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Pan-London Quality and Regulation Unit

Imperial College Healthcare NHS Trust
Intensive Care Medicine
Specialty Focused Visit

Quality Visit Report

3 November 2015

Final Report

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Visit Details	
Trust	Imperial College Healthcare NHS Trust – Charing Cross Hospital site only
Date of visit	3 November 2015
Background to visit	The Head of School for the London Academy of Anaesthesia called for a review of the intensive care medicine (ICM) training environment at the Charing Cross Hospital site at Imperial College Healthcare NHS Trust because of a number of on-going concerns. The Care Quality Commission (CQC) visit in June 2014 and the resulting published report in September 2014 stated that improvement was needed in critical care. In particular the CQC report stated that there needed to be improvements in the high dependency bays, the levels of staff, including health care assistants (HCAs) to provide improved patient care. The ratio of beds to staff formed a key line of enquiry for the quality visit team, as there had been a persistent issue reported from the Charing Cross site that involved trainees in ICM were continuing to perform nursing roles that were not appropriate. The trainees were not trained to perform these roles and were also not able to provide adequate clinical cover at the same time as nursing patients and this resulted in a patient safety concern. The development and implementation of the escalation policy also needed to be verified and assessed as this had reportedly been the catalyst for trainees performing nursing roles. The introduction of an effective escalation policy was raised as a mandatory requirement from the last Specialty Focused Visit in June 2014 and this action was still open with no satisfactory outcome presented to the Head of School at the time of the visit in November 2015. The use of the escalation policy and how the Trust was monitoring the use of the policy needed to be assessed to ensure that there was a robust system in place that would guarantee patient safety and an adequate training environment, especially in light of the start of winter pressures. The General Medical Council National Training Survey (GMC NTS) results for 2015 also highlighted concerns regarding workload, available teaching, clinical governance and overall satisfaction which all needed to be reviewed at the visit. The e-Portfolio for ICM had been recently implemented and the visit team was interested to review how the department had adapted and how this was affecting the trainees' curriculum progression.
Visit summary and outcomes	The visit team met with the chief of service for ICM, the ICM college tutor and the deputy director of nursing in the first session of the day. This was followed by a session with trainees which included: one senior clinical fellow, an anaesthetics higher grade trust doctor, a core medical trainee, an academic clinical fellow in neurology, a core surgical trainee, an acute care common stem (ACCS) trainee with emergency medicine as the main training stem and one ACCS trainee with acute medicine as the main training stem. The trainees stated that there was one anaesthetic trainee but they were ill on the day of the visit. The visit team then met with the educational and clinical supervisors. There had been notable progress made in the ICM department, regarding teaching, clinical supervision, the new rota and evidence of a consultant body that had a proactive approach to education and training. The local induction was good, but the Trust must review and improve the Trust induction which was impinging on the local induction. Areas for improvements within the department included the monitoring of the hours the higher training grade, or equivalent trust grade doctor spent on outreach referrals and the lack of clarity regarding the allocation of the floating nurse. There were also undermining behaviour mentioned and the lack of different conduits to report such behaviour needed to be improved within the department. The department must be commended for the work and progress made. This was however, overshadowed by the patient safety concerns regarding the escalation policy, trainees undertaking nursing roles and the lack of awareness and monitoring of the frequency the escalation policy was being triggered. The escalation policy had been a patient safety issue for several years and needed to cease immediately in the interests of patient safety.

Visit team			
Lead Visitor	Dr Claire Shannon, London Head of Specialty School for Anaesthesia	**GMC Representative**	Kate Gregory, Joint Head of Quality, General Medical Council
Trust Liaison Dean	Dr Chandi Vellodi, Trust Liaison Dean	**GMC Representative**	Alex Blohm, Programme Manager, General Medical Council
External Representative	Dr Orla Lacey, Consultant Anaesthetist, The Royal Marsden NHS Foundation Trust	**Trainee Representative**	Dr Emily Gowland, Medical Education Fellow
External Representative	Dr RosalindeTilley, Critical Care Consultant, Guy's and St Thomas' NHS Foundation Trust	**Lay Member**	Kate Rivett, Lay Representative
Visit Officer	Lizzie Cannon, Quality and Visits Officer		

