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Health Education England

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Quality and Regulation Team (London and South East)

North Middlesex University Hospital NHS Trust
Medicine
Specialty focused visit

Quality Visit Report

15 March 2016

Final Report

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Visit Details			
Trust	North Middlesex University Hospital NHS Trust		
Date of visit	15 March 2016		
Background to visit	The specialty focused visit to the North Middlesex University Hospital NHS Trust was triggered by the results of the General Medical Council National Training Survey (GMC NTS) 2015 results which presented red outliers in workload, access to educational resources and study leave, as well as there being some feedback of difficult relationships for trainees, and some comments relating to bullying and undermining. To obtain an overview of the trainees' experience at the Trust the visit team felt it needed to: • review core medical training and establish whether trainees were getting to induction • explore whether there was stress on the wards and how this impacted on the trainees • explore the interface between ward clerks • look at the interpersonal relationships with the nursing teams • assess the levels of senior support to the trainees • review the educational structure • review the interface between intensive care unit (ITU) and medicine		
Visit summary and outcomes	The visit team would like to thank the Trust for accommodating the visit. The visit was well attended and the visit team had the opportunity to meet with the clinical director for acute and general medicine - elderly care and the specialty lead for acute medicine, followed by a meeting with 10 higher specialty medicine trainees and 13 core medicine trainees. The team then met with the educational and clinical supervisors (ES and CS) from nephrology, acute medicine, geriatric medicine renal medicine and diabetes and endocrinology. Overall, the visit team found the consultant body in medicine to be very supportive to the trainees and noticed that the ESs all felt they had a sufficient time to undertake their training and educational activities. The visit team also found the Trust to be an organisation where there was an excellent breadth of clinical experience and the ability for trainees to be able meet all the relevant competencies for their training. However, the visiting team found there were several areas of serious concern which the Trust needed to address immediately, particularly in relation to the medical trainees' interaction with the critical care outreach and the intensive care unit teams. The visit team found that patients were being transferred out of the emergency department resuscitation area, while medically unstable, often without the knowledge of the medical team. The visit team issued the Trust with two immediate mandatory requirements as a result of these concerns. Furthermore, it was felt that core trainees needed to have more structured clinic access in order to be able to meet their curricula requirements. There also needed to be a more structured approach to allow core trainees to gain their procedural competencies. Due to some serious concerns the trainees expressed, the visit team was informed by the cohort of trainees that they would not recommend the Trust as a place of treatment for family members if they had to attend the emergency department or the intensive care units. The visit team was also informed by the trainees that they would not recommend the post to another trainee at this time.		
Visit team			
Lead Visitor	Dr Catherine Bryant, Deputy Head of School of Medicine	**External**	Dr Helen Burgess, Consultant in acute medicine,

	and Medical Specialties	**Representative**	West Middlesex University Hospital
Trust Liaison Dean	Dr Andrew Deaner, Trust Liaison Dean, Health Education North Central London	**Trainee Representative**	Dr Tehmeena Khan, Trainee Representative
Lead Provider Representative	Dr Elizabeth Carty, UCLP TPMC chair/TPD for CMT	**Observer**	Jannatul Shahena, Quality Support Officer, (Quality and Regulation, London and the South East)
Scribe	Nimo Jama, Quality Support Officer, (Quality and Regulation, 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			
M1.1	**Patient safety** The visit team heard from the medical higher trainees and core medicine trainees (CMT) of all levels, a number of serious incidents affecting patient safety out of hours. The trainees reported that when they needed to refer a patient to the intensive therapy unit (ITU) they often found the ITU team to be obstructive and argumentative. They stated that ITU would refuse the referral, not listening to the trainees unless they had spoken with their consultant, who would then contact the ITU themselves. The trainees told the visiting team that this wasted a lot of time, and was often a matter of serious concern if the patient they were treating was critically ill. The visit team was told that the trainees spent a lot of time going back and forth with the ITU team when they should have been attending to the patient. The trainees highlighted several patient cardiac arrests and deteriorations that had occurred while they waited for ITU; on one particular occasion trainees stated that they had referred a deteriorating and unstable patient to ITU from the emergency medicine (EM) resuscitation area, but the ITU team member was unhelpful and chose not to provide assistance to the trainee. The trainees stated that they had not heard from the ITU doctor after making this referral and had to resort to moving the patient with the assistance of the nursing team to the ITU ward themselves, even though the patient was medically unstable. They told the team that there was a bed ready for the patient by the time they had reached the ITU. The trainees also reported to the visit team that they had patients arresting after the ITU team rejected admissions. They reported an incident where a patient was hypoxic, and had further arrests, with the patient eventually being bagged, tubed and admitted to ITU. They reported that at	There needs to be an introduction of a log of patients referred to critical care outreach and ITU. There needs to be a weekly review of patient safety issues identified. There needs to be an immediate review of the arrangements for transfer of patients from EM resuscitation area to non-resuscitation beds or the acute medical unit (AMU) to ensure patients are not transferred when unstable and/or without the knowledge of the medical teams.	Immediate Mandatory Requirement Immediate Mandatory Requirement

