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Pan-London Quality and Regulation Unit

Barking, Havering and Redbridge University Hospitals NHS Trust
Medical Specialties (acute medicine including general (internal) medicine, endocrinology and diabetes mellitus and infectious diseases)
Specialty Focused Visit

Quality Visit Report

18 November 2015

Final Report

THE NHS CONSTITUTION
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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 Trust was last visited for a Trust-wide Review in 2013. The London School of Medicine requested to align with the Trust-wide Review in 2015 in order to visit the various medical specialties (including acute medicine, general (internal) medicine, endocrinology and diabetes mellitus and infectious diseases) due to on-going concerns with the educational and training experience of trainees. The school had undertaken many visits to medical specialties over the years, and had noted minimal improvements in action plans. It appeared from feedback both formally, from the GMC National Training Survey (GMC NTS) and informally from training programme directors that there continued to be concerns. Unfortunately due to the small numbers of trainees in medical specialties such as endocrinology & diabetes mellitus and Infectious diseases in the Trust, the visit team was unable to review the GMC NTS outliers. Acute medicine generated eight red outliers and four pink outliers in the GMC NTS 2015 survey. It was a particular concern that the specialty received red outliers in overall satisfaction, clinical supervision and clinical supervision out of hours.
Visit summary and outcomes	The visit teams met with the senior management team, the medical director provided a presentation on the journey since the Care Quality Commission (CQC) visit which had resulted in the Trust being placed into special measures. The visit team met with the director and the service manager for the division of specialist medicine which included endocrinology & diabetes mellitus. The visit team was informed that the infectious diseases specialty was aligned to respiratory medicine in the Trust structure and was part of the same specialist medicine division. Unfortunately the visit team did not meet any of the educational leads including the local training lead who held responsibility for trainees in acute medicine, infectious diseases and endocrinology & diabetes mellitus. This had been requested by the visit team on the timetable and was a missed opportunity to understand the structure and educational activities of medical specialties. The visit team met with the acute internal medicine trainees including core medical trainees currently in acute medicine and a selection of specialty medicine trainees who were dual accrediting in general (internal) medicine (GIM). The visit team was pleased to have the opportunity to speak with the trainees in GIM and Geriatric medicine where there had been a visit (conversation of Concern) earlier in the year to receive an update on training in this specialty. The visit team then met with a core medical trainee in endocrinology & diabetes mellitus (E&D) and specialty trainees in infectious diseases and E&D. Finally, the visit team met with the educational supervisors. The Trust-wide Review lead visitor provided the medicine feedback at the end of the visit. The visit team was pleased to hear that trainees of all levels and from all medical specialities received good local teaching and were regularly released for mandatory regional training. There appeared to be excellent opportunities for endocrinology & diabetes mellitus trainees at King George Hospital to attend clinics in the hospital and community setting, and the trainees were easily able to fulfil the requirements of the specialty curriculum. However, although there was a mechanism for clinic attendance for the E&D trainee at Queen's Hospital the visit team heard that the trainee rarely attended. The range of infectious diseases and practical hands-on experience was good at the Trust. The visit team felt that the material at this Trust would suit further infectious diseases training if it was properly managed. The visit team recommended that the structure of the infectious diseases post should be reviewed to ensure that it meets the curriculum requirements. An ambulatory care system had been implemented and had potential to work well in reducing the pressures of the heavy patient in flow from the emergency department. However there appeared to be a lack of consistency on how this was managed at a senior level, so while it could represent a

	useful training opportunity the visit team suggested that the Trust should introduce a more robust process for clinical supervision from consultants. The current acute medicine rota did not allow for continuity of care for patients or the doctors looking after them. The medicine visit team heard of two serious patient safety concerns, which required immediate mandatory requirements. These concerns related to the 'plus one' protocol of referring patients to the ward without an allocated bed and the Rapid Assessment Treatment (RAT) system in the emergency department. These concerns were triangulated by trainees and trainers in the Trust-wide review team, in which two immediate mandatory requirements were issued to the Trust. The trainees reported that they would be happy for friends and family to receive elective treatment in the Trust, but they would have concerns for emergency treatment.

Visit team			
Specialty Lead Visitor	Dr Karen Le Ball, Head of London Specialty School of Medicine	**External Representative**	Dr Vivek Sristavava, Acute Medicine External Clinician
External Representative	Dr William Lynn, Infectious Diseases External Clinician	**External Representative**	Dr Bernard Khoo, Endocrinology and Diabetes Mellitus External Clinician
Lead Provider Representative	Dr Maria Barnard, Lead Provider Representative for Endocrinology and Diabetes mellitus	**Lead Provider Representative**	Professor Peter Wilson, Lead Provider Representative for Infectious Diseases
Trainee representative	Dr Nabeela Mughal, Trainee representative	**Lay Member**	Robert Hawker, Lay Representative
Visit Officer	Michelle Turner, Quality and Primary Care Manager		

