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Pan-London Quality and Regulation Unit

Barking, Havering and Redbridge University Hospitals NHS Trust Foundation Specialty Focused visit

Quality Visit Report

18 November 2015

Final Report

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Visit Details	
Trust	Barking, Havering and Redbridge University Hospitals NHS Trust
Date of visit	18 November 2015
Background to visit	The Care Quality Commission (CQC) inspected the Trust in October 2013, and found there were serious failures in the quality of care and concerns that the management could not make the necessary improvements without support. The Trust was placed in special measures in December 2013. Since the inspection a new executive team had been put into place including a new chair, new members of the board, a chief executive, medical director, deputy chief executive, chief operating officer and a director of planning and governance. The executive team was being supported by an improvement director from the Trust Development Authority. A director of medical education had also just been appointed. The Trust developed an improvement plan ('unlocking our potential') that was being monitored and contributed to by all stakeholders on a monthly basis. The CQC re-inspected in March 2015 in order to check on improvements, apply ratings and to make a recommendation on the status of special measures. Overall, it was found that the Trust still required improvement. Both Queen's Hospital and King George Hospital were rated as 'requires improvement'. Of the five key questions that the CQC asked, they rated the Trust as 'requires improvement' for caring, safe, effective, and well-led; responsive was rated 'inadequate'. The Trust had not been visited for two and half years but the North East Thames Foundation School (NETFS) was encouraged that foundation trainees had requested to attend the Trust for training. A Specialty Focused Visit to the Trust was required to review the education and training environment for foundation trainees at both sites, the Queen's Hospital site and the King George Hospital site. The ramifications of low levels of staffing, especially amongst middle-grade doctors needed to be assessed, especially in the area of training opportunities, workload, and clinical supervision.
Visit summary and outcomes	The visit team thanked the Trust for accommodating the visit to Foundation and was impressed with the attendance levels of trainees and Trust staff. The visit team first met with the senior management team, followed by a meeting with the medical education team and Foundation Training Programme Directors (FTPD). The visit team then had sessions with foundation year one (F1) trainees in both surgical and medical specialties, a separate session with the foundation year two (F2) trainees in both surgical and medical specialties and a meeting with educational and clinical supervisors. The visit team commended the work of the medical education team and FTPDs who were reported by the trainees to be very supportive and responsive to the trainees' pastoral and training needs, despite being exceptionally busy and stretched. It was evident that the medical education team and the FTPDs were committed and enthusiastic about how to improve the training environment at the Trust. This was evidenced through the work done to improve accessibility to foundation teaching across the Trust. The visit team also found a consultant body, who although constrained by the service and clinical commitments provided good educational supervision and in some departments good teaching opportunities too. The senior management team although enthusiastic about the pace of education within the Trust did not translate this enthusiasm into tangible support and responsiveness, for both consultants and trainees. Whilst trainees said that they were well supported a number reported unscheduled moves of placement at short notice which they were not happy about. These appeared to benefit some trainees but disadvantage others and were unrelated to service reconfiguration. These moves were not instigated by the Trust. The visit team suggested that approval from trainees and from NETFS should be required for swaps as well as from the local team. This had also been highlighted as a concern on previous Foundation visits. The F1 trainees were more enthusiastic surrounding the support and training opportunities with nearly 70 per cent recommending the Trust to a peer for training. The F2 trainees were considerably more subdued with fewer trainees recommending the post. However, both cohorts of trainees stated that the Trust was a friendly and supportive environment to train within. The friendly and supportive environment that has been created is a testament to the staff especially in light of working with systems that were described as archaic and with low staffing levels and a high workload. The Trust is urged to immediately address the information technology (IT) systems available at the

