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Pan-London Quality and Regulation Unit

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

Quality Visit Report

19 November 2015

Final Report

Visit Details	
Trust	Barking, Havering and Redbridge University Hospitals NHS Trust
Date of visit	19 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 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'. A Trust-wide Review had not been conducted by Health Education England since May 2013, and in the interim, there had only been one specialty-focused visit to geriatric medicine in April 2015. A Trust-wide Review was therefore arranged for November 2015 and various parallel specialty-focused sessions took place alongside the Trust-Wide Review over the course of this two day visit. The School of Anaesthetics requested to align with this visit to conduct a review of anaesthetics.
Visit summary and outcomes	The visit took place on day two of the Trust-wide Review. The visit team met with a number of clinical directors and college tutors as well as trainees and trainers from anaesthetics. No immediate mandatory requirements were issued for anaesthetics. The visit team met with clinical directors, college tutors, five core trainees in anaesthetics, one DRE-EM (direct route of entry into emergency medicine) trainee and five higher trainees. The visit team note the following areas of good practice: ODA (operating department assistant) support out of hours had improved enormously since the last visit with investment in a floating ODA to assist trainees out of theatre. There had been investment in critical care outreach and it was clear that the trainees knew who the team members were and felt appropriately supported in managing critical care patients out of intensive care while waiting for a bed to be available. Clinical training was reported to be good by the trainees and in particular the neuro-anaesthetic training was commended. There was appropriate programmed activity (PA) allocation to allow educational supervisors time to support trainees and to fulfil the GMC requirement for trainers. The visit team noted the following areas for improvement: Induction – There was a lack of clarity around roles and responsibilities during out of hours at night and the escalation policy at local induction; the visit team felt that the communication of these roles needed to be improved. There was also an issue where trainees who started on nights were not receiving inductions. Rota – There was a lack of consistency in the management of rotas; clinical input was required when allocating trainees to appropriate lists with consultant

	trainers and recognised SAS trainers. The visit team highlighted that non-consultant staff who were allocated trainees for teaching should fulfil GMC requirements for clinical supervision activities. Statutory and mandatory training – there were serious concerns with regards to the access to the study leave budget, and the requirements of the trainees to complete their mandatory and statutory training in their own time; it was sometimes not achievable to complete this within a three month placement and this was also impinging on clinical training time.

Visit team

Lead Visitor	Dr Claire Shannon, Head of London Specialty School for Anaesthetics	**Lead Provider Representative**	Dr Jane Lockie, Consultant Anaesthetist, University College London Hospitals NHS Foundation Trust, Deputy Regional Advisor North Thames Central
Deputy Lead Visitor	Dr Cleave Gass Lead Head of London Specialty School for Anaesthetics	**External Clinician**	Dr Helena Scott, Consultant Anaesthetist, Guy's and St Thomas' NHS Foundation Trust
External Clinician - ICM	Dr Gary Wares, Training Programme Director, London Intensive Care Medicine Training Programme, The Royal Marsden NHS Foundation Trust	**Lay Member**	Caroline Turnbull, Lay Representative
Scribe	Becki Dunn, Business Support Manager – Quality and Regulation Team, London and the South East		

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
GMC Theme 1) Learning environment and culture			
A1.1	**Patient safety** The core trainees and the direct route entre into emergency medicine (DRE-EM) trainee reported in general that they were well supported by consultants although some commented that if they had not completed airway training at their previous Trust, they would have struggled to meet the demands of the job in their current posts. The visit team heard of one occasion when a core training year one (CT1) trainee with limited airway skills was asked to cover the intensive treatment unit (ITU) at short notice and did not feel that the level of supervision was adequate, despite a specialty training year six (ST6) trainee covering them from the neuro ITU. This was raised as an issue, but the trainee involved did not think that this had been addressed. The	The Trust must ensure that trainees working on the ITU have the appropriate airway skills to manage ventilated patients. The Trust must ensure that there is an anaesthetic on call 'team leader' who can give assistance to the more junior members of the team if required. Roles and responsibilities of each member of the out of hours team must be made clear to trainees at induction and evidence	Mandatory Requirement

