Health Education
North Central and East London

TRUST-WIDE REVIEW VISIT REPORT

Visit Details	
LEP	Homerton University Hospital NHS Foundation Trust
Date of visit	25 February 2015
Background to visit	The Trust had not had a Trust-wide Review since March 2012. The Postgraduate Dean requested this visit which took place alongside specialty-focused reviews of emergency medicine, ACCS and obstetrics and gynaecology. The North-East Foundation School also aligned with this visit to carry out a separate review of foundation training. Separate reports were created for each part of the visit.
Visit summary and outcomes	The visit team met with members of the postgraduate team and senior management team, a large number of trainee representatives in medicine (including gastroenterology, geriatrics, rheumatology) paediatrics, neonatology, general practice, radiology, anaesthetics and surgery, as well as a number of educational leads from respiratory medicine, paediatrics, radiology, general practice, medicine, neonatology, micro-biology, pathology, rheumatology and anaesthetics. The excellent attendance by such a large number of specialties was commended by the visit team. The visit team was pleased to note that a superb educational governance structure was in place at the Trust with a number of functional local faculty groups with strong trainee involvement. The visit team found that the clinical and educational supervisors felt well supported by the postgraduate medical education department and that in general the faculty was very engaged in the provision of good education and training. Most trainees reported that they had access to excellent teaching opportunities, with many being given daily teaching sessions. All the trainees stated that they would recommend the Trust to their colleagues as a good place to train and the majority would be happy to have their family and friends being treated there. The visit team had concerns about the following: 1) The lack of a clear policy for the management of the escalation wards was felt to be putting patients at risk. The visit team heard that there had been functional problems when the escalation ward had first opened in November (for example, the absence of effective resuscitation equipment) but that there had been improvements (for example, the allocation of a permanent nursing sister to the escalation ward during the day). However, the visit team was unclear about who held the overall responsibility for admission of patients or for clinical management on a daily basis. The visit team would like clarification of the out of hours arrangements in terms of composition of the nursing and medical staffing (proportion of bank and locum staff), their direct clinical supervision and the standard operating policy for the ward including admission / exclusion criteria.

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	2) The competence of the middle-grade surgical Trust doctor on duty at night, clinical supervision and the support that was provided to the deteriorating patient. The impact of the apparent inconsistency of the decision making by surgical trust doctor appeared to have an effect on the anaesthetics department including the ITU. The visit team would like the Trust to undertake a review of the out-of-hours cover provided to acute surgical patients and their outcomes. 3) The medical and surgical higher and core trainees were concerned about the vulnerability of the FY1 trainee looking after all the medical and surgical patients at night; however, during the foundation review, none of the FY1 trainees mentioned that they felt overwhelmed when on call, which left the visit team with the impression that perhaps the FY1 trainees did not have the experience to recognise a deteriorating patient and request assistance from a consultant, or a higher trainee out of hours. The visit team recommends that the Trust undertakes an urgent review of the hospital at night provision, considering the workload, level of clinical experience / expertise / skills required, ease of access to supervision by middle grade doctors of FY1s and any additional manpower requirements to run a safe and effective system. Further details and additional requirements and recommendations are outlined below.

Visit team

Lead Visitor	Helen Massil	**Trust Liaison Dean**	Indranil Chakravorty
Lay Rep	Kate Rivett	**Lay Rep Observer**	Diane Moss
Visit Officer	Jane MacPherson	**Lay Rep Observer**	Catherine Walker

