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Pan-London Quality and Regulation Unit

Barking, Havering and Redbridge University Hospitals NHS Trust

Geriatric Medicine

Quality Visit Report

Date of visit: 30 April 2015

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Health Education
North Central and East London

CONVERSATION OF CONCERN REPORT

Visit Details	
LEP	Barking Havering and Redbridge University Hospitals NHS Trust (Queen's Hospital)
Specialty	Geriatric Medicine
Date of visit	30 April 2015
Background to visit	It was brought to the attention of Health Education North Central and East London (HE NCEL), that there were a number of education/training concerns regarding geriatric medicine at Barking Havering and Redbridge University Hospitals NHS Trust. HE NCEL, as responsible commissioner for the Trust and as the accountable body to the General Medical Council (GMC), was obliged to investigate and act upon any patient safety, education and or training concern. With the above in mind a focused Conversation of Concern was requested at the Trust as a matter of urgency. This Conversation of Concern was arranged to focus on concerns that had been raised with HE NCEL regarding: 1. Patient safety concerns particularly regarding Acute Medicine and Stroke Medicine. 2. Trainees undertaking tasks beyond their level of competence – representing a patient safety concern. 3. Inadequate staffing levels at night – leading to patient safety concerns and concerns in regards to the department's capacity to deliver high quality education and training.
Visit summary and outcomes	The visit team was impressed by the attendance and engagement of individuals from senior medical and management teams and the department of geriatric medicine, and trainees. There seemed to be a real desire from senior clinicians and from the senior management team to acknowledge past failures and to try and improve the quality of education and training for the trainees. The visit team was pleased by the honest and thoughtful reflections of some of the trainers that there had been problems but noted that there seemed to be a willingness to change; this was evidenced by the newly convened local faculty group, the new proposed higher trainee timetables and the appointment of a training lead within the department. The introduction of seven day working had also had a positive impact and the visit team felt that in general there were consultants who wanted to teach and deliver education and training. The visit team was reassured by the new Medical Director's zero tolerance stance towards bullying although the visit team did hear of a number of

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	concerning incidents of undermining from some of the trainees. The visit team was interested to hear about plans for the multi-professional delivery of care and about plans for improving hospital at night, and requested further updates on these two areas. The visit team highlighted the following areas for development: The visit team indicated that there needed to be a Trust-wide review of the medical rotas including hospital at night which should include utilising non-medical staff to support the delivery of acute care and review how consultants and medical trainees could be most effectively utilised. The visit team indicated that there must be trainee involvement in this process. The one in four rota was felt to be unsustainable and would inevitably lead to more sickness and absence as the trainees felt particularly over-worked; furthermore the rota had a negative impact on available training time due to the number of zero days that were necessary for it to be an European Working Time Directive (EWTD) compliant rota. Of the trainees interviewed, none would recommend the hospital for training but they did acknowledge that it could be a very good place to train if they were afforded better training opportunities. The case mix and pathology were reportedly excellent but the trainees were too over-whelmed to really take advantage of the breadth of educational opportunities available; the visit team felt that what was required to make training excellent was leadership at consultant level. None of the trainees interviewed had attended a departmental induction or had received an appropriate learning agreement. The visit team required the Trust immediately to introduce a departmental induction (for current trainees) which should include ward orientation, staff structure, patient safety issues escalation and allocation of consultant supervisors. The induction should be accompanied by training agreements with trainees. Many trainees seemed unaware of who their clinical supervisor was although they were aware of their educational supervisor. The visit team indicated that it should be made clear to the trainees how to escalate both patient safety and training concerns. Furthermore, some trainees were concerned about the risk of victimisation when they had reported incidents. The visit team required the Trust to ensure that trainee confidentiality was assured and that trainees were encouraged to report incidents and were well supported when they did so, without fear of recrimination. There was a lack of regular consultant ward rounds of the whole ward and a lack of multi-disciplinary meetings. The introduction of more regular consultant ward rounds would allow trainees to complete the necessary workplace-based assessments for their training. The regular local teaching schedule should be disseminated to all trainees and their attendance facilitated. The visit team recommended the establishment of a Trust-wide forum for trainees so that they could feedback any concerns. There would need to be representation at a senior level so that the trainees felt that their concerns were being taken seriously.