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
GMC Theme 1) Learning environment and culture			
M1.1	**Patient safety** The visit team heard that new leadership within the Trust had been able to implement changes to address the educational and patient safety concerns which had been present for many years. The medical director reported that the CQC re-inspected the hospitals in March 2015, and several areas of outstanding practice had been noted. The CQC generated 30 must-do actions and the Trust had refreshed their improvement plan 'Delivering our Potential' from the report findings. A serious concern had been highlighted with regards to prescribing, and the visit team heard that		

	work streams had been set up and training provided by pharmacy staff. **Plus One** The trainees reported that a new scheme named 'plus one' had been introduced, in which patients ready for discharge were moved from the emergency department (ED) to a ward, with the expectation that a patient from the ward would be discharged so that the ED patient would have a bed. They reported that theoretically the scheme should work, but there were many misuses of the scheme, which resulted in inappropriate patients being moved on the 'plus one' scheme. The trainees stated that every day the ward nurse was asked how many potential discharges there would be for the day, if two patients were being discharged, then two patients would be moved to the ward from the medical assessment unit (MAU). However, the consultant may then complete the ward round and find that the patient due to be discharged needed further treatment or tests and so there was a bed shortage of patients. The trainees reported that the nurses changed over at 7am; there was always a flurry of activity at the morning changeover with patients moving to different areas. Usually several 'plus one' patients were moved to wards, without being reviewed by the acute medicine day team. The visit team heard of an incident the day before the visit in which an acutely ill patient was left in a wheelchair waiting for a bed. The patient had a spiking temperature and was taking morphine for pain relief. Patients had often been left in corridors for many hours without a bed and with no cardiac monitoring equipment. When patient safety incidents had occurred, the trainees had raised concerns to bed managers who reported that they would complete an incident form. The infectious diseases representatives on the panel also commented that this also could raise significant infection control issues with patients waiting for beds in open ward areas who could potentially be infectious. **Rapid Assessment Treatment (RAT)** The trainees reported that the RAT system was a patient safety concern. The trainees explained the RAT system: patients were briefly assessed in the ED, and then referred directly to the assessment unit or medical specialty. The patients had not been formally accepted or examined by the medical team, but following the RAT it was unclear as to who had clinical responsibility for the patient in the interim. The patients would wait in the ED for the medical on call doctor, which on a busy night at Queen's Hospital could be an 11 hour wait. Thad been incidents of patients waiting on trolleys in corridors for long periods. Whilst waiting for the medical team the patients regularly had not had treatment started, or basic tests performed. The trainees reported that the ED was busy, and there were staffing issues; there had been many incidents when patients had been referred to a specialty without being stabilised. The trainees stated that it was common for patients to be referred to the wrong department. There were pressures on the ED teams to refer patients and to meet the four hour target, which resulted in patients often being referred to medical teams when they should be under surgical teams. The trainees stated it was a disservice to patients.	The medicine visit team heard serious concerns from both trainees and trainers regarding the 'plus one' protocol of referring patients to the ward without an allocated bed. The visit team heard various examples of patient safety concerns which related to the wrongful referral of these patients to these wards. *An immediate mandatory requirement was issued from the Trust-wide Review visit team regarding the 'plus one' protocol.* The medicine visit team heard potentially serious patient concerns with the Rapid Assessment Treatment (RAT) system in the emergency department. Patients were being referred to medical teams, without receiving appropriate treatment from the emergency medicine team. The medical specialty trainee would attend the emergency department to receive the patient, and patients had often been left without vital treatment. *An immediate mandatory requirement was issued from the Trust-wide Review visit team regarding the triaging and referral of patients from the emergency department*.	