	Trust. The visit team were told the IT systems were slow, cumbersome and made accessing clinical guidelines and communication around the Trust very difficult. The IT system could not support the e-handover system in Friday afternoons sue to the volume of users and was impacting on the efficiency and accuracy of handover, with implications for patient care and safety. The systems for requesting scans and bloods were all paper based and the visit team heard reported incidences of errors and delays based purely on this ineffectual system. The systems also exacerbated the high workload of the trainees. There were other areas that needed improvement including the culture surrounding serious incident reporting, the trainees reported incidences of being discouraged to report while others described reporting as purposeless because there was no evidence of response to concerns raised. There was also friction between trainees, bed managers and others who were responsible for bed capacity. The visit team was concerned to find that bed capacity issues had resulted in the prioritisation of the discharge rate rather than the quality of patient care. The access to training opportunities for some foundation trainees was poor, such as in care of the elderly, urology and neurosurgery, while other trainees reported that the high workload and varied patient cases worked in favour of being exposed to training opportunities. The workload was exacerbated by performing inappropriate tasks and many trainees could not access departmental teaching, ward rounds or other valuable educational opportunities. The visit team was concerned to hear that there was a lack of conduits for trainees to raise concerns and issues regarding training with no foundation trainee forum. The Trust was required to address reports of perceived bullying and undermining behaviour in urology, neurosurgery, radiology and from bed and site mangers. Two Immediate Mandatory Requirements (IMRs) were issued relating to serious patient safety concerns. The first regarded the lack of clinical supervision and consultant presence in the urology department, with consultants rarely performing ward rounds. The second involved one F1 trainee being unsupervised, isolated, and responsible for the care of 16 patients on the Sky A and Sunrise A wards for several days. A lack of clinical supervision from consultants and other senior staff was a common theme across the Trust, due to a high workload and shortage of staff. This was felt most acutely out of hours, with the lack of formal hospital at night processes and on weekends, where there was limited consultant presence in the Trust. There were serious concerns regarding the lack of compliance with infection control and this was more concerning when placed in combination with the plus one policy. The plus one policy is a severe patient safety concern and was raised as an IMR in another visit. It was a symptom of a Trust, which had a lack of beds, staff, and processes that did allow for an efficient patient care pathway.

Visit team

Lead Visitor	Dr Keren Davies, Foundation School Director, NE Thames Foundation School	**External Representative**	Dr Tamilselvan Perumal, Foundation Training Programme Director, The Princess Alexandra Hospital NHS Trust
Trust Liaison Dean	Dr Indranil Chakravorty	**FY2 Trainee Representative**	Dr Sarah Wikeley, F2 trainee representative, North East Foundation Training School
Lay Member	Ryan Jeffs	**FY1 Trainee Representative**	Dr James de Boisanger, F1 trainee representative, North Central Foundation Training School
Visit Officer	Lizzie Cannon, Quality and Visits Officer	**NETFS Manager**	Clare Morley, Manager, NE Thames Foundation School

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
GMC Theme 1) Learning environment and culture			

1.1	**Patient safety**		
	The F1 trainees in care of the elderly on the Queens' Hospital site stated that frequently an F1 trainee would be left to run the Sky A and Sunrise A geriatric wards for several days without any clinical supervision or support from other senior doctors. This not only constituted a severe patient safety concern, where an immediate mandatory requirement (IMR) was issued on the day of the visit, but it was also distressing for the foundation trainees who felt isolated and unsupported.	All trainees must have access to clinical supervision at all times and this must be enabled through effective rotas. The Trust is required to review the rotas to ensure senior support is always available to FY1s on the geriatric wards.	Immediate Mandatory Requirement
	The visit team heard that the F1 posts had been removed from the urology department on the Queen's Hospital site as a consequence of Broadening the Foundation Programme changes but there were now serious internal concerns regarding the viability of the F2 posts that remained in the department. The visit team heard that there was a consensus amongst the foundation trainees that the urology placement was exceptionally difficult. The visit team heard that the urology consultants did not undertake ward rounds, which led to a lack of consultant review of patients on the wards and also meant there was no clinical supervision or support for trainees. The workload was very high and the trainees felt that there were no training opportunities available because of constant service provision.	Urology consultants must do daily ward rounds from Monday to Friday and ensure adequate support and supervision on weekends.	Immediate Mandatory Requirement
	The F1 and F2 trainees in care of the elderly reported that during the weekends there was one F1 and one F2 trainee allocated to be on call and cover the fourth and second floors which included a minimum of six wards and then included the Critical Care Unit (CCU) from 4pm. The trainees stated that the combination of nurses not being able to take bloods, the excessive number of patients and the lack of senior support meant that the trainees felt overwhelmed and the workload meant that trainees frequently did not eat during the weekend on calls. The trainees stated that during the week, out of hours, the trainees were responsible for the same areas in the hospital but this was manageable because of the routine jobs, such as bloods, had been done during the day.	The Trust must provide the outcome of a review of clinical supervision and support throughout the Trust. This review must cover the provision for out of hours, weekends and day working. Immediate areas to review; surgery, medicine including geriatrics at the Queen's Hospital site.	Mandatory Requirement
	The F1 trainees in surgery stated that the way in which work was distributed across the surgical departments at Queen's Hospital was a patient safety concern. It was reported that there was one middle-grade doctor responsible for covering all new patients and wards out of hours and because of the lack of staff, jobs would accumulate throughout the day and would cause delays to patient care. The trainees stated that it was a real struggle to get even the majority of jobs done during the day and the evening.		
	The visit team heard from all trainees that there were serious concerns regarding the escalation policy for when the Trust was operating above capacity. It was a well-known fact that the Trust is short of beds however the plus one policy that was in operation by the Trust was regarded by all visit teams to be a danger to patient safety. An immediate mandatory requirement was issued by another visit team to immediately address the severe patient safety concerns of the plus one policy. The policy involved patients who were to be discharged moving into corridors to await discharge while an acutely unwell patient was moved into the space on the ward. However, the trainees reported that the acutely unwell patient was the patient who waited in the corridors and this would mean there was no consultant ownership of these patients, who were unmonitored and were left for over six hours with no care or medical attention. The trainees reported that this could		