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	The visit team strongly supported the appointment of a second college tutor with a remit for general internal medicine (GIM). The visit team recommended that the newly appointed lead for education should be embedded into the University College London Partners (UCLP) structure and also should attend the regional Training Programme Management Committee (TPMC) meetings for geriatric medicine with engagement with the training programme director. **The visit team requested a proactive approach to dealing with these issues and requested an update on progress made, including trainee feedback by June 2015. Further feedback would be expected at the Trust-wide review planned for later in the year.**

Visit team

Lead Visitor	Dr Catherine Bryant, Deputy Head of London Specialty School of Medicine	**Deputy Lead Visitor**	Dr Jonathan Birns, Deputy Head of London Specialty School of Medicine
Trust Liaison Dean	Dr Indranil Chakravorty	**Lead Provider Representative**	Ms Helen Jameson, UCLP Representative – Director for Education
Lead Provider Representative	Dr Hasan Rizvi, UCLP Representative – Associate Director	**Trainee Representative**	Dr Corinne Quah, UCLP Geriatric Medicine Trainee Representative
Visit Officer	Ms Jane MacPherson	**Lay Member**	Mr Ryan Jeffs

Findings

GMC Domain	Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
1	1.1	**Rota** The visit team heard that consultants were on the shop floor for acute medicine from 8am to 8pm and that seven day working was in place in geriatric medicine. The visit team heard that trainees did one in four weekends on call. The service manager confirmed that the rota was European Working Time Directive (EWTD) compliant as diary card exercises had taken place. The visit team felt that this rota meant that the trainees had to take too many zero days which in turn impacted negatively on their training time.	Conduct a Trust-wide review of the medical rotas including hospital at night which should include utilising non-medical staff to support the delivery of acute care and review how consultants and medical trainees could be most effectively utilised. There must be trainee involvement in this process.	Amber Mandatory Requirement

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		The service manager reported that two higher trainees were allocated to the overnight shift between 8pm and 9am alongside three core trainees. They were responsible for covering the take and the wards. One higher trainee was purely based in the emergency department taking referrals and the second was based on the wards covering the sick patients. The three core trainees worked according to where they were needed most. There were no foundation year one trainees on duty overnight. The visit team heard that there were approximately 20 to 30 admissions at night to a hospital with 645 medical beds, not including surgery. The visit team heard that there were acute medicine consultants on call from home from 8pm. It was reported that patients clerked by the on call team during the daytime were then seen by the specialist consultant. The trainee who clerked the patient contacted the consultant once the patient was ready for post-take. There was a handover meeting at 8pm during which all patients who still had not been 'post-taken' were discussed. It was felt by senior management that this system worked well. There was reportedly an electronic e-handover system that everyone could access. The acute medicine consultant was the lead consultant on call for everyone. The visit team heard that there was no hospital at night team at the time of the visit but the medical director reported that he had started a piece of work to look at trying to develop a hospital at night system. This was initially being tested at the King George Hospital site. The divisional director admitted that the department had not been good at managing absences and sickness but that plans were in place to try and address the trainees' concerns about the rota, for example, it had recently been agreed to move the trainees' zero day to after their on call rather than the Thursday before. The head of medical education reported that during the recently convened local faculty group, the rota had been discussed and that the trainees were happy with the newly adjusted rota. The visit team heard that the introduction of three specialty training year two trainees (ST2s) to the day rota had improved the rota and that the department had received positive feedback about this. The visit team was informed that the Trust had made a great deal of effort to secure good locum staff, and that if locum staff was found to be lacking in quality, this was fed back to the agency.		