	The trainees stated that all patients who were deemed to be medical patients were referred straight to the MAU. There was a frequent backlog of patients requiring beds, and this resulted in patients waiting in corridors without beds. The trainees were concerned that if a patient became unstable, they were not next to any medical equipment which was potentially a patient safety concern. The visit team heard examples of patients using bed pans in corridors, and unstable patients with no bed. The trainees were unaware who made the decision to move which patients, but they confirmed that wrong decisions were often made. The medical higher trainees in particular felt that when this (and the ward transfers) started happening they were not included in the decision making and as a result 'lost control' of the take. The trainees at King George Hospital stated that the RAT system worked more efficiently than at Queen's Hospital. The wait to see a medical on call doctor was often no more than four hours, so patients' wait times were much shorter and patients had deteriorated less frequently. The educational supervisors reported that there were some on-going concerns with the RAT system. The visit team heard that in theory the system should be beneficial but it was not being utilised correctly. The educational supervisors explained that the RAT area had six trolleys, and was covered by a consultant or a senior specialty trainee and a doctor's assistant. Patients were admitted and assessed by the EM team and treatment should be initiated, however, it was becoming clear that some staff were cutting corners when the ED became busy and there were pressures on the department to clear patients. The educational supervisors were aware of concerns raised with the process not being correctly followed, particularly during periods of handover. The medical teams would often accept patients who had no treatment started.	Measures must be put in pace to ensure appropriate communication occurs between the on call higher trainee and the personnel involved in implementing these RAT and +1 initiatives so that they remain engaged and also their awareness of the patient clientele may be able to support this process better.	Mandatory Requirement
M1.2	**Serious incidents and professional duty of candour** The core medical trainees stated that they had raised concerns regarding the 'plus one' scheme to the ED manager, and a meeting had been booked to discuss concerns as a group. The trainees stated that they had indicated to management that they planned to report the 'plus one' scheme as a clinical incident, and were discouraged to as it was the Trust policy and was not eligible for reporting on. The bed managers had informed trainees that it was better for patient safety for patients to be moved to a ward or corridor of the ward than to wait on a stretcher in ED. The trainees reported that the falls rate had increased in many of the wards were there had been a high use of the 'plus one' scheme. The numbers of pressure points and fractures reported had greatly increased due to the extra patients and heavy workload of nurses on these wards. All incidents were placed onto the risk register, which resulted in some wards not accepting 'plus one' patients for a period of time until the fall numbers stabilised.	Trainees must be empowered to report incidents if they feel that they are impacting on patient safety even though it may be hospital policy. This will be covered on the TWR action plan.	Mandatory Requirement
M1.3	**Appropriate level of clinical supervision** The clinical leads stated that the medicine department had been running a seven day consultant	There needs to be greater clarity as to who is supervising the trainees throughout the day on	Mandatory Requirement

	delivered service since 2012. Consultants were available on the wards until 8pm, seven days a week, and after this time they were available by telephone. The Trust had strict criteria for when consultants should be on site, and this was rigorously followed. The E&D trainees reported that they received good levels of clinical supervision and there were daily ward rounds. There was an equal distribution of beds on the ward between the consultants. All new patients were divided between the two consultants, so every new patient was seen by a consultant on the day they were admitted. The trainees reported varying methods of clinical supervision. The trainees in acute medicine stated that there were on average three consultants on each day shift, and they were allocated a specific clinical supervisor, but if this individual was busy the trainee would be referred to another clinical supervisor. The trainees reported that it was not always clear if there was a named person, but the consultants shared the responsibility of clinical supervision. The GIM trainees reported that the acute assessment units were well staffed, there was a consultant led ward round, and all patients were actively reviewed. The implementation of regular consultant input had improved patient safety and the continuity of care. The trainees reported that patients admitted to ED, were then moved for assessment at the Clinical Assessment Unit (CAU) then moved to the medical ward. Patients were able to stay in the CAU for up to 48 hours. Some patients were referred straight to the endocrine wards from the ED. The visit team heard that many of the patients on the ward were general medical patients. The visit team heard that the endocrine ward was on the ground floor which resulted in the ward accepting a higher amount of general medicine patients with psychiatric issues. The trainees indicated that there were often no specialist nurses available to look after the patients with different issues. The trainees stated that the previous winter (2014-2015) there was a substantial increase in medical outliers; wards had to be reassigned to care of the elderly or orthopaedic geriatric wards. This continued to be an issue through March to July 2015. The issues were raised to the management and chief executive many times as responsibility and the assigned consultants were not clear. The specialty trainees were assigned to patients, but they were unaware which consultant was responsible for which patient.	the AMU such as a clear rota of consultants. On the assumption that the ground level ward will continue to receive a quantity of patients with specific psychiatric needs there should be a plan in place to educate both nursing and medical staff in this area to manage these patients better. This could be a valuable learning opportunity and also improve the care of these patients receive. There needs to be a clear process in place for the identification of medical consultants responsible for outliers on non-medical wards. This needs to be shared with the relevant wards and the medical (and surgical) staff. Consider linking consultants as this sometimes helps.	Mandatory Requirement Mandatory Requirement
M1.4	**Responsibilities for patient care appropriate for stage of education and training** The trainees did not report concerns with undertaking tasks beyond their level of competence. The core trainees at King George Hospital reported that they held the referral bleep for the specialty they were working in. On the whole the core trainees found this a useful experience though the higher trainees reported it was dependent on the level of expertise of the junior doctor and that an inexperienced foundation year two trainee (F2) could find the interactions challenging and were also less willing to enter into discussion with the caller. The core trainees on both sites commented that they had good opportunities to discuss patients with a consultant when they were on the day shift rota but at night it was almost impossible. The trainees stated that in terms of training they always had opportunities to discuss patients although they were also allowed an appropriate level of professional autonomy.		