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
GMC Theme 1) Learning environment and culture			
ICM1.1	**Patient safety** The visit team heard from the trainees that because of the difference in approaches of the consultants' patient management plans could change and although this was not a patient safety or care issue, there could be a lack of consistency in care. The visit team heard from the chief of service for ICM that the escalation policy had been developed in response to a GMC action plan. This reported that when the intensive therapy unit (ITU) had reached its capacity and there were no beds free within the ITU patients were ventilated in the recovery areas in theatre, which was inappropriate. All the consultants interviewed stated that they did not like the escalation policy and had misgivings of its effectiveness and use. They stated that the policy was now under internal review. The consultants stated that it would be better to return to the practice that when the ITU was at full capacity the patients would stay in either recovery or theatre, where they would be in the duty of care of the recovery or theatre nurses, until a bed was available on the ITU. The visit team stated that there were concerns that if the escalation policy was rescinded, although patients would be in the care of trained nurses in either recovery or theatre, it would not solve the problem of patients waiting for an extended period of time for admission into the ITU.	The escalation policy was inadequate and detrimental to patient care as trainees felt they were being asked to perform tasks outside of the trainees' remit and the policy removed a doctor from the ITU when at its most busy. The policy must be immediately reviewed. The Trust is required to ensure doctors in postgraduate medical education training are not performing tasks outside of the trainee remit. Robust on-going monitoring must be implemented to ensure compliance.	**Red** Immediate Mandatory Requirement

	The visit team also heard that since there had been an increase in the nursing staff within the ITU the policy was used less frequently. This was at odds with reports from trainees and in fact data produced to the visit team that showed three episodes in a six month period. The deputy director of nursing stated that there had been a large drive for nurse recruitment to the ITU that had included overseas staff. This had brought down the previously high nurse vacancy rate and the ITU was now at a vacancy rate of approximately five nurses for 20 beds, but this was excluding the use of the floating nurse. The deputy director nursing stated that the annual nurse turnover was approximately 12-15 per cent, which was still quite high for the London average. The visit team enquired as to what happened if there was a bed or monitoring space in the ITU but no nurses, and whether the escalation policy would be triggered. The visit team was informed that because of the increase in nursing, the use of a floating nurse and the nurse in charge of the ITU was supernumerary there were always nurses available. The floating nurse was clarified as a fully trained nurse in intensive care who would be able to provide care if a patient came into the ITU in a monitoring space or a patient within the ITU needed more that one on one patient to nurse support. However, the visit team was informed by the trainees that there was not always enough nurses on the unit and the floating nurse was only used if the department knew of a planned patient transfer to the unit. Trainees also reported that the floating nurse was often reallocated or sent home if not required as nursing shift managers received considerable pressure to cancel nursing staff if possible. Thus if an unplanned patient needed to come into the ITU there would not be enough nursing support. The chief of service for ICM stated that there were enough nurses to run the 18 beds within the ITU and that they planned to recruit more nurses when they opened two more beds for the winter. This would bring the total number of beds to 20 within the ITU, 10 level two beds and 10 level three beds. The locations of the different level beds were in two different wards that were separated by a corridor, which consultants deemed was a safe distance, and did not endanger patients or affect clinical supervision levels. Trainees stated that the separation of the ITU geographically, even across a corridor was not a patient safety issue in itself. However, the trainees expressed concerns that when the higher training grade was called away to other areas of the hospital for referrals and another trainee was managing a patient in line with the escalation policy then that left one section of the ITU devoid of a doctor. This they felt was a potential patient safety issue. The chief of service reported that they monitored the use of the escalation policy through a dedicated, data collection team. The consultants stated that they tracked the patients that entered the ITU from the emergency department; wards, theatres and other hospitals form the patients' notes, and the time of referral to critical care. The consultants stated that they always knew when patients entered and left the ITU. The trainees confirmed that the higher trainee worked with the consultants to identify whether the referral patient could enter the ITU at either a level two or level three. They stated that the consultant was involved in the decision if patients could be discharged and moved to another ward, the high dependency unit or another hospital. The chief of service stated that if the escalation policy was triggered a serious incident form did		