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		The visit team was informed by the service manager that because of vacancies, there were gaps in the day and night rotas. The visit team was told that on call rotas were reviewed six weeks in advance to ensure that gaps could be filled. The service manager reported that there were on-going vacancies which exacerbated the problem, but that the Trust was looking to fill these vacancies with long-term locum doctors. The medical director reported that the stresses on the weekend and night rota were well recognised and that the Trust was engaged with the trainees in trying to improve the rota. The Trust was reported to be looking at alternative ways to support the rota, for example by the use of non-medical staff such as physician associates and advanced nurse practitioners (ANPs). The medical director informed the visit team that Queen Mary's University London (QMUL) was designing a physician associate course and that Barts Health NHS Trust was supporting the design of this course. In the meantime, the Trust was trying to identify those already trained as physician associates and offer them job opportunities. The Trust had also looked at recruiting UK graduates and physician assistants from America. The plan was to bring in 10 to 12 extra personnel to begin with, and then train others in a joint arrangement between Barts Health NHS Trust and Barking Havering and Redbridge University Hospitals NHS Trust. The visit team was told that the new rota would be in place from August 2015. The director of medical education (DME) reported that the trainees had designed the rota three years ago but that service redesign in the interim period now meant that it no longer worked as well as previously. Attempts had therefore been made to produce a rota which would function well in the long-term. However, the Trust did not want to change the rota mid-rotation and there were also other challenges with regards to Broadening the Foundation Programme which had meant that it had not been possible to fix the rota issues immediately. This had resulted in plans to expand the workforce using ANPs and physician associates. The DME reported that he and his team met regularly with the junior doctors and were always at pains to fix rota issues if any were brought up. The trainees reported that most shifts were not fully staffed. The majority of staff on the on call shift was reported to be locum staff both at the Queen's Hospital site and the King George Hospital site. The trainees reported that they did not have much opportunity to review patients post-take. The foundation trainees in particular were often too busy on the ward to be able to review		

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		patients post-take with the consultant.		
1	1.2	**Clinical supervision** Following admission, patients were reportedly initially seen by a consultant but then from that point onwards, they would normally only be seen by the foundation trainees. The visit team heard that different consultants had different schedules but it was felt by the trainees that these were not always followed. The trainees at the King George Hospital site reported that there was a Monday and Thursday ward round. At the Queen's Hospital site, the visit team heard that there were multi-disciplinary board rounds. The trainees commented that the board rounds were informal in style, no paperwork was kept and they were not held in a private location. They felt that a formal sit-down multi-disciplinary meeting would be preferable. The visit team heard that no team had a formal multi-disciplinary teaching session apart from at the King George Hospital site on a Wednesday.		
1	1.3	**Tasks undertaken according to competence or experience** Some of the foundation trainees (F1) reported that their consultants did not discuss treatment with the patients and families and therefore the trainees themselves were expected to hold these discussions, including regarding end of life decisions. Some of the foundation trainees had been expected to make Do Not Attempt Resuscitation (DNAR) decisions. The trainees in the elderly assessment unit reported that they had a lot of support from their consultants.	Review the level of work undertaken by the trainees to ensure that they are not expected to complete tasks beyond their level of competence.	Amber Mandatory Requirement
1	1.4	**Serious incidents** Most of the trainees seemed unaware of how to report serious incidents. Some trainees were unsure who their clinical supervisor was at all times. Those that had reported serious incidents were concerned about the risk of victimisation since their name was apparent on the incident reporting form.	See Ref 6.1 below.	