M1.5	**Rotas** The clinical leads stated that the Trust relied on a substantial use of locum doctors to fill gaps on the rota. This was required in order to make the rota more manageable. The clinical leads reported that there were 20% nursing vacancies in the endocrinology ward, Clementine B, and the ward was on the Trust risk register. At times that there were significant vacancies in nurse staffing, and patient numbers on wards were decreased. Each ward had a doctor's assistant who was responsible for supporting the needs of the team on each ward. The higher trainees reported that they were often asked to cover the on call rota if there were gaps on the rota. However they commented that they were not bullied into accepting the extra shifts. The trainees stated that they had previously been asked to cover shifts for acute medicine, but the staffing numbers appeared to have improved, and this had been less regular over the previous two months. The trainees reported that the on acute call rota consisted of three specialty trainees, but due to rota gaps there were often only two trainees on the on call. In these cases it was indicated the shift could be a disaster. The specialty trainee would cover the stroke calls as well as the acute ward. Some trainees indicated that since August 2015, they had only completed two nights on the on call rota when the full cohort of three specialty trainees were on site. The visit team heard that there should be three core trainees (an F2, CT1 or CT2) and minimum of two specialty trainees to cover the wards and the acute take. The visit team heard that there was one core medical trainee at night. The core trainees were often pulled to cover different gaps in the rota. The trainees indicated that they often felt coerced by the consultants into covering the out of hours rota. There were previously five vacancies, but this had decreased to three. The trainees were often forced to cover bleeps when it was not their allocated time on the rota. The trainees reported that acute medicine and care of the elderly medicine had become a part of the emergency care division, and this had resulted in the specialties being seen as an extension of the ED. This was a real challenge for the specialty trainees and the departments. The care of the elderly and acute medicine specialty trainees were on the rota until 8pm. The trainees could not see all patients as there were far too many for the staff to review. They saw only the patients who were a priority. A higher trainee was in the resuscitation department which meant that all patients were deemed as safe; the concerns raised were with regards to the volume of patients being admitted. The higher specialty trainees reported that there was minimal foresight and planning on the rota, for example members of the same specialty team were often on-call/nights at the same time. The trainees had tried to implement quality improvement projects:they had highlighted with several weeks in advance that there were impending problems on the rota and nothing had been addressed. At short notice, trainee doctors were pulled across the department to cover the gaps in the rota. They felt that the rota could be pro-actively managed but it was not. The acute geriatric		

	trainees were seen as supernumerary in clinics and so were able to be pulled across to where there were gaps. However in general the feedback regarding geriatrics as a whole was more positive than on the last visit and they reported that they were able to raise concerns with the trainers and that these were taken seriously. In fact they complimented the department lead as to her input in addressing their problems. The trainees reported that the medicine trainees had not had their rotas diary-monitored in a long time. Recent exercises had been undertaken but some trainees were omitted from the monitoring. The Trust had informed trainees that the response rates were insufficient. The core trainees reported that they felt their rota was in the wrong banding. They had reported their concerns to the British Medical Journal and had discussed the rota with the rota manager. The meeting with the rota manager had been postponed many times and issues had not been addressed.	The trainees in medical specialties do not have EWTD compliant rotas. A diary card monitoring exercise must be completed to ensure they receive the correct banding and all rotas are EWTD compliant.	Mandatory Requirement
M1.6	**Induction** The trainees stated that the inductions received were variable. Trainees who started on night shift did not receive a formal Trust induction, and were often given a tour of the department by staff on the on call rota. The trainees were all provided with the essential log-in but there was no access to mandatory training modules. Much of the Trust induction was e-learning which was not easy to access. The department inductions were variable. The main August induction was well organised with formalised timetables for all trainees. The visit team heard that care of the elderly had instituted a block induction for every rotation; trainees were not aware of this being set up for other medical specialties.	The Trust should submit details as to the method of induction to the medical departments and the strategy for starters who start out of synch with the rotation.	Mandatory Requirement
M1.7	**Handover** The clinical leads stated that there were regular handovers in the medical assessment unit. There was a formal handover at 8am from the night teams to day teams, a midday handover following the morning work, a multidisciplinary handover at 4pm to the twilight team then a formal handover at 8pm to the on call night team. The consultants were requested to speak to trainee doctors before they left for the day. The acute medicine trainees stated that the post-take was an issue. Only a small number of patients were discussed at the 8.45am handover, and unless a patient was acutely unwell they would not be discussed. The trainees reported that most hospitals would have a consultant led ward round in the morning, but due to the high numbers of admitted patients from the ED it was impossible for this to occur daily. The consultant attended the handover, asked which patients were of the highest priority and then reviewed only those. The specialty trainees at King George Hospital confirmed that their experience was similar to the		