	also involve two unwell patients and that if a planned discharge did not go ahead the unwell patient either stayed in the corridor or if possible moved back to the acute medicine unit. The foundation trainees stated that they had raised this as a concern with the chief executive officer but the response had been that the wrong patients had been selected for a policy that was workable. This policy did not appear to work and was a major patient safety risk. The visit team was also concerned to hear that patients who were known to have contracted MRSA would be moved into the general patient population, which could be via the plus one policy. The foundation trainees reported non-compliance with infection control protocols, which involved a lack of hand washing and sterilising equipment but also not following protocols correctly for patients with tuberculosis who were also not isolated from the general patient population. The F2 trainees reported difficulties in accessing equipment, especially at King George Hospital where there was a lack of blood culture bottles. This resulted in substandard patient care. The F2 trainees also reported that after an external consultancy firm reviewed the Trust and identified that equipment was being taken from stock rooms, it was decided to lock all equipment away and only allow certain members of staff access. This had resulted in trainees having to take nurses away from acutely unwell patients in the intensive therapy unit (ITU) and high dependency unit (HDU) to ask the nurse to unlock the stock room. The nurse had to leave the patient who needed constant monitoring because it was accessed via finger print. All the trainees reported delays in patient care due to the antiquated, paper-based system for requesting scans. The F2 trainees in emergency medicine stated that this was a patient safety issue because it could take more than 30 minutes to request a computerised tomography (CT) scan for a patient who had suffered a stroke. The trainees stated that the radiology resources were not equitably distributed across the sites and King George's Hospital did not have a radiographer after 8pm and needed a radiology higher-grade onsite constantly, because at the time of the visit the on call radiology service Medicare had reported gross inaccuracies with the scans done during the day.	The Trust is required to review the compliance of infection control policies and ensure that the guidelines are up to date, accessible to all staff and all staff are informed of the protocols at induction. The Trust is required to ensure that equipment is well stocked and accessible to all staff without the need to take other staff away from patients. The Trust is required to review the systems for requesting bloods and scans and the impact this has on workload, patient care and training opportunities. The visit team urges the Trust to consider investing in an upgrade to IT facilities that could then support electronic systems for scans and bloods.	Mandatory Requirement Mandatory Requirement Mandatory Requirement
1.2	**Serious incidents and professional duty of candour** The F1 trainees stated that there was no information given to trainees about serious incident reporting included in the induction, although it was included in an e-learning module. The trainees stated that reporting was actively encouraged but the method for reporting was learnt once on the wards. The F2 trainees stated that there was no training in incident reporting. One trainee stated that the serious incident forms were not processed appropriately and as a result a submitted form relating to nursing care had been circulated to members of the nursing team which led to tension in the working relationship between medical and nursing staff on the ward. The F2 trainees also reported that after escalating serious incidents regarding serious patient safety concerns the trainees were demoralised that the Trust had taken the decision to de-	The Trust is required to review the feedback mechanism and learning from serious incidents. A system should be implemented which does not discourage trainees from reporting. *This will be dealt with on the TWR action plan, ref TWR1.2.*	Mandatory Requirement