	not need to be completed because the policy was part of a formal protocol and the trainees confirmed this stating that they did not complete a Datix serious incident form either. The visit team was very concerned to find that there was a disconnect between the perceptions of the consultants and what was reported by the trainees, regarding the escalation policy. The escalation policy, the trainees stated, was used quite frequently due to a lack of nurses. Patients, who had been transferred into the ITU into one of the monitoring spaces, were nursed by trainee doctors because of the inadequate number of nurses in the ITU. The trainees stated that they had two patient safety concerns regarding the escalation policy. One, they were not trained to nurse patients, which they were asked to do in light of the escalation policy and two, by trainees having to stay and nurse the patients it meant that the unit, when it had reached its maximum capacity only had one other doctor on the shop floor. The visit team heard that the latter could be exacerbated because the higher training grade or equivalent could be external from the ITU for extended periods due to referral call outs. The consultants were unaware of the length of time the higher trainee was absent from the ITU at night. The escalation policy was an expedient and ineffective solution which was not being effectively monitored through Datix or any other method. The lack of an effective policy had been an issue for many years and Health Education North West London was deeply disappointed and disturbed that the Trust had not engaged more effectively with this issue. It remained a patient safety concern and placed the trainees in a compromising and inappropriate position. The visit team acknowledged that the consultant body did not like or agree with the policy but was concerned that the consultant body appeared to underestimate the frequency that the policy was being triggered and the implications this had on the trainees. The escalation policy was a medical expedient measure to a problem relating to a nursing shortage. An immediate mandatory requirement was issued on the day of the visit with the Trust allowed a maximum of five days to respond.	The visit team found that there was a lack of awareness within the department regarding the amount of time the higher trainee or equivalent trust grade doctor spent external to the ITU when on outreach referrals and the impact this has on the higher grade supervision and support available to other trainees in ITU. The Trust is required to review the frequency and length of time is spent outside of the ITU and the effects this has on the provision of ITU support.	**Amber** Mandatory Requirement
ICM1.2	**Serious incidents and professional duty of candour** The ICM consultants stated that there was a monthly quality meeting that all staff were invited to attend, and a monthly morbidity and mortality (M&M) meeting. Occasionally the trainees were invited to present at the M&M, which included all the cases from the previous two - three months, but the consultants stated that attendance was variable and could be emphasised more to the trainees. The consultants stated that there was one serious incident in March 2015, which they immediately had a staff debrief for, with another one after the serious incident had been investigated. The consultants stated that they supported the trainees as much as they could regarding serious incidents. Feedback was given in the form of a divisional newsletter, a local newsletter, and a poster in the department that had the four major, multi-professional projects the ITU was developing. The newsletters are sent out to the trainees via personal and trust emails. The visit team heard from the trainees that they all knew how to fill out a datix form and the	The Trust is required to ensure that trainees are able to attend the M&M meetings and attendance recorded.	**Amber** Mandatory Requirement

	feedback would be emailed back. The trainees stated that the consultants were supportive when trainees were involved in serious incidents and when datix forms had been submitted.		
ICM1.3	**Appropriate level of clinical supervision** The visit team heard from the consultants that a second tier had been implemented in the rota that meant that there was always higher-grade clinical cover 24/7 on the ITU. The consultants stated that this allowed for improved clinical supervision for core trainees who came onto the ITU, such as acute care common stem (ACCS) trainees. The trainees stated that there was excellent clinical supervision, especially with the additional higher-grade trainee or equivalent trust grade, and that if a consultant was not in the department it was clear which consultant to call and all consultants were happy to be called in at night. The trainees stated that consultants were supportive and approachable. All trainees stated that if there were concerns regarding training or patient safety they would escalate to either the head of department or the educational supervisor.		
ICM1.4	**Responsibilities for patient care appropriate for stage of education and training** Trainees fulfilling nursing roles when the escalation policy had been triggered had been an on-going issue for numerous years that the Trust had failed to resolve satisfactorily. The ICM consultants, who included the chief of service for ICM, were confident that trainees were not fulfilling nursing roles on the ITU. They stated that there were clear guidelines and roles defined for group of staff working within the department, which were not outside the remit of any trainee and were clearly communicated to all staff, before they started on the unit. The consultants stated that the reason trainees might feel roles in the escalation policy were outside of the trainees' remit was because the escalation policy was infrequently used and trainees were not used to it. The trainees reported that they received help turning patients from nursing staff but they were still expected to participate in this and that they felt inadequately trained for this and other core nursing skills occasionally expected of them.		
ICM1.5	**Rotas** The chief of service for ICM stated that there was a day and night rolling rota, which involved 18 doctors of varying grades. There was a minimum of one higher training grade or equivalent, one middle training grade or equivalent and then consultants, with half the day comprised of double consultant cover. All higher training grades or equivalent trust grade doctors have airway skills, but some middle grades may not. The trainees stated that the new rota was a vast improvement on the old rota, and appreciated the additional higher training grade or equivalent; however, the trainees stated that the additional higher grade trainee or equivalent was not always airway trained. The chief of service stated that the rota had changed in response to the GMC NTS 2015 results and there were short day and long day shifts, which gave a third, higher training grade or		