	this incident there was no trained airway doctor at the scene. The visit team heard that the early warning system had not been used prior to arrest. Further patient safety concerns were reported by the trainees saying that they had attempted to refer an encephalopathic patient to the ITU, but the ITU teams had advised them to wait for a second organ failure. The visit team heard that the patient had had an arrest before going to the ITU. Concerns were expressed to the visit team by trainees that ITU would often not take in to account the whole condition of the patient being referred (all of the relevant clinical information) and would tell trainees to palliate patients instead of considering ITU admission. The educational supervisors (ESs) stated that the hospital process relating to referral to the ITU was to ideally call the ITU early, so they could attend to the patient quickly; however, sometimes there were unnecessary delays. They said that anecdotally, the team would either view the patient as not sick enough, or by the time they attended to the patient, the patient was too sick. The ESs also corroborated the trainees' views that if a trainee needed a decision, it would require a consultant speaking to another consultant, which sometimes could be too late for the patient. They said that the system being used by the ITU team could have been a way of reducing patient numbers to the unit, as there were bed pressures but it could end up looking after sicker patients as a result. The trainees reported that they had concerns regarding non-invasive ventilation (NIV); they informed the visit panel that there was no high dependency unit (HDU) at the Trust but there was instead a progressive care unit (PCU) and NIV could only be undertaken within the ITU or PCU. They stated that there was a reluctance to deliver NIV to patients in the ITU despite clinical indications being in line with national guidelines. They stated that treatment tended to be NIV for hypoxia whether or not NIV was indicated. The trainees reported that there were no NIVs on the wards where a number of medical problems such as chronic obstructive pulmonary disease (COPD), could have been dealt with, which meant that certain conditions took longer to treat. Trainees reported that that they thought that patients for whom NIV was indicated according to national guidance were not accepted by the ITU or PCU. The medical higher trainees and the CMT trainees expressed dissatisfaction with the referrals from the EM department. The trainees stated that the quality of referral from EM middle grade doctors was poor and that there was no support for foundation year (F2) doctors within EM. They informed the visit team that although the F2 doctors themselves were fantastic to work with, the medicine trainees spent entire shifts doing what the middle grade doctors in EM should have been doing. They said that the moment they attended to the EM department, patients would be entirely left in their care, with the EM doctor no longer taking responsibility for them.	The quality of referrals and number of referrals from the emergency department to the medical team needs to be audited and monitored.	Mandatory requirement.
M1.2	**Serious incidents and professional duty of candour** Most of the trainees interviewed informed the visit team that they had completed and reported a number of serious incidences via Datix. The majority of trainees stated they had not received feedback and were unaware of whether any steps had been taken to address, or deal with the	The Trust must provide feedback to trainees for	Mandatory