	Queen's Hospital trainees. The handover only reviewed the patients the on call team were worried about. The trainees reported that at Queen's Hospital there was a night handover for the on call team at 8pm, and this was a relatively effective handover and more structured than the day handover. The trainees were aware of improvements to the handover process having occurred, and the handover now followed a designated pro-forma. The trainees at King George Hospital stated that they were not aware of a pro-forma for handover; the handover had not been structured. The visit team heard that trainees at King George Hospital were often not informed about changes; they were only notified if it came up in informal conversations. The visit team heard that there was no formal sign-in process for handover at King George Hospital, and no other teams or staff attended. It was a simple medical handover. The trainees at Queen's Hospital stated that their handover was much improved. They discussed all patients who had been admitted to intensive treatment unit (ITU) or critical care. They discussed all sick patients that the on call team should be aware of. The trainees stated that their experience of the night handover had been good. There were two specialty higher trainees covering the hospital at night, with up to 40 admissions out of hours, so a robust handover was essential. The trainees reported that if there was a sick patient on one ward, it made the on call shift difficult as they were pulled in different directions. The trainees often had to make decisions about which patients to see when there were frequent bleeps. The educational supervisors stated that the Trust had good processes for handover. They ran a handover course for external colleagues. The educational supervisors for acute medicine stated that they led the handover meetings; primarily in gastroenterology, and cardiology. Officially there was no formal consultant cover for the care of the elderly. Patients could be highlighted on the e-handover data if they needed to be seen by a consultant. The consultants asked the senior trainee to cover the wards without a consultant present every morning, to ensure that potentially deteriorating patients were picked up and reviewed.		
M1.8	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The geriatric and respiratory medicine GIM trainees stated that there were issues with the acute take rota. The acute medicine of the Trust was busy which allowed the trainees to receive ample experience of admitting patients. However, they commented that there was no learning from the take, and there was no opportunity to discuss if the management plans they had started were correct or effective for that patient. The trainees indicated that they felt like secretaries. They understood that it was a logistical challenge to manage the patient numbers in the ED and AMU but there were limited opportunities for feedback and training. The core trainees stated that they reviewed patients and made treatment plans but then were not updated once the consultant reviewed the patient. So they were left unaware if the treatment plan made was correct or not, the trainees felt that this was a lost learning opportunity, which resulted in	The Trust should implement a way that the trainees involved in the on-call receive feedback as to how the patients they saw have fared in order fro them to consolidate the learning experience	Mandatory Requirement

	trainees feeling that they were at the Trust to cover the service rather than for training. The trainees reported that they had many opportunities for self-learning by reviewing patients on the acute on call rota; there were good learning opportunities due to high patient footfall, the large population the Trust served and the interesting cases admitted. The visit team heard that trainees felt that the busy workload for consultants often affected the opportunities for bedside teaching but there had been significant improvements.		
M1.9	**Protected time for learning and organised educational sessions** The core medical trainees stated that they were often taken away from service requirements to complete audit work. The trainees were informed that this was non-negotiable and the trainees indicated that this evidenced the understanding of the core trainee role by the Trust. The trainees felt that they were there to cover the service and that wherever the Trust required a doctor the core trainee would be moved accordingly without thought for their competencies or educational requirements. The core medicine trainees stated that they did not have protected time to attend specialty clinics The acute medicine higher trainees stated that they were essentially supernumerary in clinics and had opportunities to attend. The trainees in care of the elderly posts stated that they attended an endocrinology clinic which educationally was not beneficial. They had limited training specific to geriatric medicine. The trainee indicated that the trainers had made an effort to allocate a clinic for the rota but it was not possible to attend a geriatric clinic. The E&D trainees at King George Hospital reported that they had many clinics that they were able to attend. There was a monthly transition clinic for paediatric diabetes clinics which were particularly interesting. The trainees stated that there were ample clinics in the community for diabetes patients, the clinics in the hospital were mainly endocrine patients. Generally the community clinics were led by the consultant. The trainees commented that they would be keen to attend more community clinics as they had the chance to see complex patients for metabolic assessment but attendance at community clinics was dependent on staffing numbers. The trainees had attended anti-natal diabetic clinics on a Friday, but these were not regular. The experience of the E&D trainee at Queen's Hospital appeared to be less positive, with limited opportunities to attend clinics. The educational supervisors indicated that they were establishing a specialty trainee clinic list for some specialties, as this would then be deemed as a protected list, which trainees would not be pulled away from. They were trying to be proactive and think of new ideas to protect training time. The consultants were keen for trainees to attend clinics and actively encouraged attendance; the trainees found clinics to be supportive learning environments. The visit team heard that trainees did not have an assigned clinic list, but they were able to pick patients, review the patients independently and discuss with consultants when required. The educational supervisors confirmed that all E&D trainees should attend a minimum of two clinics	CMT trainees in the Trust should have clear learning objectives set when they join the Trust so that they can ensure that the relevant parts of their curriculum are being met, in particular their clinic requirements. Ensure that all trainees have protected time to attend clinics which are educationally relevant to their training and curriculum requirements. The endocrinology and diabetes trainees should go to the endocrinology clinics and the geriatrics trainees should go to the geriatric clinics.	Mandatory Requirement Mandatory Requirement