Findings

GMC Domain	Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
		Educational Structure The visit team was pleased to see that a very clear educational structure was in place at the Trust. The Director of Medical Education (DME) reported that she held a one-to-one meeting with the Medical Director every month and could approach him at other times as and when required. The visit team heard that the education committee met		

		monthly and was attended by the education leads. In addition to this committee, there was also a strategic educational leadership committee which informed the Trust Board. This committee had a multi-disciplinary focus. The DME stated that she was confident that via these two avenues, there was a clear link to the Board and commented that she could also ask to be invited to the Board meetings if she felt that educational issues needed to be raised. The educational leads stated that they felt supported by senior management.		
1	TWR1.1	**Hospital at night / Out of Hours** The visit team was aware that at the previous Trust-wide Review in 2012, the trainees had not felt that the hospital at night system was sufficiently robust. The DME reported that following the previous visit, feedback about the hospital at night system had improved. The visit team heard from the core and higher trainee representatives that in medicine one higher trainee, one core trainee and one foundation year one (FY1) trainee were on call at night. A site practitioner was also present. This reportedly worked well depending on the experience of the site practitioner who was on duty. There was a handover meeting at the start of each night shift at 9.30pm which was well attended. The visit team heard that the FY1 trainee was responsible for the wards at night, whereas the core trainee managed the take and the higher trainee managed the ACU. The FY1 was effectively responsible for all the medical and surgical patients at night and was regularly bleeped by the nursing staff. The core and higher medical and surgical trainees felt that the FY1 was sometimes overwhelmed at night due to the heavy workload. The core trainees commented that they tried to assist the FY1 at night, but this was not always possible if the Acute Care Unit (ACU) and take were busy. The visit team was told that at times the FY1's workload was not too onerous but that this all depended on the take, which varied between five and 20 patients admitted overnight depending on the time of year. One higher trainee felt that irrespective of how busy it was, it was not ideal for the relatively inexperienced FY1 trainee to be expected to cover the different areas single-handedly.	The visit team recommends that the Trust undertakes an urgent review of the hospital at night provision, considering the workload, level of clinical experience / expertise / skills required, ease of access to supervision by middle grade doctors of FY1s and any additional manpower requirements to run a safe and effective system. With regards to the escalation wards, the Trust	Amber Mandatory Amber

		The medical trainees informed the visit team that there were up to three escalation wards which were normally occupied by recovering patients. One had been opened since November 2014, whereas the others had been opened for a few days at a time and then closed again. During the day, the ACU team staffed the wards but at night the FY1 covered the wards. The higher and core trainee reps commented that the previous month had been particularly difficult with the FY1 trainee being expected to look after an increasing number of sick patients. The trainees reported that previously there had been nursing support by bank staff on the wards but the visit team was told that this had improved in the previous two months and that there was now a permanent ward sister. Furthermore, following issues in November 2014 (for example, the absence of appropriate resuscitation equipment when the ward was opened) an in-situ simulation had been run by the resuscitation officer and many issues had since been escalated and subsequently improved. The core and higher trainee reps were not aware of any patient safety issues which had arisen since the wards opened but felt that some near misses may have occurred. They commented that at times sick patients who should have been in resuscitation in the day deteriorated overnight on escalation wards; furthermore the core and higher trainee reps were concerned that the FY1 trainee was not adequately experienced to diagnose and deal with critical or deteriorating patients. The core and higher trainee reps reported that when deciding which patients to move to the escalation wards, this decision was usually made by the trainees in discussion with the bed managers. The core and higher trainee reps were happy with this process. They reported that normally these were patients who were stable and getting ready for discharge, although this was not always the case; occasionally patients were unstable and core and higher trainees were therefore concerned that they could deteriorate overnight while being looked after by the FY1. They felt that the FY1 would not always be able to recognise this, especially when starting their first post in August. The core and higher trainee reps reported that the patients who were moved to the ward were under the care of different consultants; although this provided for continuity	should review the staffing, policies for admission, senior-led transfer decisions and daily consultant supervision of junior doctors in these areas and provide details of out of hours staffing.	Mandatory