	trainees commented that it would be useful to have an allocated team leader on duty at night. The higher trainees corroborated the core trainees' views that it was inappropriate for such junior trainees to be running the ITU with little experience and no airway training. The educational and clinical supervisors reported that trainees who were on the rota to attend theatre were not called to ITU and the staff grades covered the theatre lists. Due to the shortage of staff who had trained airway skills the trainees that ran the theatre also collected patients from the ITU.	of the effectiveness of this must be sought. The Trust must produce evidence that both these requirements are being met and monitored.	
A1.2	**Serious incidents and professional duty of candour** The visit team heard that the majority of datix forms submitted related to medical management, pressure ulcers and a lack of intensive treatment unit beds for elective surgery. The divisional managers reported that they worked closely with the college tutors who in turn worked closely with the clinical supervisors to deal with incidents raised. There was an improvement plan which sat within the divisions as well as an over-arching Trust improvement plan. The visit team heard that there were quality and safety managers for each division. Most core trainees had not yet reported any serious incidents. The trainees seemed aware of a new process which involved them receiving feedback by email. They also confirmed that they were included in audit meetings where all incidents were discussed. Although the higher trainees had not reported any incidents, they confirmed that they knew how to do so and also that they attended clinical governance meetings where incidents were discussed.		
A1.3	**Appropriate level of clinical supervision** The visit team heard from the educational and clinical supervisors that there was a mixture of staff on the rota at night and the Trust had developed policies and documentation to highlight team functions with contact details for the trainees and important roles and responsibilities. The visit team heard that the core trainees felt well supported by their clinical supervisor colleagues but that support from their staff grade colleagues could be variable. They commented that for at least 50% of their rota they were allocated with a staff grade (60% of the time for neurosurgery). The quality of training offered by the staff and associate specialist (SAS) doctors was variable, with some (notably in neurosurgery) functioning as good trainers and others were poor. This lack of consistency for trainees was sometimes difficult and occasionally made it difficult to get the workplace-based assessments completed in a timely fashion. The trainees said that it was unfortunate that their rota did not include working with a higher trainee as they would find this beneficial. The visit team heard that the core trainees felt supported on the wards and that the support from the operating department practitioner (ODP) was invaluable. The visit team was pleased to hear that investment in a 'floating' ODP to assist trainees out of hours was making a real and positive impact to the environment for trainees out of hours.	Non-consultant staff who are allocated trainees for teaching should fulfil the GMC requirements for clinical supervision activities.	Mandatory Requirement

	The neurosurgery ITU was reported to be very good and well supported. Similar good feedback was given about working in obstetrics. The educational supervisors reported that all elective paediatric cases were covered by a consultant at the weekend. Difficult cases were left for during the week if possible. The educational supervisors reported that all units had an anaesthetics consultant available but the on-call consultant covered both sites. They suggested that it would be helpful to have an anaesthetics consultant available until midnight. They stated that they would like there to be consultant anaesthetic presence from 8am to 8pm from Monday to Sunday.		
A1.4	**Rotas** The visit team heard that there were 44 trainees in total: 17 core training year two trainees, eight acute care common stem trainees, five direct route entry into emergency medicine trainees (DRE-EM), as well 14 higher trainees. The trainees worked predominantly at Queen's Hospital although the core training year one trainees also undertook out of hours work and elective work during the daytime at King George Hospital. The visit team heard that the department had lost its rota coordinator, and that a consultant was now in charge of the rota. The visit team heard that on induction day trainees were expected to complete a form regarding their expectations for their time at the Trust. The visit team heard that annual leave and study leave were not fixed in the rota, but trainees who worked in the intensive care unit were unable to take annual leave unless they could swap with a colleague; this had impinged on their ability to gain exposure to a sufficient number of cases. The visit team heard that trainees were not allocated to service lists during the day nor were they required to cover bleeps so that they instead had time to concentrate on their module. The visit team heard that there was seven day consultant cover, even at the weekend. A consultant was available until 6pm on the weekend days, and until 10pm during the week. At the weekend, the resident consultant was responsible for emergency work, and the lists were covered separately. The visit team heard that the department was staffed with an on call consultant and a core trainee (year two), who would be on call for theatre. Two trainees covered the maternity ward from 8am to 8pm with a consultant on call. The educational leads reported that trainees received a lot of support from consultants while on call – there were fixed telephone numbers that trainees could use to request help. The core trainees reported that they always knew who they need to call when working out of hours as this was communicated on the rota. They confirmed that a consultant was available all weekend. The visit team heard that since the rota coordinator had left, the job was split between a consultant and an administrative person and that this had resulted in some issues. There were often gaps in the rota, and there were also many locums. Some of the trainees had been asked	There is a lack of consistency in the management of rotas; clinical input is required when allocating trainees to appropriate lists with consultant trainers and recognised SAS trainers.	Mandatory Requirement