	escalate the incident even though it involved a patient not being monitored for three days, which had severely compromised the patient's life. The foundation trainees stated that there was no formal feedback mechanism but you could request feedback. However, the F2 trainees stated that once you submitted the form if trainees wanted to review what had been submitted trainees would not be able to find this on the system, as the form had been deleted. The visit team was concerned to hear that the F2 trainees had become demoralised in response to these actions and the de-escalation of serious incident forms that had been submitted without communication of the reasons. This had resulted in trainees not reporting serious incidents because trainees did not think it would make any difference to patient care.		
1.3	**Appropriate level of clinical supervision** As reported in section F1.1 there was a lack of clinical supervision for foundation trainees in care of the elderly, urology and out of hours on the medical and surgical wards. The senior management team conceded that there had been an attempt to establish a hospital at night procedure but that this had not come to fruition. This was obvious from the circumstances the foundation trainees reported and the lack of clinical supervision and support trainees received throughout the Trust while out of hours. Most foundation trainees, except those in care of the elderly, and urology confirmed that during the day the trainees felt supported, but this was not the case out of hours. Foundation trainees also confirmed that that there were no consultants present during the weekends. The foundation trainees in surgery at the Queen's Hospital site stated that there was a lack of clinical supervision especially out of hours and that because there was a lack of middle-grade doctors and so the foundation trainees felt that the higher-grade trainees' training was suffering because there was no buffer between the foundation trainees and the higher-training grades. However, F1 trainees at King George's Hospital stated that there were good clinical supervision levels in breast and colorectal surgical specialties. The trainees concluded that this was because King George's Hospital was less busy in comparison to Queen's Hospital and staff were able to support one another because there was less pressure from the workloads. F2 trainees at King George's Hospital stated that there was good clinical supervision levels during the day and there was always known support on call. During the week, the F2 trainees stated that there was a consultant on call that the trainee could call, but at the weekends it was more difficult to find support as there were few staff on site. The F2 trainees stated this was true for both sites, but that clinical supervision during the day was better on the King George's site. The F2 trainees stated that in the acute medical unit, there was always consultant presence and they were supportive and willing to teach trainees. Both F1 and F2 trainees stated that the majority of staff were very friendly and supportive.		

1.4	**Responsibilities for patient care appropriate for stage of education and training** The foundation trainees reported antiquated systems for ordering scans and bloods, which, combined with a lack of staff to support these systems, created a lot of inappropriate tasks for foundation trainees and added to an already high workload. All systems for radiology and phlebotomy were paper based and this included handwriting labels on the blood bottles. The system meant that forms commonly went missing, and scans and bloods would be delayed. The trainees reported that there was also a lack of phlebotomists in the Trust and this meant increased workload for trainees and delays in patient care. There were occasions reported where the phlebotomists stopped halfway through a ward in respiratory because it was the end of the shift and this was not communicated to staff on the ward. The F1 trainees at King George's Hospital in surgery stated that frequently trainees would be asked to break bad news to patients and families because the higher-grade trainee was in theatre and the middle-grade trainees were clerking. The foundation trainees stated that all though this was a good learning opportunity the trainees often felt unprepared and unsupported to answer the questions that families and patients asked, which were often outside the trainees' level of competence. The foundation trainees reported that resuscitation decisions could often be left to foundation trainees out of hours because the middle-grade and higher-grade trainees or equivalent Trust grade doctors were frequently absent from the wards and did not want to return to make such decisions. The trainees stated that they had limited knowledge of the resuscitation guidelines and were unable to access them easily on the intranet. F1 trainees reported that there was an absence of protocols for referrals in the Trust and trainees were frequently asked to refer patients by senior colleagues. Foundation trainees stated that referring patients was difficult due to a lack of guidance but also because other doctors would not respect the authority of the foundation trainees to make referrals. This was particularly difficult for F1 trainees when trying to obtain microbiology guidance.	It is recommended that the Trust review the number of phlebotomists and the hours available for the service at the Trust. As per ref 1.1 above. The Trust is required to review the clinical guidelines. Provide copies of up to date clinical guidelines and ensure that trainees have easy access to them.	Recommendation Mandatory Requirement
1.5	**Taking consent** The F1 trainees confirmed that they had never been asked to take consent, site mark or prescribe cytotoxics to patients. The F2 trainees stated that in haematology and oncology, a nurse had asked trainees to prescribe patients with chemotherapy but the trainees stated that this was not within a foundation trainee's remit and the nurses accepted it. The F2 trainees confirmed that except for this instance no trainees had been asked to site mark, take consent or prescribe cytotoxics.		
1.6	**Rotas** The visit team heard from the F1 trainees in gastroenterology at the Queens' Hospital site that the rotas had been distributed very late and trainees were supposed to receive rotas six weeks	The Trust should conduct a review of all the foundation trainees' rotas. This should ensure	Mandatory Requirement