		of care, it also meant that there was no named consultant dedicated to the ward. The core and higher trainee reps reported that consultant input into the escalation wards varied from consultant to consultant. The trainee reps commented however that their consultants were all very supportive. The educational leads, on the other hand, felt that there was always senior presence and that all the patients had regular consultant input. They were confident that patients were safe overnight. The senior management team reported that the escalation wards were managed by the surgical directorate, with permanent staff being drawn from other wards and with patients being admitted under the admitting medical consultant. They confirmed that there was no written policy for who should be admitted to the escalation ward. The Medical Director stated that the lead nurse from the surgery division was in charge of the escalation wards on a daily basis and that the consultants in conjunction with the bed managers should ideally make the decision regarding who should be moved to the escalation ward. The visit team heard that there was a middle grade surgical Trust grade doctor on duty at night. Some core and higher trainee reps were concerned about the quality of clinical decision-making for acute surgical patients overnight. This sometimes resulted in the deterioration of patients who were then admitted to the ITU as an emergency. The visit team also heard that the Trust doctor often called the anaesthetic trainees to request them to carry out simple tasks such as inserting cannulas. Some core and higher trainee reps expressed concerns about inordinate delays for patients requiring surgery who were admitted overnight. In paediatrics, the hospital at night system appeared to work well with one core trainee and one higher trainee on duty as well as a twilight system. Similarly in neonatology there were two core and two higher trainees on duty. The visit team heard that the neonatal handover, which had previously been slightly disjointed, was now working	The Trust should conduct a formal review of the quality of surgical out-of-hours cover to ascertain whether the skills and senior supervision of the doctors providing cover is appropriate to ensure the safe management of surgical patients.	Amber Mandatory

		better. An evening handover reportedly took place with consultant presence and this was felt to be more formal. In radiology, no issues were reported in hospital at night.		
1	TWR1.2	**Serious Incidents (SIs)** The visit team heard that a 'Datix' serious incident reporting system was in place. When an incident occurred, the Trust aimed to hold a meeting within 24 hours to discuss the incident. Everyone involved in the incident was reportedly invited to this meeting which was normally led by the Medical Director or the Chief Nurse. The DME would also be invited this meeting if a trainee was involved. The DME felt that the process worked well but commented that a trust-wide review of the serious incident reporting and investigation system was taking place to ensure that the process was robust. The DME reported that during the induction process she informed the trainees of the different avenues that they could take if they had any problems or wanted to report any issues or incidents. Therefore she felt confident that the trainees could bring up any issues without fear of recrimination. The DME also reported that the Trust was very keen to ensure that lessons were learned from serious incidents investigations and many incidents were incorporated into the Trust's simulation programme. She stated that all simulation training was multi-disciplinary in nature. Most trainee reps reported that they attended clinical governance meetings and that they knew how to report incidents. The visit team did not gain the impression however that all the trainees had received sufficient feedback on incidents they had reported. The trainee reps also suggested that perhaps not all incidents were reported since the Datix forms were cumbersome to complete. The trainee reps and educational leads confirmed that they were aware of the 24-hour meeting policy and felt that this worked well. They stated that incidents were openly	Once the trust-wide review of the complaints process and serious incident process is complete, please forward a copy of the revised policy to the Quality and Regulation Unit. This should include details of how feedback is provided to the trainees who have reported incidents.	Amber Mandatory

		discussed during these meetings and that no blame was apportioned.		
1	TWR1.3	**Clinical supervision** All the trainee reps reported that their level of clinical supervision was good or excellent. Nobody was expected to carry out tasks beyond their level of competence.		
1	TWR1.4	**European Working Time Directive** No major issues were reported in this area.		
2	TWR2.1	**Local Faculty Groups (LFGs)** The DME reported that LFGs were in place in each specialty area but the frequency of the meetings varied according to each specialty. These meetings were led by the specific educational lead for each area. It was reported that trainee reps were in attendance at each LFG and that there was also good consultant attendance. The visit team noted that there were terms of reference for the LFG. Minutes were also taken at LFGs and at times a member of the education managerial team attended an LFG to take minutes. The visit team was informed that there was also trainee representation at the Medical Education Committee (MEC). The trainee reps confirmed that they attended LFGs and they all agreed that they could raise any issues they had during these meetings. The educational leads corroborated this. They also felt that there was a very good interface with the MEC.		
6	TWR6.1	**Induction** The visit team heard that the main Trust induction was held centrally and took place on a monthly basis. It was reported that departmental inductions took place, following which feedback was collected. Most trainees confirmed that they had attended a Trust induction apart from one	Ensure that all radiology trainees attend an	Amber