	equivalent on shifts and allowed for better planning for annual leave and study leave. The visit team heard from the trainees that the rota was fair and the long and short days did allow for annual leave. The trainees stated that although the 13-hour shifts were long, if the shifts were shorter it would be detrimental to handover. The chief of service stated that they liked to include the more junior trainees in rota management to expose them to management roles and that changes in the rota were always communicated to trainees in good time. The visit team heard the rota coordinator could be told very late on if training posts were not going to be filled and with an ineffectual human resources department, this meant there was not enough time to advertise for a six-month locum job. The consultants were confident with the locums that were used, often being known trainees. The trainees stated that the new rota was distributed in a tardy fashion because human resources had delayed it.	The Trust must ensure that the human resources support to the department is effective to enable better rota coordination, locum appointments and rota distribution.	**Amber** Mandatory Requirement
ICM1.6	**Induction** The visit team heard from the ICM consultants that there was a one-day Trust induction followed by a one-day local induction, this had changed in August 2015 from half days for each. The visit team was pleased to hear that the department sent out all of the guidelines before the trainees arrived, including information on the rota coordinator and a who's who of the ITU. All the trainees stated that they received this, except one because the department had the incorrect email address. The ICM consultants stated that the local induction included a tour of the unit, meeting clinical and educational supervisors. The consultants also stated that there had been huge amounts of negative feedback from trainees regarding the Trust induction. The trainees elaborated on this statement stating that it was the worst Trust induction experienced and was so poorly organised that it ran into the local induction, which was detrimental to an otherwise good local induction. The trainees did state that they would appreciate a section in the local induction, which included how to work the different machines within the department.	The Trust is required to improve the Trust induction to allow for adequate time to complete the local induction and ensure that trainees are given all passes, logins and ID badges.	**Amber** Mandatory Requirement
ICM1.7	**Handover** The visit team congratulated the ICM consultants for the green outlier for handover in the GMC NTS 2015 results. The consultants informed the visit team that the handover was part of the consultant ward round and included all the patients in the ITU.		
ICM1.8	**Protected time for learning and organised educational sessions** The college tutor for ICM stated that they had recently changed the teaching programme in response to trainee feedback at the local faculty group (LFG). The one-hour teaching session was now held weekly on a Wednesday morning at 8.30am after the ITU handover. This involved a case based discussion that was presented by the trainees so that they could sign off on curriculum requirements. The consultants stated that they had had positive feedback from the		

	trainees regarding the new teaching, but the consultants thought that maybe the trainees did not realise that the consultants were covering the trainees' workload when attending teaching. The trainees stated that because of the rolling rota that was fixed for each trainee, it inhibited the trainees' attendance. The trainees stated that those on nights can attend on zero days, but trainees were exhausted after a night shift and used the zero days to recuperate. The trainees stated that the teaching was bleep free and a register to track attendance but trainees could attend infrequently because of the busy workload. The core surgical trainee stated that the ICM local teaching clashed with the core surgical anatomy teaching, which was compulsory. The visit team commended the department on the green flag in the GMC NTS in 2015 for regional teaching. The consultants stated that there was a concerted effort made to ensure trainees could attend local and regional teaching. The ICM consultants stated that because there was a range of different trainees, it was difficult to focus the teaching. The consultants stated that they started at the basics and built up from there. The visit team heard that there was also a journal club held on the last Wednesday of every month where old or new cases were discussed. The visit team also heard that the basic course was available for all trainees and if there was not enough space the trainees could go to The Royal Marsden NHS Foundation Trust to attend the basic course.	The department should continue to work with trainees to improve access to local teaching for all trainees and monitor attendances.	**Amber** Mandatory Requirement
ICM1.9	**Access to simulation-based training opportunities** The visit team heard that the ITU department was soon going to be able to perform simulation scenarios and the intention was to ensure these were multi-professional. This would be available to all, but the consultants felt there would be a need to focus on the core grade trainees to ensure they were confident in practical procedures and major events such as a major haemorrhage or anaphylaxis.		
GMC Theme 2) Educational governance and leadership			
ICM2.1	**Appropriate system for raising concerns about education and training within the organisation** The chief or service for ICM stated that it had taken a while but the ICM department had a higher profile within the Trust and the Trust board had begun to discuss critical care. The other consultants informed the visit team that the department still felt isolated from the rest of the Trust. However, the consultant for academic clinical fellows stated that there was a good set up for all academic clinicians to meet up and discuss inter-specialty, which was very useful. The trainees stated that there was a good local faculty group and they felt happy raising issues and concerns to the consultant body, via the educational or clinical supervisors.		