	per week at King George Hospital. They had good exposure to community clinics, diabetes clinics and also ante-natal clinics.		
M1.10	**Adequate time and resources to complete assessments required by the curriculum** The core trainees stated that the acute medicine rota did not allow for consistency of consultants or specialty trainees which resulted in difficulties in completing WPBAs. The core trainees stated that there were concerns for them as a group of trainees, with not meeting the minimal numbers of some procedures.i.e. directly observed procedural skills (DOPs). They commented that a recent development at Queen's Hospital was to encourage specialty trainees to supervise procedures undertaken by core medical trainees; this had been put in place due to the concerns raised by trainees with not meeting competencies. The higher trainees stated that from a specialty trainee point of view they often struggled with the set-up of reviewing the acute take patients but not following through with the post-take, which limited their opportunities to complete e-portfolio assessments in a meaningful way. The trainees at Queen's Hospital stated that the medical assessment units were extremely busy and this affected the opportunity to complete procedures with appropriate clinical supervision for assessments. The trainees based at King George Hospital stated that they also experienced difficulties with completing procedures but this was linked to the limited range of specialties available at the site.	The designated educational supervisors should ensure that their trainees are on track with their competencies and have in place strategies to ensure they meet them within the attachment time frame	Mandatory Requirement
GMC Theme 2) Educational governance and leadership			
M2.1	**Effective, transparent and clearly understood educational governance systems and processes** The medical director stated that the Trust was delivering on quality improvement projects which had not previously been possible. This had been enabled by the funding provided by Health Education England. The Trust had appointed Darzi Fellows who were looking at quality improvement projects. The Trust held patient safety meetings every Tuesday; this was led by either the MD or director of nursing in which a patient safety case from the previous week was discussed. The medical director commented that the learning around service delivery had been excellent and the Trust was in a better position to learn from harm.		
M2.2	**Impact of service design on learners** The service manager explained the clinical set-up of services for the specialties being visited: • Respiratory medicine which covered infectious diseases at Queen's Hospital had eight consultants covering two wards (Bluebell A and B ward) totalling 60 patients, the specialty provided inpatient treatment and a referral service from King George Hospital and clinics on both sites. The department had five specialty trainees in total, including one infectious diseases trainee. The infectious diseases trainee worked as part of the respiratory medicine team, based at Queen's Hospital and was part of the on call rota.	The structure of infectious diseases training post should be reviewed to ensure that it meets the curriculum requirements.	Mandatory Requirement

	• Endocrinology & diabetes mellitus had wards at both sites; there was one specialty trainee at King George Hospital and three specialty trainees at Queen's Hospital. The core trainees stated that an ambulatory care unit had been implemented, but there was currently no defined role for the unit, and no guidelines regarding which patients should be treated there. The trainees covering the unit had a target to review 20 patients. The visit team heard that some of the patients referred to the unit, had been moved from the ED and they were not appropriate to be reviewed in a clinic setting. An example was shared, when patients required being put on cardio equipment which the trainees felt should take place in the ED setting. The trainees commented that they often reviewed patients in the MAU which they felt should be reviewed by ambulatory care, and this was a missed opportunity to support the workload of the MAU. The ambulatory care unit was nurse-led. The unit had moved recently to an admissions ward, but if there was an increase in patients admitted the ward would take back a bay, which caused logistical problems for reviewing patients' confidentially. The trainees expressed concerns that there was no robust system as yet, and they were worried how it would function during the winter months. The educational supervisors reported that there had been no updates regarding the change in the ED for King George Hospital. The Trust had been saying for a number of years that the ED was to be closed but it continued to be open. The visit team heard that whilst it would be beneficial to understand what was happening with the ED at the site, the medical teams were well supervised during this period of uncertainty and had access to good teaching sessions. All ward rounds had consultants available, and the trainees had greater opportunities to discuss patients.	An ambulatory care system has been implemented and has potential to work well to reduce the pressures of the heavy patient in flow from the emergency department; however, there is a requirement for a substantive consultant to lead on this and clear learning objectives for the trainees to be identified.	Mandatory Requirement
M2.3	**Appropriate system for raising concerns about education and training within the organisation** The gastroenterology trainees reported that there were suitable numbers of core and specialty trainees on the wards, and the consultants were supportive. There were good numbers of nursing staff on the ward; however, the skill set of the nurses was often an issue. The nurses were often unable to complete basic procedures such as cannulas which increased the pressure on trainee doctors. The trainees commented that there had been issues with infection control in one of the bays on a ward, and there were no signs up so relatives/visitors were unaware of the increased need for hygienic standards. Generally all staff were stretched, and it was difficult to actively be involved in quality improvement projects.		
M2.4	**Systems and processes to make sure learners have appropriate supervision** The E&D trainees reported that there was a 28 bedded ward at King George Hospital. The trainees reported that the department was well staffed by doctors and so clinical supervision was sufficient. There was one higher trainee, two CT1, two F2 and three F1 doctors. However, there were concerns with the staffing levels of nurses and a subsequent increase in bed sores, which resulted		