	by management if they wanted to work overtime but were not pressurised to do so. The higher trainees reported that they were on an eight week rolling rota, and worked a maximum of three nights in a row. When on call they covered the neurosurgery patients in the ITU but were also regularly called to help with airway management on the general high dependency unit and ITU and also to the resuscitation area. The higher trainees reported that they covered both King George Hospital and Queen's Hospital when they worked out of hours. They confirmed that consultants were on site until 9pm during the week. The educational supervisors agreed that the rota issues were disruptive. At times they had had to work a 24 hour shift as there was no junior doctor available to cover the rota. They stated however that it was rare for trainees to have to cover gaps themselves. They felt that the trainees were protected from many of the rota issues and that if necessary staff grades would be asked to cover more work if needed. They all agreed that they were proactive about ensuring that the trainees were not under too much pressure and were able to complete their modules appropriately. They did not think that the trainees had to cover too much service work to the detriment of their training. They commented that they would like an electronic rota system.		
A1.5	**Induction** The educational leads reported that the trainees' induction consisted of mandatory online training plus half-day workshops. Although the trainees were given time to complete their online training, the half-day workshops were more difficult to complete. The trainees often had to take annual leave to undertake them and they were ineligible for study leave until the induction workshops had been completed. In general though, the educational leads felt that the trainees were positive about the entire Trust and local induction process. The core trainees stated that they had struggled to attend the mandatory child safeguarding training since this only took place once a month; as a result many had been unable to take study leave or obtain study leave funding (or reimbursement for courses already paid for) since they had not completed their mandatory training. All the higher trainees confirmed that they had received a good Trust induction. Most had also attended a local induction apart from one trainee who had started out of synch with the rotation. The visit team heard that some trainees who started working nights at the beginning of their posts in the Trust had not received an adequate induction. The higher trainees corroborated the core trainees' views about study leave. They were expected to complete the mandatory training before they could apply for study leave funding to be reimbursed. The clinical and educational supervisors reported that the induction process had been revamped;	The Trust must provide access to statutory and mandatory training during work time and study leave funding must not be dependent on completion of this training. Please provide evidence that this has occurred. The Trust must ensure that all trainees receive the necessary induction at the start of their posts Please provide evidence that this is being carried out.	Mandatory Requirement Mandatory Requirement

	a booklet had been created which listed useful phone numbers and other policies and procedures for both sites.		
A1.6	**Handover** The consultants reported that there was a handover at 8pm with everyone involved. They reported that there were four consultants on duty during the day for 13 hours with an overlap for handover. Three left at 6pm and one stayed until 9pm for the evening handover.		
A1.7	**Protected time for learning and organised educational sessions** The core trainees reported that they were released to attend regional training. The higher trainees could attend regional training but only if they could find someone to swap their on call – this was difficult with limited theatre days. The higher trainees confirmed that they were released to attend their regional teaching sessions but they commented that the Tuesday afternoon teaching session for ITU was not protected. There was also no dedicated anaesthetics teaching. The higher trainees reported that if they were not on call it was easier for them to attend regional teaching as they were covered until 5pm so that they could attend.		
GMC Theme 2) Educational governance and leadership			
A2.1	**Impact of service design on learners** The divisional leads felt that the changes that the Trust had undergone had not impacted negatively on the trainees. They cited the trainees' keenness to return to the Trust for a second year as evidence of this.		
A2.1	**Appropriate system for raising concerns about education and training within the organisation** The visit team heard from the clinical directors and college tutors that formal local faculty groups had been established, which were minuted.		
A2.3	**Systems and processes to identify, support and manage learners when there are concerns** The educational leads reported that they had quarterly meetings with the trainees. Issues had been raised in the past regarding the completion of workplace-based assessments. With 26 specialty doctors in post, they stated that there needed to be a certain amount of doubling up. The educational leads commented that they had been proactive about tackling any issues raised. They stated that they were sensitive to the trainees' needs; prior to the trainees arriving at the Trust, they looked at the modules that the trainees needed to complete to meet their curriculum requirements, and then designed the rota around those modules. The visit team was informed that		

