS trainees said that they felt able to take their whole one hour and generally did not feel rushed back, although it was their responsibility to make sure they got a break as no one checked in on this. The higher trainees told the review team that working at Queen's Hospital was challenging as it was busy, there was a lack of space (which meant seeing patients in corridors), the ED was understaffed, there were tense relations with the specialties, and processes for simple tasks were extremely convoluted. The higher trainees said many of the challenges faced at Queen's Hospital were system-wide issues at the present but there were additional challenges at Queen's Hospital which did not exist elsewhere. The higher trainees said that working in the ED felt like you were barely swimming above water. The foundation and GP VTS trainees flagged to the review team that the process for arranging imaging was difficult and the trainees could agree something with the radiology team but then find the out of hours team had taken over and there were different systems they had to follow. The higher trainees described the process for obtaining a CT scan which involved completing a form on the computer, printing it (which took time as not all computers were linked to all printers) and taking the form to the radiology department where it must be physically signed (despite an electronic signature already being completed). The higher trainees commented that the process for ordering an MRI scan was more complicated. The higher trainees said that there seemed to be different rules for ordering imaging according to the radiology colleague you spoke to and there were different rules in hours and out of hours. The higher trainees told the review team they thought this was because of a wider culture of blame at Queen's Hospital which meant people feared being blamed if they did not follow processes exactly. The review team heard that the higher trainees often took patients down for imaging themselves because they knew that it would be three to four hours before they were taken otherwise. The higher trainees highlighted that radiology was not close to the department and the time they spent doing this was time taken away from other patients. The higher trainees said they felt management prioritised porters for bed moves rather than taking patients to imaging or diagnostics. The higher trainees said the process for obtaining imaging needed streamlining. The DME reported that the Trust was committed to embedding the internal professional standards (IPS). The ESs and CSs said that the IPS	EM2.1c

	was supposed to help address difficult relationships between the ED and other departments but was not yet fully implemented, and they hoped it would be soon. The ESs and CSs said that once the IPS was in place, it would need to be monitored to ensure it was being adhered to. The ESs and CSs said they recognised that some behaviours from the specialties were demoralising for the trainees in the ED. The ESs and CSs told the review team that generally they tried to avoid confrontational encounters in the ED because it negatively affected the mood of the department. The foundation and GP VTS trainees said that their relationships with the specialties were generally good and they found the various teams to be helpful. The foundation and GP VTS trainees said that when they had escalated occasions where they had had difficulties with the specialties, their seniors had addressed these. The higher trainees said that speciality doctors (of all grades) were rude and had a complete lack of respect for ED staff, including the consultants. The higher trainees said that the most challenging colleagues were those working in radiology and general surgery but had experienced similar problems with urology, orthopaedics, and medicine. The higher trainees explained that they often had push back from general surgery when trying to refer to them and it felt like a "game of delays" where the surgeons would ask them to do a whole series of tests before accepting the referral. The higher trainees said that this was not unique to Queen's Hospital but that the scale of it and the animosity was significantly worse than in other Trusts. The higher trainees said they thought it was important the consultants were aware when these situations occurred so they did flag them. The higher trainees said consultants were generally very nice and expressed that they were sorry the situation had occurred, but generally took the route of least resistance because there was a general fatigue of dealing with these interactions. The higher trainees said there were differences between how some consultants dealt with these situations and some did engage in further discussions with the specialties. The higher trainees said whether this happened or not was more related to personality type than any other reason. The higher trainees explained that this generally meant they had to do all of the tests requested by general surgery meaning that even when the four-hour waiting time target could have been met, it was not. The higher trainees highlighted that having to complete all these tests also took them away from other patients. The higher trainees said this animosity with specialities added to the dissatisfaction they had with their jobs.	
2.2	**Appropriate systems for raising concerns about education and training** The Education Lead said the ED had quarterly LFG meetings with trainees followed by a discussion for ESs who supervised higher trainees. The ESs and CSs said they could run LFG meetings more frequently if the review team recommended this.	EM2.2a EM2.2b