	beforehand. The F1 trainees stated that rotas had been changed and trainees who had initially been placed on placements at the King George's site were now being placed on the Queens' Hospital site and this had not been communicated to either the trainees or North East Thames Foundation School. The trainees stated that this was inconvenient as trainees had already bought zone six travel tickets but it was also perceived to be unprofessional. F2 trainees reported that one of the major problems at the Trust were the rotas. The trainees worked excessive hours, did not have changes communicated to them in a timely fashion, stated that there were many gaps, and did not allow for adequate staff on shifts. The F2 trainees in neurosurgery stated that the rota was terrible with only five people on an eight person rota. The trainees felt pressured into the extra on calls, as there was no one else to cover the on call. There was a total lack of middle grade cover on the wards and the trainees were not able to access clinics or theatres because the trainees were purely providing service on the wards. The trainees stated that the consultants were aware of the problems, as was the rota coordinator but there was no possibility of recruiting to the department. The neurosurgery post for the F2 trainees was reported as having no educational value.	that the rotas are EWTD compliant and have adequate senior support too. A diary card exercise should be executed to monitor before and after the review is conducted. Changes to posts and site of working for Foundation trainees should be communicated to the Foundation school and changes to rotations should have permission granted from NETFS before any changes are made.	
1.7	**Induction** The foundation trainees stated that there was a Trust induction, which included a lot of e-learning modules but not much useful or practical advice. The trainees stated that they would like a tour of the Trust, the Trust's intranet and be given a Trust map to facilitate when trainees were on call. Trainees had also not heard of Dr's Toolbox which would be an excellent resource for the foundation trainees to use. It was reported that that it had taken two to three months for some trainees to receive IT logins and so trainees had been using one another's login details for discharging patients. The trainees would also like the training on the arterial blood gas machine (ABG) so that trainees could be given a code. Trainees stated that nobody had training in the ABG machine and all used a code that had been passed down from trainee to trainee. The F2 trainees in urology stated that there was no formal induction and trainees were placed on call the following day, with only a brief introduction to urological emergencies. The trainees were given no information about the shift hours or the specialties trainees had to cover when on call. The F2 trainees in critical care stated that the induction was not particularly specific to the critical care unit, with no information given on how to use certain systems or how to discharge patients.	The Trust is required to improve the Trust induction for foundation trainees, incorporating the recommendations of the foundation trainees. This could be discussed at a local faculty group. The Trust should also address the variability of departmental inductions. IT governance should be reviewed to ensure all trainees have personal logins and passwords for all necessary systems.	Mandatory Requirement
1.8	**Handover** The visit team heard from the F1 trainees at Queens' Hospital site that the surgical and medical handovers differed slightly however both were found to be inadequate and frequently meant patients were not handed over and the trainees stated that there was a definite possibility that	The Trust should review the handover system for the weekend. This should assess whether	Mandatory Requirement