		radiology trainee who had been in post three weeks but had not been offered any induction. Another trainee rep who had started out of sync with the rotation confirmed that an induction had been organised just for two people. All the trainee reps confirmed that they had attended a departmental induction. Some medical trainees commented however that they had had to do an acute medical nightshift when they first started in post without having had a departmental induction. In paediatrics, the trainee reps commented that the rotas were arranged so that the new starters did not have to cover the night shift as soon as they started in post. In anaesthetics, a Trust doctor covered the night shift during the induction period. The visit team was informed that the Trust planned to move to a paperless system (ACE) in summer 2015 and therefore in anticipation of this, training was already underway. The Head of Medical Education commented that the August induction would need to be undertaken online so that there was sufficient time for the ACE training which would last for half a day. The visit team heard that the ACE team would be training super-users on the wards, so that they could help people on the ground at a later stage.	appropriate Trust induction. Ensure that all trainees attend an appropriate departmental induction prior to undertaking an on call shift.	Mandatory Amber Mandatory
6	TWR6.2	**Trainees in Difficulty** The DME reported that if she was informed about the arrival of a trainee in difficulty, she arranged to meet with the trainee early on in the rotation. She also stated that if there was a specialty trainee in difficulty, the trainee's consultant would alert her to the issues. She was confident that the process in place to deal with trainees in difficulty was robust. The educational leads stated that support was always available from the education team if they needed it. At the end of each MEC meeting, there was a session where trainees in difficulty were discussed.	We recommend that the educational lead for	

		The educational lead for radiology stated that the department was not informed in advance about trainees in difficulty who were to be allocated to the department and she suggested that she and her colleagues would be able to provide more bespoke training to the trainees in difficulty if the department were forewarned.	radiology communicates with the Head of School of Radiology regarding this issue. The Quality and Regulation Unit will also bring this issue to the attention of the Head of School.	Green Recommendation
6	TWR6.3	**Educational Supervision** The visit team was informed that the Trust had now achieved 81% compliance in the GMC trainer census (versus 53% several months earlier) and was on target to meet the GMC requirements by 2016. The DME reported that traditionally appraisals had been carried out by the DME and Deputy DME on a three year basis, but that the appraisal process was being devolved to the educational leads. The DME stated that if there were any resistance to complete an appraisal by any individual consultant, she and the Medical Director would have no qualms about removing the trainees so that the consultant would no longer be an educational supervisor. The DME reported that in undergraduate training great strides had been made to ensure that a proportion of the undergraduate tariff came directly to the education team so that this money could be used for salaries for trainers. The DME was keen to move towards a system whereby she was also responsible for a proportion of the tariff for postgraduate training so that she could ensure that the clinical and educational supervisors were allocated appropriate SPA time for training and education. The educational leads confirmed that they had been given an appraisal. They all agreed that the postgraduate medical education department had implemented a strong structure for appraisals. Some educational leads expressed concern however that the task of appraising their educational supervisors had been devolved to them and commented that they had not been given additional time in their job plan to undertake this work. The visit team heard that the amount of SPA time allocated to clinical and educational	The visit team found that many trainers were not receiving appropriate SPA time for their educational	Green