Domain 3 – Supporting and empowering learners		
3.1. Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required. **3.2.** Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes. **3.3.** Learners feel they are valued members of the healthcare team within which they are placed. **3.4.** Learners receive an appropriate and timely induction into the learning environment. **3.5.** Learners understand their role and the context of their placement in relation to care pathways and patient journeys.		
HEE Standard	**HEE Quality Domain 3 – Supporting and empowering learners**	**Requirement Reference Number**
3.1	**Access to resources to support learners' health and wellbeing and to educational and pastoral support** The Education Lead informed the review team that the ED had a Wellbeing Consultant who ran forums and workshops for trainees. The Education Lead said that this Wellbeing Consultant had been appointed during the Covid-19 pandemic. The Education Lead said that the ED also had an embedded psychologist and a buddy system. The Education Lead reported that the buddy system meant that foundation trainees were paired with higher trainees and this provided additional support to the foundation trainees and leadership experience for the higher trainees. The Education Lead said that the buddy scheme had been pioneered by higher trainees and the consultants were encouraging them to present the scheme at conferences. The foundation and GP VTS trainees said some of them were aware of the Wellbeing Consultant, had seen emails from them, and were aware of meetings that they had arranged. The foundation trainees said that they had a higher trainee buddy who had contacted them and they knew was available if they wanted to talk to them, but most had not met them in person as their shifts had not overlapped. The foundation and GP VTS trainees said they thought that no one in the department really checked in on them to see how they were and they felt like they were just a number, rather than a part of a team.	
3.2	**Time for learners to complete their assessments as required by the curriculum or professional standards** The foundation and GP VTS trainees said that some CSs had been very good at getting their assessments done. Some of the foundation and GP VTS trainees thought that sometimes CSs suggested that they send tickets through when they saw a patient so the assessment was ticked off, but the experience did not feel like a good learning encounter. The higher trainees said that some consultants needed more encouragement to help them sign off assessments than others but generally they had been able to get things signed off. The higher trainees flagged that it had been difficult to get paediatrics assessments signed off during Covid-19 surges.	
3.4	**Induction (organisational and placement)** The Education Lead said that the ED had worked with the PGME team to add the departmental induction to the Trust app. The review team heard	

	that the department's guidelines were also available to trainees via the app. The Education Lead said the department had worked to enhance the local induction at King George Hospital to include a walk around with current trainees. The foundation and GP VTS trainees told the review team that the departmental induction had been good and had provided a tour of the department as well as providing details of common cases. The foundation and GP VTS trainees told the review team that the Trust induction was fine for those who were able to attend in person but there had been the option to attend online and this had been a poor experience. The review team heard that the trainees who attended online appreciated the effort but they could not hear or see what was going on a lot of the time and were not sent any written information. The foundation and GP VTS trainees said that they did not receive their IT logins promptly and this resulted in some trainees having to complete shifts without IT access or trying to find the site manager to gain a temporary login. The foundation and GP VTS trainees said they would have appreciated information about parking in their induction. The review team heard that the Trust had asked trainees to fill in a feedback form about their Trust induction but they had not heard anything further since then.	EM3.4

Domain 4 – Supporting and empowering educators
4.1. Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body. **4.2.** Educators are familiar with the curricula of the learners they are educating. **4.3.** Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression. **4.4.** Formally recognised educators are appropriately supported to undertake their roles.

HEE Standard	HEE Quality Domain 4 – Supporting and empowering educators	Requirement Reference Number
4.2	**Educators are familiar with the learners' programme/curriculum** The GP VTS trainees said that they had had to explain how the new GP VTS curriculum worked to their CSs and said that their CSs were not able to see their reflections (which they used to be able to). The GP VTS trainees said that some CSs were good at helping them to fill in their assessments but some struggled.	
4.3	**Educational appraisal and continued professional development** The review team heard that any new consultants who expressed an interest in becoming an ES was mentored through the process. The ESs said that the department received a lot of support from the postgraduate medical education department.	
4.4	**Appropriate allocated time in educators job plans to meet educational responsibilities** The review team asked the Trust representatives if ESs had enough time in their job plans for educational supervision and heard that it was challenging at times for consultants to make enough time but time was allocated for ESs to supervise. The review team heard that the	EM4.4

	department was reviewing the current job planning process to consider that higher trainees required more supervision time and were hoping to implement a more structured scheme in 2022. The ESs said that time was allocated for supervision in their jobs plans but said that the trainees found the environment of the department difficult because of the pressures, a lack of space and difficulties with specialities. The review team heard that both trainees and non-trainees were allocated a supervisor. The ESs and CSs informed the review team that the way ES allocation worked was that four ESs supervised one higher trainee (occasionally two) each, two ESs supervised four foundation trainees each and two ESs supervised four GP VTS trainees each. The review team heard that this was because higher trainees needed more support achieve the required competencies.	