		The trainees did not raise any patient safety issues to the visit team. They were concerned with the volume of work at night but did not have any particular concerns about patient safety.		
1	1.5	**European Working Time Directive (EWTD)** The trainees felt that the staffing issues were the main obstacle to them receiving good training. Some foundation trainees felt that they were working many more hours than they were paid for.		
1	1.6	**Stroke Medicine** The clinical director responsible for stroke medicine reported that a meet and greet policy was in place which meant that stroke patients bypassed Accident and Emergency. The higher trainee and core trainee were on duty from 9am to 9pm, and from 9pm the core trainee covered the unit with a non-resident consultant available on call, plus a trauma nurse. It was reported that on one occasion in the last six months there had been no core trainee available and the consultant asked the acute medical team on call to provide cover.	See Ref 1.1 – with update pertinent to Stroke being fed back to the London Clinical Director for Stroke by the Quality and Regulation Unit.	
2	2.1	**Local faculty groups** The visit team heard that the local faculty group reported into the postgraduate medical education committee which took place on a monthly basis. The postgraduate medical education (PGME) committee fed into the academic strategic group and the Trust Board. The visit team was informed that trainee fora had not always worked well in the past due to poor attendance. The DME felt that a senior presence was required to make such meetings worthwhile. The head of medical education reported that she attended ward rounds and talked to trainees to try and engage with them and understand how they were feeling. Some consultants felt that she would be well-placed to facilitate a doctors' forum. The trainees confirmed that they had attended recent local faculty group meetings and felt that their concerns were listened to. However, at the King George Hospital site, the trainees reported that the clinical lead had	The visit team recommends the establishment of a Trust-wide forum for trainees so that they can feedback any concerns. There needs to be representation at a senior level so that the trainees feel that their concerns are being taken seriously.	Green Recommendation

		not attended the recent local faculty group.		
6	6.1	**Induction** None of the trainees at either Queen's Hospital, or King George Hospital had received a departmental induction apart from one trainee working in the elderly receiving unit who had attended an acute medicine induction. The trainees commented that they would have liked to learn more about the department's policies and procedures and they would have liked to meet the consultants; they would also have appreciated a tour of the department. The general practice (GP) trainees on the elderly receiving unit were not given a timetable. The foundation trainees were not issued with a timetable either although they were given a rota so knew when they were on call. The higher trainees reported that when they started in post they were expected to be on the same ward all day every day for their allocated period of time to the hospital (usually one year) and were not allocated to clinics.	Introduce immediately a departmental induction (for current and future trainees) which should include ward orientation, staff structure, patient safety issues, complaints and escalation procedures with assurance of confidentiality and absence of recrimination, and allocation of consultant supervisors). The induction should be accompanied by training agreements with trainees. The regular local teaching schedule should be disseminated to all trainees and their attendance facilitated.	Amber Mandatory Requirement
6	6.2	**Training** The clinical leads for geriatric medicine informed the visit team that they wanted to improve the structure of training and that a local faculty group had been established. The clinical leads reported that when trainees had complained about aspects of their training, they always tried to address the concerns and ensure that the trainees received more specialty training. The visit team heard that trainees had requested to do more community work and therefore the clinical leads reported that as a result of this they had devised new timetables which would facilitate this. One of the trainees who had just started the new timetable implemented one day before the visit reported that it was good. The educational lead, being new in post, was still unaware of the University College London Partners (UCLP) Training Programme Management Committee. She reported that she would like to meet with the training programme director for the region to discuss the sample new timetables that had been constructed and to discuss other training issues.	The visit team strongly supports the appointment of a second college tutor with a remit for general internal medicine (GIM). The visit team recommends that the newly appointed lead for education should be embedded into the University College London Partners (UCLP) structure and also should attend the Training Programme Management Committee (TPMC) meetings for geriatric medicine with engagement with the training programme director.	Green Recommendation