		supervisors was variable. Some were allocated time for their educational work but this was not necessarily felt to be proportional to the work they did. Some educational supervisors only received 0.25 PA for their educational work whether they had one or four trainees. The educational lead in radiology commented that clinical and educational supervisors in radiology did not have any SPA time allocated in their job plan for their work. Some educational leads did not appear to be given additional time in their job plans for the work they did in their larger roles. The senior management team reported that there was a Trust policy on job planning but that in reality this may not be equitable in job plans. The educational leads all agreed that they received good support from the postgraduate medical education department. They were regularly informed about courses and workshops both in-house and externally. They commented that it was not uncommon for the Trust to develop in-house initiatives. All the trainee reps confirmed that they had an educational supervisor.	work. The visit team recommends that the DME should hold the responsibility for the postgraduate funding tariff which in turn would allow a more equitable distribution of SPA time to trainers. Educational leads should be rewarded accordingly for their additional work.	Recommendation
6	TWR6.4	**Teaching and Training** The visit team heard that in medicine there were various educational meetings within the Trust and there were also general medical training days at a regional level. The higher trainee reps reported that they were able to obtain study leave to attend these days. The core trainee reps in medicine reported that they did not have much opportunity to attend the regional training days as they were unable to obtain study leave to attend. Some trainees were unaware of the minimum curriculum requirement for regional teaching. The core medical trainee reps reported that there was timetabled weekly core medical teaching for an hour a week.	The core medical trainees should be released from their commitments to attend regional teaching so that they can meet their curriculum requirements. The educational lead for core medical training should review the attendance, confirm that trainees are meeting the current recommendation (usually 75%) for ARCP and submit a report to the Quality and Regulatory unit.	Amber Mandatory

		In anaesthetics, the trainee reps confirmed that they were able to attend the regional post-fellowship and pre-fellowship days as this time was built into their rota. It was reported that there were also teaching sessions on a Friday morning within the hospital. In surgery, the junior surgical trainee reps confirmed that they were able to attend skills training every month. Although they were sometimes unable to attend the monthly regional teaching, in general they felt that they were attending enough to meet their curriculum requirements. In neonatology, it was reported that there was excellent local teaching. In paediatrics, the visit team heard that a teaching session took place every morning for half an hour. Although there were no curriculum requirements to attend regional teaching, the higher trainees were encouraged to go. In general, however, they reported that it was difficult to obtain study leave for other regional training due to rota commitments. For ST1-ST3 the trainee reps commented that they were unable to request study leave as they were told it was incorporated into their rota. The department was reported to be flexible, however, in allowing trainees to swap if they specifically wanted to attend a course. The trainee reps in core paediatrics commented that the consultants carried out ad hoc teaching but that since their working day started an hour later than the trainees' teaching session, the trainees felt that their teaching was predominantly trainee-led. The GP trainee reps reported that they were unable to attend teaching in obstetrics and gynaecology. The radiology trainee reps reported that they had weekly teaching sessions. In general surgery some trainees reported that they were expected to attend five clinics per week as opposed to the recommended two clinics (or three, if one is a specialist clinic). They confirmed that on the whole they were able to attend four half-	Teaching sessions for paediatric core trainees should be consultant-led. The educational lead for paediatrics in conjunction with trainee reps should review the teaching programme and ensure that appropriate consultant input is provided and confirm via minutes of MEC. Surgical trainees should attend no more than two clinics per week (plus one specialist clinic). The educational lead for surgery should review the requirement for clinic attendance at the surgical	Amber Mandatory Amber Mandatory