	in the ward decreasing as a temporary measure to only 18 beds. There was a phased increase back up to 28 beds. The E&D trainees stated that the Trust had well known concerns with medical outliers. The outliers were divided between elderly care and endocrine teams. The visit team heard that the department had been responsible for 25 outliers during one busy period over the past year; this was no longer an issue, as responsibility for outliers had been reorganised. The department had on average one or two outlier patients to look after which the F1 doctor took responsibility for. The educational supervisors stated that there were concerns with covering two hospitals for the on calls, clinics and in addition now community clinics. There were specific issues with care of the elderly and endocrinology. The educational supervisors stated that there was good junior doctor cover on the wards, particularly at weekends and out of hours. However, some wards did not have sufficient cover at weekends i.e. respiratory and gastroenterology.		
M2.5	**Organisation to ensure access to a named educational supervisor** The trainees in E&D, acute medicine and GIM training all confirmed that they were aware of who their educational supervisor was, and met regularly. The educational supervisors reported that with the consultant numbers in the Trust those who were substantive posts had no choice but to be educational supervisors for four or five trainees. They indicated that all staff worked beyond their capabilities; the increase in locum consultants in post had added pressure to the educational supervisors.		
GMC Theme 3) Supporting learners			
M3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees reported that there had been many examples of conflicts between the ED and medical teams. They would often receive calls for referring patients who they had already stated that they could not accept, and the ED team pressurised the specialty teams to accept a patient. The trainees commented that this was because of the pressure on all teams. The trainees did not report any further concerns with feeling undermined or bullied within their placement.		
M3.2	**Timely and accurate information about curriculum, assessment and clinical placements** The visit team heard that there had been concerns with the care of the elderly post; there was only one specialty trainee in post at one point which affected educational opportunities. There were now five trainees in care of the elderly and the department had made a concerted effort to provide weekly department meetings, and ensuring access to specialty clinics and training needs. However, the visit team heard that the increase in opportunities was often affected and interrupted by the acute medicine on call.		

	The visit team heard that some trainees were not given notice of what site they would be working at when they started in post, which created delays in requesting study leave. The core medicine trainees reported that they were often notified of teaching opportunities with minimal notice, but when they were able to attend the teaching was of a good quality.		
M3.3	**Academic opportunities** The acute medicine trainees reported that a Darzi Fellow had been in post for a month at Queen's Hospital; they were unaware as yet of any academic opportunities being available. The trainees were aware that the Trust was looking to increase fellow appointments to four Darzi Fellows.		
M3.4	**Access to study leave** The clinical leads reported that there were concerns with specialty trainees not being able to take study leave when on the acute medicine on call rota. Similarly trainees in acute medicine were not able to take study leave when working on the specialty wards. This had been an issue for cardiology but should be resolved. The trainees in acute medicine stated that study leave had been an issue previously. The frequency of on call caused difficulties with taking study leave, as trainees were not able to book leave on an on call day. It was extremely difficult to organise a swap in shifts with colleagues, as all trainees felt at times overburdened with the on call. The visit team heard that care of the elderly trainees had attended limited teaching sessions due to the frequency of the on call. The E&D trainees reported that they were generally able to access study leave, but the only difficulties were when they were on call.	The Trust should ensure that all trainees have appropriate study leave availability.	Mandatory Requirement
M3.5	**Regular, constructive and meaningful feedback** The specialty trainees in GIM stated that they rarely received feedback on their patient treatment plans which affected their learning ability. They were unaware if they had made mistakes. The visit team heard that trainees tried to remember cases they were not certain about, and looked at the patient notes for changes in treatment plans. The trainees confirmed that there were no patient safety concerns, as all patients were reviewed by a consultant. The trainees confirmed that the lack of feedback was an educational concern. The educational supervisors commented that they would review sick patients with the trainee doctors but there was limited scope to review a treatment plan made by trainees. The educational supervisors were aware that the current structure of the acute on call rota reduced the opportunities for education and training. The educational supervisors stated that there were concerns with the continuity of care due to the acute on call rota. The rota had previously had blocks of on call, but this was removed a few years ago due to the intensity of the on call and the pressures on trainees. The visit team heard that the only members of staff that continued the clinical service were the F1 and consultant, the core and	The current rota in acute medicine does not allow for continuity of care for patients or the doctors looking after them. This restricts educational and learning opportunities between the core trainee, specialty trainee and consultant. The trust/ department to ensure that all trainees on the acute medicine on call rota have access to regular, constructive and meaningful feedback which is currently a missed opportunity due to the lack of continuity in the rota.	Mandatory Requirement