	incidents. Those who had received feedback were less than satisfied with it, as the feedback was not sufficient and sometimes copied from Trust document guidelines, instead of addressing the content of the incident itself. The CMT trainees told the visit team that they had lost faith in completing Datix forms as no actions had been taken by the Trust and that they did not see any evidence of anything changing. The medical higher trainees reported an incident they had experienced with a defibrillator where it charged to shock without being touched. They informed the visit panel that the defibrillator was malfunctioning and they had recorded this incident. They said that the equipment was sent off for tests, however during the feedback process they were told by the Trust they were mistaken, despite there being a number of other colleagues witnessing this incident. The trainees said that the feedback was somewhat contradictory and they had no way of knowing if it would be addressed properly. The trainees reported that they had informed their college tutor of the poor feedback they received from incidents they had reported. The educational supervisors (ES) stated that the logging of incidences via Datix was an issue and that responses were inadequate. They informed the visit team that there were patient safety concerns and these were on-going issues with trainees not receiving feedback. The trainees reported there were four cardiac monitors on the acute assessment unit (AAU). They told the visit team that the monitors could not print, or be interrogated and therefore any abnormalities had to be directly viewed on the monitor.	all incidences submitted via Datix so that all incidences can be learnt from. The Trust is to submit the outcome of the serious incident process review, including details of how the policy will be strengthened. See action ref TWR 1.2 on action plan. The Trust should review the use of monitors on AMU to ascertain whether they are fit for purpose.	requirement Recommendation
M1.3	**Responsibilities for patient care appropriate for stage of education and training** The core trainees reported there were a number of occasions when they had asked the ITU team to assist with seeing a patient, the patients concerned often being elderly or (do not attempt resuscitation) DNAR patients but there was a refusal by the ITU teams because of their age or resuscitation status. Some of the trainees explained that the refusal by ITU teams to take on referrals might be due to lack of willingness, but it could also be that they were not confident enough to take responsibility for the patients.	Please refer to reference M1.1 above.	
M1.4	**Rotas** The visit team was told by the consultant leads for medicine that they had a full rota and were fully staffed with 40 plus trainees covering the medicine rota, with 22 of them being higher medicine trainees. The visit team was informed that the majority of posts were filled at the time of the visit. The visit team heard that there were three consultants covering the AMU and the ACU and overseeing the running of the department each day from 8am – 5pm with a medical consultant on site until 8.30pm. It was explained that the night shifts were busy, conversion rates were low and could impact on the medicine trainees as they were being pulled in to support the EM department		

	as well. The trainees told the visit team that were different types of on-call rota, each with its own challenges. They reported that the day-time ran smoother than the nights and the weekends but the night on-call rota tended to be very busy as they could be seeing up to 20 patients, which they found to be very stressful. The trainees also said that there was a very busy period from 5pm onwards and there was a lot of pressure from post-take ward rounds (PTWR). The medical higher trainees stated that since the ITU anaesthetic trainees had been removed there had been an endless rotation of locum doctors in the ITU department who they could not discuss patients with. The trainees explained that were some gaps in the medical rota which were well anticipated and flagged up to the lead consultants in geriatrics two months earlier but there was no one willing to cover them, and no locums available. The trainees informed the visit team this affected the attendance of some clinics and at times due to busy ward rounds they could not leave their colleagues on the ward to cope alone.	Trust to review the rota gaps in view of the trainee feedback discussed at this visit.	Mandatory requirement
M1.5	**Induction** The medical leads told the visit team that there was a general induction in place with all individual teams having their own departmental inductions, with the exception that the trainees who were on-call not being able to attend but who had the opportunity to take a catch-up session later. The medical higher trainees informed the team that having missed a local induction, they were able to meet with their ES on a one-to-one basis and go through the programme with them. They stated that they found this helpful as it allowed them to catch up which was good for their rotation. Some of the trainees stated the Trust induction was less effective as they received no information relating to their role and were not given the necessary information which they needed, such as computer access and log-in details. The trainees said that if the Trust induction was not proactively requested by the trainee it could go unnoticed. Some of the trainees the visit team met were yet to have a Trust induction after having been in post for some weeks.	The Trust must ensure that all trainees receive their Trust induction at the start of their employment with the Trust.	Mandatory Requirement
M1.6	**Handover** The medical leads told the visit team that there was a consultant-led formal handover in place seven days a week in the AMU with a representative from each of the ward teams going through staffing issues and discussing all patients from the AMU to receiving wards. They told the visit team that the night handover was not consultant led; however, it was attended by the nurse practitioner and the specialty core trainee. The medical leads stated that the whole hospital at night system needed to be strengthened and the teams needed to pull together. The visit team was informed that there was a project in place to help this happen. Some of the trainees reported that was no consistent standard of handover of patients admitted from ED to AMU during the 9pm to 9am shift with some trainees saying patients would get lost periodically, often in the AMU, and they had to spend some time looking for them in the bays. They said that when the patient was found, the handover was often poor.	The Trust is required to ensure the night handover is reviewed and ensure that patients are handed over in a more coordinated manner.	Mandatory requirement