		day operating lists per week.	LFG and report to the Quality and Regulatory unit via minutes of the MEC.	
6	TWR6.5	**Simulation** The DME stated that some simulation sessions were mandatory and some formed part of the regional training programmes. In addition to this, she reported that in-situ simulation sessions had been running for many years in some specialties. An in-situ simulation programme had also recently been introduced for medical higher trainees on the acute care unit. The sessions took place every Wednesday at 11am after hand-over and ran during their shift as on-the-job training during which the trainees' bleep was held by someone else for an hour. The trainee reps confirmed that in-situ simulation had recently started for the medical trainees. Most of the trainee reps with whom the visit team met had not yet had the opportunity to undertake the training but those who had confirmed that it was excellent. The visit team heard that for foundation trainees, non-technical skills were taught in approximately 50% of the simulation training (with the remaining 50% being more clinical training), whereas for higher training levels, non-technical skills training was given even more importance.		
6	TWR6.6	**Bullying and undermining** The visit team was aware of two issues that had been raised in this area in the GMC National Training Survey in 2014. The DME reported that following the results of the GMC survey, meetings had been organised with the educational leads to investigate further the complaints raised. In addition, focus groups and feedback sessions had been arranged, some of which were attended by specialty leads and some of which were not. At times external representatives had been invited to the sessions; some sessions had also been run by the Local Negotiation Committee (LNC) and by HR. The DME also commented that anonymous surveys had been set up on Survey Monkey to try and ascertain the full extent of the problem. Action plans had been created to address any problems raised. The DME stated that she was confident that		

		the issues had been fully investigated and resolved. The trainee reps confirmed that a robust system was in place if complaints about bullying and undermining were raised. An example was given in anaesthetics where the information-gathering process had taken a long time with surveys and private interviews, but the trainee reps were pleased that the process had been so thorough and felt that the issue had been taken seriously and dealt with appropriately. All the trainee reps confirmed that they would feel comfortable about bringing up any problems about bullying and undermining if they arose. Although the GP VTS trainees commented that they had never been subject to bullying and undermining behaviour themselves, they did feel that in obstetrics and gynaecology there was a culture of undermining in the department as many people were exceptionally critical often in public. The educational leads all agreed that the system in place for dealing with these issues was robust. In neonatology, for example, junior - junior meetings took place for just the trainees and the minutes from these meetings were sent to the educational lead who in turn disseminated this information to this colleagues. The educational lead for neonatology felt that the department was very supportive of its trainees and ensured that the trainees knew who they could approach for help if required. The other educational leads agreed and commented that the trainees were made aware of the structure and hierarchy at induction and therefore knew who to contact to raise any issues. One educational lead suggested that in many areas a consultant-delivered service was in place which meant that consultants were interacting more and more with trainees, and this therefore could lead to perceptions of undermining if a consultant criticised a trainee's work. None of the educational leads felt that that there was a culture of undermining at the Trust.	The Trust should undertake an anonymised survey in the O&G department specifically related to bullying and undermining as well as organise a focus group amongst trainees and staff seeking help from HEE's Professional Support Unit, if needed. The outcome of the review and survey should be reported to the MEC and minutes shared with Quality and Regulatory unit.	Amber Mandatory

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8	TWR8.1	**Library** The Library Manager reported that trainees were informed about the library services during a half-hour slot of their induction. The visit team heard that the library had a computer room with 11 computers and a laptop and that there was also a 24/7 learning hub within the main hospital with 10 computers. The Head of Library reported that the Trust had invested heavily in increasing electronic journal provision, had access to Uptodate on all computers and that plans were underway to provide more e-books too. WIFI was reported to be available within the main building as well as other hotspots.		

Good Practice	**Contact**	**Brief for Sharing**	**Date**
The in-situ simulation sessions provided to many trainees were felt to be very educational and an example of good practice.			
The education governance structure was effective and engagement with local faculty group was very well established.			

Other Actions (including actions to be taken by Shared Services)

Requirement	**Responsibility**

Information and reports provided to the team prior to the visit

DME Annual Report	*No*	Regulator Reports/Data	*No*	LFG Reports	*No*	MEM minutes	*Yes*
GMC Survey - trainees	*No*	GMC Survey - trainers	*No*	Previous visit reports & action plans	*Yes*		

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PVQs - trainees	*No*	PVQs - trainers	*No*	Result of school survey	*No*		
Signed							
By the Lead Visitor on behalf of the Visiting Team:	*Helen Massil*						
Date:	*23 March 2015*						