	each trainee should be in the right placement for his/her training needs with one allocated educational supervisor; they added that a clinical supervisor often supported more than one trainee because of the large number of trainees in post.		
GMC Theme 3) Supporting learners			
A3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The visit team heard that following complaints about the lack of library access, this had now been restored. Previous study leave issues had also reportedly been resolved and the Trust was trying to address the car parking issues. The visit team heard from the clinical directors and college tutors that novice training had been arranged for the core medical trainees (year one) and that this had received good feedback. The visit team heard that other improvements had been made e.g. refurbished areas, new lockers, a sofa bed, a place to eat.		
A3.2	**Behaviour that undermines professional confidence, performance or self-esteem** No issues were reported in this area.		
A3.3	**Access to study leave** The trainees reported that they were able to take annual and study leave but at times this was disorganised and requests needed to be made well in advance.		
GMC Theme 4) Supporting educators			
A4.1	**Sufficient time in educators' job plans to meet educational responsibilities** There had been positive improvements in job planning since the last visit. Educational supervisors received 0.25 programmed activity (PA) per supervisee. Trainers reported that they had no issues being released for interviews or other educational meetings.		
A4.2	**Access to appropriately funded resources to meet the requirements of the training programme or curriculum** The clinical directors and college tutors gave the visit team a summary of the major changes in the senior management team since the last visit. The visit team heard that a new divisional structure was now in place, which facilitated closer working. The clinical directors felt that a great deal of change had taken place since the Care Quality Commission visits and that the new executive team was more outward-facing. They also reported that the management team was working with the clinicians on the shop floor. There was praise for the college tutors who		

	reportedly worked above and beyond their job role. The clinical directors also commended the executive team for supporting recruitment activity to try and ensure gaps were covered. The visit team heard that the department had worked hard with the previous director of medical education to try and address the issues raised in the General Medical Council National Training Survey.		
GMC Theme 5) Developing and implementing curricula and assessments			
A5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** The trainees reported that they had been asked to sign off their competencies within six weeks of starting in post before they had been allowed to go on the on call rota. After they had raised this as an issue with their college tutor, this had been resolved and they were now allocated three months to complete their competencies. In general, both core and higher trainees reported that they were able to complete their competencies and felt well supported. Although some trainees stated that they needed to be proactive about completing workplace-based assessments, some trainees commended the ITU consultants who often mentioned completing case based discussions and other assessments before the trainees did. The trainees also felt that they received good training from the staff grade doctors. The higher trainees reported that they had good training opportunities during the day. There was a separate list for elective cases which the trainees could attend with a consultant. The trainees stated that their consultants were supportive but were happy to give the trainees autonomy if they requested it. The higher trainees working in the neurosurgery ITU reported that they had a good working relationship with the neurosurgery trainees and consultants. The anaesthetics trainees conducted a ward round with the neurosurgery trainee and consultant and there was shared ownership of patients and collective working. The visit team heard that there was good continuity of care. On the whole, the neurosurgery post was reported to be excellent, and the obstetrics post had also exceeded expectations.		
A5.2	**Regular, useful meetings with clinical and educational supervisors** The trainees confirmed that they had met with their allocated educational supervisor.		

Good Practice	Contact	Brief for Sharing	Date
Other Actions (including actions to be taken by Health Education England)			

Requirement	Responsibility

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Claire Shannon*
Date:	*22 December 2015*