	patients could be missed and go untreated for days, especially over the weekend. The foundation trainees in surgical and medical specialties stated that there was an e-handover system for the weekends which included every single patient on the wards which includes the patient problems, tasks to be performed and the resuscitation status of the patient. This was then printed off in a 27-page document and given to the F1 and higher-grade trainee responsible for covering the wards over the weekend and the higher-grade trainee responsible for the emergency surgery list. The F2 trainees stated that the lack of IT systems within the Trust genuinely caused problems for patient care and efficient service delivery. The IT system was normally very slow because everyone in the Trust was uploading patient details on to the handover system, on the Friday afternoon, which meant foundation trainees had to stay late and this was exacerbated by the fact that patients had to be on the system by 5pm; however, blood results were normally not back until much later. The F1 trainees stated that uploading patients' details to the e-handover system was the responsibility of the F1 trainees and there had been known incidences of patients being missed off the list. The trainees also stated that if the trainees responsible for handover were absent, the handover would not occur. The foundation trainees in surgical specialties stated that there was a verbal handover in the evening that handed over patients to the relevant staff on call to be reviewed. The foundation trainees in medical specialties stated that the consultants were present at the evening handovers. The handover system for the weekdays at King George Hospital was stated to work more efficiently than that at Queens' Hospital site. The trainees stated that the electronic handover system worked well for medicine. There was no face to face handover, unless there was an acutely unwell patient involved.	the current IT system can support a large scale handover across the Trust.	
1.9	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** The foundation training programme directors and the education team stated that there were not enough educational supervisors to supervise foundation trainees. The average number of trainees each educational supervisor had was seven. The consultants were worried that this did not allow for suitable levels of educational supervision. The F1 trainees had all met the assigned educational supervisor but that feedback was not given as the consultant did not know the trainee clinically. The trainees stated that depending on the allocated consultant the relationship could be very distant. The trainees did however think that they would receive feedback on the team assessment of behaviour (TAB) soon. The F2 trainees confirmed that all had met with the assigned educational supervisor and the trainees received advice and feedback on the e-Portfolio. The visit team would like to commend the work the foundation training programme directors	The Trust should review the number of educational supervisors available to Foundation training and ensure they are compliant with the necessary training	Mandatory Requirement

	undertook to review the foundation trainees' e-portfolios and assess the trainees' progress. The visit team also met with some of the consultants who would like to see the e-Portfolio used to highlight exceptional trainees not just those who could possibly be in difficulty. The consultants felt that the e-Portfolio did not offer the interaction with the trainees and therefore the educational supervisors that the visit team met, felt there was no rapport built up with the trainees. The visit team would recommend the consultants build rapport with trainees in addition to the use of the e-Portfolio. This would add an extra dynamic to the educational supervision the Trust provided. The consultants also stated that the slow IT system did not facilitate easy use of the e-Portfolio or sign-off of trainees' competencies.		
GMC Theme 2) Educational governance and leadership			
2.1	**Impact of service design on learners** The visit team heard from trainees, consultants and management that the Trust intranet was slow and cumbersome. The trainees stated that if there was a computer available, the computers were slow and this, combined with the cumbersome intranet meant that trying to find clinical guidelines or anything else, was not efficient. The F2 trainees confirmed that finding clinical guidelines was a major problem in the Trust. The F2 trainees in emergency medicine stated that this was felt acutely in the emergency departments on both sites, but the Trust was now trying to get the trainees to develop a set of clinical guidelines. The F2 trainees stated that there was no search function on the intranet for locating guidelines and most of the time trainees either googled the clinical guidelines or went to the pharmacy to ask someone directly. Foundation trainees stated that they did not know where the clinical guidelines were located on the intranet and the trainees at the King George site used smart phone applications to access up to date clinical guidelines. The trainees at Queen's Hospital could not access mobile applications, as there was no mobile signal within the hospital setting. The visit team was perturbed to hear that consultants suggested confiscating trainees' phones, because the consultants deemed that foundation trainees were using them excessively and inappropriately. The visit team was pleased to hear that not all consultants agreed and saw the need for trainees to access clinical guidelines; however they stated that trainees should make the patients aware why they were using the smart phones, to ensure professionalism. The visit team felt that it was inappropriate for consultants to suggest confiscating phones rather than entering into a dialogue with trainees about professionalism and appropriate access to guidelines and protocols. The visit team advocated consultants and trainees discussing these issues within a local faculty group to reach a joint understanding of the use of smart phones at the Trust. The senior management team stated that many services were being reconfigured and services moved from King George Hospital to Queen's Hospital. The consultants stated that these changes could occur suddenly and with no prior communication. The lack of communication was reported to disrupt training and education and put the consultants at a disadvantage when trying to provide educational and clinical supervision.	The Trust is required to provide a policy that has been discussed by trainees and consultants on the use of mobile phones in the Trust. The Trust should ensure timely communication of service changes to the consultants and education team to allow time to buffer the impact on education and training.	Mandatory Requirement Mandatory Requirement