GMC Theme 2) Educational governance and leadership			
M2.1	**Organisation to ensure access to a named clinical supervisor** The trainees informed the visit team that their clinical supervisor was supportive and at times when they had to call them out of hours at home, they were responsive to the trainees.		
M2.2	**Organisation to ensure access to a named educational supervisor** The trainees informed the visit team they had access to their educational supervisors and found them to be approachable and helpful.		
GMC Theme 3) Supporting learners			
M3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The visit team heard that within medicine the trainees were well supported, the department was well run, with good interactions. The trainees reported that they found the consultant body in medicine to be supportive, but they had nonetheless experienced traumatic working environments and often felt demoralised due to the interactions they had had with the ITU and in EM, with some trainees further expressing that it would be difficult for them to continue practicing general internal medicine in the future. The visit team was told that in EM middle grade doctors often spoke to them in an accusatorial way and were not very helpful and there was less appreciation for them as medical trainees, even though they were just as busy and felt they were under significant pressure. The trainees informed the visit team that they had shared their concerns with their supervisors and that further higher level meetings had taken place but they had not had further information provided to them. Most of the trainees the visit team met with stated that due to the issues relating to ITU and EM they would not recommend their rotation to another trainee. The medical leads reported that they had monthly meetings with the medical higher trainees and were already addressing the working relationships with EM. The ES informed the visit team they were made aware of the poor relationships and interactions the medicine trainees had experienced with the ITU teams, but they themselves felt powerless to act on them as they were told they were not welcome on ITU, and often their specialist advice regarding patient management was ignored. The ES agreed that the ITU doctors were more receptive to consultants than their Trust middle grade doctors and they conceded that trainees did have a tougher time. They said that some trainees struggled with the Trust middle grade doctors in ITU at night, and consultants would often get a different view during the day.	Trust to review the report of undermining behaviour discussed at this visit and clinical leads should hold regular meetings with the trainees to confirm that the behaviours identified have been / and or will be resolved.	Mandatory requirement

M3.2	**Access to study leave** The access to study leave represented another red outlier in the GMC NTS 2015 survey. The medical leads informed the visit team that the trainees were required to give six weeks' notice in order to be able to take leave and this was reinforced at induction to each trainee. The visit team was told that thus far, no trainee had been refused study leave if they had applied with due notice. If trainees applied for study leave with less than six weeks' notice they would try to be accommodating but there had been pressure and there might be occasions when they might not be able to let them all go as it would not be viable for the rest of the team's workload to be covered. The trainees confirmed that they needed to give six weeks' notice but it was not difficult for them to take study leave.		
GMC Theme 4) Supporting educators			
M4.1	**Sufficient time in educators' job plans to meet educational responsibilities** All the ES with whom the visit team met said that they had support from the postgraduate medical educational departments (PGME); they were all accredited and had sufficient time in their job plans to meet their educational responsibilities.		
M4.2	**Access to appropriately funded resources to meet the requirements of the training programme or curriculum** The clinical leads were asked about access to educational resources which again had presented as a red outlier in the GMC NTS 2015; however the visit team was told by the clinical leads that resources had not been formally discussed during faculty meetings and at this time they were unaware of any plans to address the issues raised in the survey.		
GMC Theme 5) Developing and implementing curricula and assessments			
M5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** The visit team heard that 50% of core trainees' time was spent in acute medicine which roughly equated to 12 months in their two years' medical rotation. The visit team heard from the ES that trainees had access to clinics, with geriatrics trainees being able to attend as it was scheduled in their rota, whereas the acute block trainees were able to do ambulatory care clinics which were an acute medicine clinic equivalent. The clinical leads informed the visit team that one of the challenges affecting teaching opportunities for the trainees was the busy ward rounds, which tended to pull trainees away from clinics. However, some of the core trainees complained of their inability to gain sufficient clinic	There needs to be an increased experience within clinics in order for trainees to meet curriculum requirements. Core trainees should have clinics timetabled in order to be able to meet their curriculum requirements of a	Mandatory requirement