		The director of medical education reported that one of the areas of weakness in the training programme was the balance of general internal medicine (GIM) training versus specialty training. He commented that trainees tended to do a lot of GIM training on call at the expense of their specialty training. He reported that plans were in place to recruit a second college tutor, so that one could concentrate on GIM training and the other on core medical training.		
6	6.3	**Teaching** The foundation trainees were unaware of any teaching opportunities available to them as they had not received any departmental induction. They had recently heard at the local faculty group meeting that teaching sessions were available. The foundation year two trainees confirmed that they had special study days which were of a good quality; the Trust facilitated their attendance by allowing them to take the whole day off the ward. The trainees reported that if they had a training day, none of the consultants were discouraging; however, the pressures of work and staffing levels often prevented them from attending. The trainees felt some consultants wanted to teach but were constrained by the system and workload levels. The visit team heard that there was a geriatric medicine departmental meeting on alternate Mondays. On Wednesdays, there was also endocrine teaching and a medical grand round on Thursdays. Directorate and clinical governance meetings also reportedly took place. The visit team heard that the Trust offered a management and leadership course called Striving for Excellence to all trainees at level specialty training year three (ST3) and above.	See Ref 6.1 above. Introduce more regular consultant ward rounds which will allow trainees to complete the necessary workplace-based assessments for their training.	Amber Mandatory Requirement
6	6.4	**Educational supervision** The visit team heard that there was an electronic job planning system in place. It was possible to interrogate the e-job planning system by specialty. The policy was clear that educational supervisors received 0.25 PA (programmed activity) per trainee (up to four		

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		trainees). The director of medical education reported that as part of the appraisal, educational requirements were included. Educational supervisors could link all the continuing professional development courses they had done to the GMC domains to see where they were deficient. The PGME was reportedly good at highlighting courses and ensuring that everyone was trained. The educational supervisors reported that they had learning agreements with the trainees. However the trainees did not agree. The trainees confirmed that they knew who their educational supervisor was.	See Ref 6.1 above.	
6	6.5	**Trainees in difficulty** The visit team heard that educational supervisors had been given training on dealing with trainees in difficulty. The visit team also heard that during induction trainees were informed that they needed to contact the head of medical education or the DME if they needed help or advice. The DME commented that he had strong links with the Professional Support Unit and could refer trainees there if necessary. The DME confirmed that there was a strong trainee in difficulty support network in place. He was concerned, however, that the trainees at King George Hospital felt distant from the educational services which were based at the Queen's Hospital site.		
6	6.6	**Study leave** All the trainees were aware that if there were study leave issues they could approach the PGME team. Study leave had also been discussed in the local faculty group meeting, the minutes from which were submitted to the visit team.		
6	6.7	**Bullying and harassment** The visit team heard that there had been a single issue raised in the GMC National Trainee Survey 2014 and that this had been dealt with robustly. This was not related to medicine.		

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		In the 2015 survey (which was still in progress at the time of the visit), one issue had been raised but the trainee concerned commented that the issue had been dealt with appropriately. The visit team heard that there were processes in place to try and protect trainees from any bullying and harassment. A guardian service had been introduced through which staff could raise any concerns. The medical director reported that the Trust had a zero policy for bullying and harassment and that if he was made aware of any issues in this area, he ensured that he was actively involved in the subsequent related conversations. The medical director cited an example of one consultant who had not known that her approach was damaging to trainees but who subsequently had changed her behaviour. The medical director reported that he was keen to engage this particular consultant in the workshops that were being implemented to help staff members learn how to deal with difficult issues. The senior management felt that trainees should know how to escalate any concerns they had in this area. This was mentioned during induction and during the local faculty group. Both the head of medical education and the medical director felt that they had been very clear in sign-posting to trainees how to raise concerns. Some of the trainees commented that when they raised concerns regarding their training, they were not always met with a supportive attitude. Some trainees reported that on occasion they had felt undermined or intimidated.	See Ref 6.1 above.	

Good Practice	Contact	Brief for Sharing	Date

Other Actions (including actions to be taken by Health Education North Central and East London)	
Requirement	**Responsibility**

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Information and reports provided to the team prior to the visit							
DME Annual Report	*No*	Regulator Reports/Data	*Yes*	LFG Reports	*Yes*	MEM minutes	*No*
GMC Survey - trainees	*Yes*	GMC Survey - trainers	*No*	Previous visit reports & action plans	*Yes*		
PVQs - trainees	*Yes*	PVQs - trainers	*No*	Result of school survey	*No*		

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Catherine Bryant*
Date:	*4 June 2015*