2.2	**Appropriate system for raising concerns about education and training within the organisation** The F1 trainees were unsure of who the F1 trainee rep was and did not know when fora were available to feedback on education and training. The F2 trainees stated that two representatives had recently been elected, one for each site and as a result had not yet attended any meetings. F1 trainees stated that departmental meetings that had been attended by trainees who asked for teaching were told that teaching was given to them at medical school. This type of reaction is not warranted and is not acceptable. The F1 trainees stated the medical education manager (MEM) was always approachable and supportive but stated that the MEM was so overworked that sometimes emails were not responded to. However the F2 trainees stated that the MEM was exceptionally supportive and always responded to emails and tried to address trainees' concerns and issues. This was also stated by the F2 trainees for the foundation training programme directors. The F1 trainees stated that they knew who the training programme directors were and they were quite visible but unfortunately due to cross-sites and a high workload there was not always opportunity to discuss issues with the TPDs. The F2 trainees were not only demoralised regarding the inaction of the Trust in response to serious incidents but also because of the lack of change that had occurred when the F2 trainees had met with the Trust board last year as F1 trainees. The trainees perceived the Trust to be apathetic to the trainees' education and training needs but to patient safety concerns too. This was compounded by the unsatisfactory response, if any from the Trust regarding emails. The communication system at the Trust was described as a black hole.	The Trust is required to set up a foundation forum for trainees to raise and discuss issues. These should be attended by consultants and trainees, with attendance and minutes taken. Feedback on changes should also be circulated to the trainees and relevant parties involved. Changes to rotations and site working must be communicated to the NETFS.	Mandatory Requirement
GMC Theme 3) Supporting learners			
3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The visit team heard that generally the trainees found the Trust to be friendly and supportive, however the visit team was concerned to hear that trainees accepted that bullying and undermining behaviour within medicine as a profession was a cultural norm. All F1 trainees reported poor relations with the radiology department. However, the F1 trainees identified that this was probably because the department was exceptionally stressed and pressured with a very high workload, which led to poor behaviour. The visit team heard that the paper based system that was used to request scans contributed to the high workload of the department. The visit team did however hear that trainees encountered bullying and undermining behaviour with a certain interventional radiologist consultant. The visit team heard that frequently foundation trainees would cry after speaking to one particular neurosurgeon consultant. This was because of the undermining language used, which questioned the clinical abilities of foundation trainees.	The Trust is required to address the bullying and undermining behaviour reported throughout the Trust and especially in neurosurgery, radiology and urology. The Trust should review the discharge policy and ensure F1s are not making discharge decisions without appropriate senior support.	Mandatory Requirement Mandatory Requirement