	experience; they told the team that although they were able to attend clinics in the ACU they did not find this to be sufficient experience for CMT. The trainees said the patients in ACU were low risk, and had already been seen in EM but were discharged to ACU. The trainees had said that some of the patients that were discharged to ACU were inappropriately done so, as they should have been instead discharged to their General Practitioner (GP). They also informed the visiting team that there was no vetting of GP letters for patients who attended the unit and felt this was a way of moving patients from the ED in order to reduce the number of patients from this area. Trainees also expressed some concerns about not being able to complete certain procedures and meet their competences by May 2016, although the visit team heard that there were plenty of procedures being undertaken in the Trust. They told the visit team they had no support to do chest drains, as it was not coordinated. Some trainees stated that the Trust was service orientated by not allowing any time for training and commented that they spent a large portion of their rotation being on-call. Furthermore, the trainees reported that as there were no NIVs on the wards they felt they could not complete NIVs as part of their competency. The trainees said they had no review of patients in the ITU and were never asked when they were on call at the weekends to review patients in the ITU. The ESs said that trainees were at times not proactive and if they were not, they as supervisors felt they had to be. They informed the visit team that there was a helpful consultant radiologist who was actively getting trainees to attend sessions in order to complete chest drains and there were lists in ultrasound. They informed the visit panel that there was a proactive consultant in acute medicine providing teaching on the job in lumbar punctures. The team heard from the ESs that the medicine trainees had a professional approach to their work and were selective about which clinics they could attend. The ESs said that at times if the medicine trainees did not see everything covered in their curriculum the trainees felt they were not doing well enough.	minimum of 12 clinics each year. The College Tutor is to collate a list of available procedural competences and explain how trainees can access exposure and assessment for them.	Mandatory requirement
M5.2	**Opportunities for interprofessional multidisciplinary working** The ESs said there was a lack of nursing in respiratory unit and the elderly care units, as well as the endocrinology ward, with a lot of bank shifts not being filled in good time, which meant more work for CMTs with them having to update families. The clinical leads and ESs said that nurses were good at supporting juniors doctors, helping them put in drips and catheters. The visit team was also told that trainees were helped by physician assistants on the acute medical wards, who were based on the wards for a long time and overall were an asset to the Trust. They informed the visit team that with each new intake of trainees, the physician assistants were able to help them settle in as they already knew their way around the wards, and had access to computer and log-in information; however there were not enough of them on the wards.		

	The trainees reported the nursing body to be helpful and supportive particularly out of hours. The trainees said that when it came to referring patients to the ITU the nurses knew of the difficulties the trainees faced and would often assist them but ultimately they were responsible for doing this. They told the team that the ITU teams were more receptive to the nursing staff than they were to the trainees. On the other hand, some trainees said that working with the nursing team could be a haphazard as their quality varied from ward to ward. The trainees stated that although the nurses in the acute assessment unit (AAU) were consistent, other wards were staffed by agency nurses, with the Tower wards proving to be problematic, as the configuration of the ward following refurbishment meant that the patients were out of the direct view of the nurses. I think this comment should be part of the Trust response-we are reporting what the trainees gave as feedback.		

Good Practice	Contact	Brief for Sharing	Date
The educational and the clinical supervisors were all supportive of the Medicine trainees and had the time to support trainees in their job plans.	Educational and Clinical supervisors across medicine	Complete the good practice case study pro forma.	June 2016

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 Catherine Bryant
Date:	13 April 2016