Domain 5 – Delivering curricula and assessments
5.1. The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards. **5.2.** Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models. **5.3.** Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

HEE Standard	HEE Quality Domain 5 – Developing and implementing curricula and assessments	Requirement Reference Number
5.1	**Placements must enable learners to meet their required learning outcomes** The Education Lead informed the review team that educational development time was embedded in trainees' rotas and it was mandatory in the department to ensure all trainees were released to attend teaching. The Education Lead said that trainees had confirmed they were always released. The Education Lead told the review team that the teaching provided in the ED was a strong point for the department and weekly skills and simulation training was provided. The foundation and GP VTS trainees informed the review team that they had found their placements to be a good learning experience and support was on hand, but it was also a very challenging environment to work in. The foundation and GP VTS trainees said they had time rostered in to cover the different areas of the ED. The foundation and GP VTS trainees said that teaching was included in their rotas and they were released to attend. The foundation trainees confirmed they were released for self-development time one day every four weeks. The ESs and CSs explained that when GP VTS trainees started the department, the supervisors discussed with them what their previous was experience was (as this was very varied) and what they would like to gain from the placement. The review team heard from the foundation and GP VTS trainees that trainees had been pulled out of their agreed shifts with the ED paediatrics team because there was not enough staff elsewhere in the ED. The foundation and GP VTS trainees said that they had been told they would	

	receive this opportunity at another time but said they did not feel confident that they would. The higher trainees said that gaining complex paediatrics training was a system-wide problem at the moment and this was the same at Queen's Hospital. The higher trainees highlighted that during Covid-19 surges, trainees were not able to get paediatrics time and every doctor was shifted to work elsewhere in the ED. The ESs and CSs told the review team that the department did not support trainees being pulled out of their paediatrics rotation (which was rostered) in order to fill gaps elsewhere as it was understood that trainees were gaining competencies. The ESs and CSs said that wherever this happened, action was taken to ensure trainees were reallocated this opportunity. The ESs and CSs said that during Covid-19 surges, emergency paediatrics teaching sessions were provided, and were still being provided across both hospital sites. The ESs and CSs that monthly four-hour paediatric competencies training was provided. The review team heard that all higher trainees were given the opportunity to work one-to-one with the paediatrics ED consultant. The higher trainees said they felt that training in the department was good but said that the defects in the department also impacted on training and meant as trainees, they were learning certain habits or practicing in certain ways. The higher trainees said that educational development time was rostered and that the department was flexible about how this was used. The ESs and CSs said the development time which was part of the new curriculum was well received by trainees. The ESs and CSs said that providing teaching on the floor of the ED was challenging due to how busy the department was and the lack of space to see patients. The ESs and CSs said that departmental teaching was well-respected and trainees were always released to attend. The review team heard that some bedside teaching did take place but that group teaching was very difficult and so trainees attended teaching such as ultrasound off the ED floor instead. The ESs and CSs told the review team that funding for the role of Clinical Educator had run out but the department was reviewing whether it could be implemented again. The review team informed the ESs and CSs that they strongly recommended doing this.	EM5.1
5.1	**Appropriate balance between providing services and accessing educational and training opportunities** The higher trainees said they felt that universally, emergency medicine trainees were treated more as purely service provision than other specialties.	

Domain 6 – Developing a sustainable workforce
6.1. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes. **6.2.** There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities. **6.3.** The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service. **6.4.** Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

HEE Standard	HEE Quality Domain 6 – Developing a sustainable workforce	Requirement Reference Number
6.1	**Retention and attrition of learners** The foundation and GP VTS trainees said that they would not recommend their placements in the ED. The foundation and GP VTS trainees said they found the job "gruelling" because of the understaffing and workload in the department which meant they often finished late and felt like they were just providing service provision 100% of their time. The higher trainees said that they thought the consultants in the ED recognised that having trainees in the department was a good thing and enjoyed having trainees so they went out of their way to help. However, the higher trainees said they did not feel this attitude was replicated in Trust management and felt this was the reason why improvements were slow to take place. Some of the higher trainees said they would recommend their placements because they felt that if someone could get through a placement at Queen's Hospital ED, they could work anywhere. The higher trainees said they have seen a lot of interesting cases and been allowed a lot of time in the different areas of the ED also. Other higher trainees said they would not recommend their placements and said that more trainees, better relations with specialties, more space and consultants who actively promoted their interests and offered to involve trainees in tasks would help to change this. The ESs and CSs said that they tried to look after trainees and provide as many learning opportunities as possible but that there were a lot of pressures on the trainees and they had to work very hard.	

Report sign off

Quaity Review Report completed by *(name(s) / role(s))*:	Chloe Snowdon Learning Environment Quality Coordinator
Review Lead name and signature:	Louise Schofield
Date signed:	06 December 2021

HEE authorised signature:	Gary Wares
Date signed:	13 December 2021

Date final report submitted to organisation:	14 December 2021

What happens next:

Any requirements generated during this review will be recorded and monitored following the usual HEE Quality Assurance processes.

As part of our intention to development a consistent approach to the management of quality across England, Quality Reports will increasingly be published and, where that is the case, these can be found on HEE's national website. Information from quality reports will usually be shared with other System Partners such as Regulators and Quality Surveillance Groups.