ICM2.2	**Organisation to ensure time in trainers' job plans** The educational supervisors stated that for 18 months there had been dedicated educational programmed activity (EPAs) integrated into the consultant job plans. The consultants stated that they appreciated the distinction between other activities and those that were for educational responsibilities. The consultants reported they all had 0.25 EPAs per trainee. The visit team heard from ten consultants that there was access to e-learning facilitated through Health Education England for educational supervisors and modules supported by the Trust.		
ICM2.3	**Systems to manage learners' progression** It was reported by the ICM consultants that because of the number of different trainees from different specialties training within the department, the educational supervisors had each been given a different trainee cohort to supervise which allowed the consultants to be well versed in the trainees' curriculum requirements and the different e-Portfolios. The trainees stated that they received very good educational supervision and the consultant was proactive to ensure they met curriculum requirements. The visit team commended the work of the department for managing the educational supervision for different trainee cohorts. The visit team heard from the trainees that the clinical and educational supervisors were the same consultant. The core surgical trainee was the only trainee who had not been allocated an educational supervisor as this was the responsibility of the surgical department and the one consultant that had been allocated was too busy to fulfill the necessary educational responsibilities. The trainee had been in contact and a new educational supervisor was soon to be allocated. All trainees stated that they had received a learning agreement and all bar two trainees had met with the allocated educational supervisor.	It is recommended that the department allocate separate educational and clinical supervisors to allow for extra conduits for trainees to feedback trainee issues.	**Green** Recommendation
GMC Theme 3) Supporting learners			
ICM3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The visit team was disappointed to hear that on occasion the trainees felt undermined by certain consultants within the ICM department, but the trainees stated that it should not be taken personally and it was not detrimental to patient care. The trainees stated that the individual in question had also made unprofessional remarks regarding the nursing staff, stating that the nurses were only good for paperwork. The trainees stated that they had not raised this behaviour with the consultants, but that the consultants probably knew about this individual. The core surgical trainee stated that in comparison to surgical departments the ITU was a supportive, open and friendly environment.	The department should review the bullying and undermining culture and the processes in place to allow trainees to report behaviour in a confidential manner.	**Amber** Mandatory Requirement
ICM3.	**Academic opportunities**		

2	The ICM college tutor stated that they encouraged trainees to take part in audits but the rotation length for some trainees in the ITU was only three months, which limited the ability to complete an audit or a quality improvement project (QIP). The consultants stated that there were QIPs that were running continuously and with 20 years of data stored in the system there were opportunities for very good research and audits to take place.		
ICM3.3	**Access to study leave** The visit team heard from the ICM consultants that the results for the GMC NTS were poor for access to study leave because of the two gaps in the rota. However, now that here had been a change to a rolling rota and the gaps were filled, the consultants stated that all trainees would be able to access study leave even if it meant organising swaps. The trainees confirmed that all study leave had been granted and it was easy to organise.		
ICM3.4	**Regular, constructive and meaningful feedback** The consultants stated that they might need to be more explicit to the trainees when feedback was given, as they were unsure whether the trainees recognised that they were being given feedback. The consultants stated that they are continuously signing off directly observed procedures (DOPs) and workplace-based assessments (WPBAs). The trainees stated that the consultants were always willing to teach ad hoc at bedsides or with formal case discussions and all had been able to sign off WPBAs. However, the trainees stated that feedback varied depending on the consultant, with some consultants being better than others. The trainees stated that all consultants would discuss the patient management plan with the trainee, but others would also discuss the entire physiology and give detailed and constructive feedback as to why the patient management plan was set in a certain way. The trainees also stated that they received an online feedback form for the presentation on the grand round.		
GMC Theme 5) Developing and implementing curricula and assessments			
ICM5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The trainees stated that they received many, varied practical procedures and were all meeting the curriculum requirements. The ACCS trainees stated that they were concerned about how they would be able to meet the emergency medicine competencies in the curriculum and the trainees did not clerk in the same as in the emergency department and did not have exposure to the more minor cases in ITU. However, one of the trainees clarified that some emergency medicine competencies could be met via the completion of an e-module. The visit team recognised this as an area of difficulty for all ACCS EM trainees due to the curriculum. The core trainees would appreciate the opportunity to accompany the higher-grade on the		

	referrals around the hospital, but were aware that with the number of doctors on the rota this was not yet possible. The trainees did state that it would be worth the ITU having a separate outreach higher-grade doctor. The visit team was pleased to hear that all trainees they met would recommend the post for training and the visit team must commend the work done by the department to make such good progress in areas other than the escalation policy.		

Good Practice	Contact	Brief for Sharing	Date

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

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Claire Shannon*
Date:	*08 December 2015*