	higher trainees rotated every day.		
GMC Theme 4) Supporting educators			
M4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The clinical leads stated that there had been confusion regarding which consultants were clinical and which educational supervisors. There had been limited reflection on where there were areas of discrepancy, and there appeared to be a disconnect between some departments. The educational supervisors stated that there were financial pressures on the Trust to ensure that education performed well. The visit team heard that the Trust often took resources from King George Hospital and gave to Queen's Hospital to meet the demands of the service. The trainers often did not feel supported or appreciated. The educational supervisors confirmed that they all understood the importance of delivering education, and prioritised it where possible. They confirmed that they each had a maximum of 0.5 programme activities (PAs) for between two to three trainees. The visit team heard that the consultants worked hard to ensure that despite the many vacancies the department functioned as a training and educational site. The educational supervisors reported that it was well known the Trust was in financial difficulty, and the trainers had all been asked to drop one PA unless they could provide a specific need for PA. The educational supervisors stated that the junior doctors and medical students were the consultants of the future and they were keen to support and develop the individuals. They indicated that due to the heavy workload within the Trust and the minimal PAs in job plans, the trainees ran on goodwill and completed educational work in their own time. The educational supervisors stated that the Trust experienced difficulty with appointing consultants. They had heard from trainees that although they were interested in remaining employed by the Trust, they were well aware of the concerns and lack of time in job plans which resulted in trainees not applying for consultant posts.	There needs to be clarity amongst the consultant staff as to their educational role, regarding who is a clinical and who is an educational supervisor. There should be evidence held in the postgraduate centre that consultants have undergone appropriate training for this role. The consultants need to be allocated appropriate time within their job plan to undertake their educational roles.	Mandatory Requirement
GMC Theme 5) Developing and implementing curricula and assessments			
M5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The core medical trainee stated that the experience was good; they had excellent supervision from higher trainees. The trainees reported that overall their experience had been positive. Training in the Trust was difficult due to the heavy workload, but the department had a supportive educational environment. The visit team heard that trainees generally received good acute medical experience at Queen's Hospital but this detracted from specialty training and at King George Hospital there were limited specialties which reduced exposure and had some impact on the ability to complete workplace-based assessments, particularly DOPs. The trainees were not aware of the training		

	experience of the trainees based at Queen's Hospital, however, the visit team heard from the different trainee groups throughout the visit who indicated that the E&D trainees at Queen's Hospital were unable to attend clinics. The E&D trainees reported that there was a weekly endocrine meeting, which doubled once a month as a multi-professional team meeting. The trainees had ample opportunities to teach and present cases. The visit team met with the E&D trainees who were based at King George Hospital; the trainees did not cover both sites and did not rotate to Queen's Hospital. The trainees stated that they interacted with consultants from Queen's Hospital as they were on the on call acute rota at King George Hospital. The trainees indicated that they received adequate diabetes training. The trainees reported that they received good training from consultants. There were many consultants who were proactive about teaching the trainees. The educational supervisors indicated that they did their best to provide the best possible training for trainees. They commented that trainees were successful in the completion of research and presenting their work externally at conferences.		
M5.2	**An educational induction to make sure learners understand their curriculum and how their post or clinical placement fits within the programme** The trainees in acute medicine and GIM training all confirmed that they met with their educational supervisor on starting in post, and put together an educational plan for their placement to ensure they met the curriculum requirements of their stage of training although it seemed as though this may need refining in some cases.		
M5.3	**Opportunities for interprofessional multidisciplinary working** The trainees stated that there was no monthly meeting in the department for the nurses and doctors to meet and discuss concerns within the department. The trainees reported that many of the wards did not have formal multi-disciplinary meetings. The trainees indicated that nurses did not have a voice in many of the department to raise concerns. The trainees informed the visit team that one of the ward matrons had resigned due to the pressures on nursing staff and lack of support. The trainees were aware of proposals for regular multi-disciplinary meetings to be implemented, which they felt was a positive move to discuss improvements in the wards. They suggested that the implementation of multi-professional meetings would not be an excessive expense to the Trust but would be a big development for all staff. The care of the elderly trainees reported that the occupational therapist joined the doctors on the board round but the limitations in space meant that there was no opportunity for a department meeting across the professions.	There must be appropriate faculty or equivalent departmental meeting where concerns and ideas are shared on a regular basis in the areas where this is not the case.	Mandatory Requirement
M5.4	**Appropriate balance between providing services and accessing educational and training**		

	opportunities The divisional director stated that with the trainee on call, annual leave and study leave the trainee doctors had limited time in their specialty. The specialty trainees in GIM reported that many of the clinics in the Trust were held every two weeks, and trainees had experienced difficulties with attending their specialty clinics due to clashes with the on call rota for acute medicine. The visit team heard that previously the Trust had a system of block on calls, which allowed for trainees to be released for specialty clinics, although the system would have worked in theory, in practical terms it did not work due to the high numbers of vacancies within the Trust. The trainees indicated that one of the acute medicine consultants had suggested a return to the block on call rota as staffing numbers were more stable. The trainees stated that a change to the acute on call rota would increase time on the specialty ward and access to clinical opportunities. The educational supervisors stated that their main issue was fulfilling the on call demands and meeting the curriculum requirements of all trainees. The E&D educational supervisors stated that there were often gaps in the rota for the on call, and their trainees were asked to cover on call shifts. They had made it clear that the trainees should not be asked to do this, and were encouraging trainees to speak up and say no. This was also a problem for care of the elderly trainees.		

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 Karen Le Ball*
Date:	*22 December 2015*