	The visit team was concerned to hear that F1 trainees in respiratory were dissuaded by consultants from reporting behaviour stating that the trainees should first think about the ramifications reporting would have on the trainees' position within the hospital. The visit team heard that there was always pressure from nurses, bed managers, and site managers to discharge patients. The trainees stated that the ward nurses would demand five discharges before 11am but the trainees would refuse because the trainees were not competent to discharge patients and there may not be patients fit to discharge. The visit team heard from the senior management team that they had an award for the ward of the week in the hospital that was published on social media. The trainees stated that this was always won by the ward that discharged the most patients. The visit team was concerned that this signified a focus by the Trust on targets and not on the quality of patient care.		
3.2	**Academic opportunities** The F1 trainees stated that there was no time to complete quality improvement projects (QIPs) and that if trainees wanted to complete these, it would have to be in the trainees' own time. The trainees felt frustrated by this, as there were many different QIPs available. The F2 trainees corroborated this and stated that just to register to be involved in a QIP was convoluted and had to go through the audit office. This process had not been explained or described to the trainees. The visit team heard that the education team had changed the teaching for foundation trainees to make this more accessible to the trainees and allow trainees from both sites to attend. This work must be commended. The foundation trainees stated that they appreciated the now ten-day sessions per year and the half-day teaching was good. However, the trainees thought that it would be good to have weekly teaching for one hour and the trainees would like to revisit the simulation training to see if they had improved. The F2 trainees would like to be informed about the teaching topics further in advance than a week before the teaching and would appreciate teaching being mapped to the curriculum and being given a teaching schedule at the beginning of the placement so that trainees could prepare for the teaching. The visit team heard from the education team that the new teaching sessions for foundation teaching were well attended however; some F2 trainees stated that trainees had to fill out study leave forms to attend and not all trainees were granted leave. The trainees all appreciated the effort that the education team had gone to organise transport between the hospital sites. All Foundation trainees reported that they would like the opportunity to receive advanced life saving (ALS) training. The visit team found that there was a total lack of facilities for educational resources with no library or study area for trainees. There was a small reference library at King George's Hospital but this was not adequate, as the larger library at Queens' Hospital had been turned into an IT training room. This was appropriate for study and the trainees' educational needs. F2 trainees stated that they had received no information regarding careers and how to start the	The Trust should ensure that trainees have support with projects with time to meet supervisors of the projects within the working week.	Recommendation

	applications for the next stage in the trainees' training.		
GMC Theme 4) Supporting educators			
4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The lack of educational supervisors due to the retirement of key consultants and the large number of trainees meant that there was a pressure on consultants to provide educational supervision. This issue was then compounded by the Trust not recognising educational responsibilities within the consultant's job plans adequately. The visit team heard that young consultants had been identified as educational supervisors but they still needed to complete the relevant, mandated training. The visit team also heard that because King George's Hospital had significantly fewer consultants than Queens' Hospital the education team was aware that there would need to be a balance of supervisors to allow access to trainees on both sites.	The Trust is required to provide adequate number of educational programmed activities in the job plans of consultants, where relevant. The Trust should support the training and recruitment of more educational supervisors.	Mandatory Requirement
GMC Theme 5) Developing and implementing curricula and assessments			
5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The F1 trainees in surgical specialties stated that the patient mix at the Trust was excellent but the trainees' workload was exceptionally high and this inhibited trainees' ability to access training opportunities. The F1 trainees in surgery stated that the high workload was exacerbated by the poor cross-cover for the sites, and the stretched rotas. The F1 trainees at King George's Hospital stated that there were few training opportunities in comparison to Queens' Hospital because the majority of work had been moved to Queen's Hospital. The F1 trainees stated that there were so many patients at Queen's Hospital that although they had access to good training opportunities, trainees would be able to access more training opportunities if the workload was not so high with many inappropriate tasks. The F1 trainees stated that they frequently missed ward rounds because of the high workload and trainees must do discharges. F1 trainees stated that there was limited time to complete workplace-based assessments (WBPAs), the only F1 trainees who stated they could complete WPBAs were on the respiratory wards and some consultants in cardiology would incorporate this into the ward rounds, however other consultants in cardiology were reported to not have a natural affinity for education. The F2 trainees stated there was time to do directly observed procedures (DOPs) and singular learning events (SLEs) but that the trainees were finding it difficult attaining sign off on the TAB because no one was replying. The visit team heard that there were a lot of foundation trainees but also core trainees and foundation trainees stated that training opportunities would be given to core trainees over	The Trust is required to review the training opportunities accessible to foundation trainees across the Trust, but especially in neurosurgery, urology and care of the elderly.	Mandatory Requirement

	foundation trainees and there were not enough training opportunities for both cohorts of trainees. The visit team heard that the F2 trainees would like to have access to the dictating tool because clinically it was very useful to access patients' notes. Some of the F2 trainees stated F2 trainees could access this but it was a long process to attain access.		

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 Keren Davies*
Date:	*22 December 2015*