QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

# Lewisham and Greenwich NHS Trust

## Trust-wide Review (University Hospital Lewisham site only)

## Quality Review report

**Date:** 17 May 2016

**Final Report**

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# Quality Review details

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| **Background to review** | The purpose of the visit was to review the education and training across the Trust. A Trust-wide review of education and training was planned, with specific emphasis on the University Hospital Lewisham site. A number of surgical specialties, foundation surgery and pharmacy were also reviewed (see separate reports).<br><br>The Care Quality Commission conducted an inspection of University Hospital Lewisham site in May 2014 and rated the hospital as: Overall - requires improvement. The intensive/critical care and services for children and young people were rated as good; however, accident and emergency, medical care, surgery, maternity and family planning, end of life care as well as outpatients were rated as requiring improvement.<br><br>Amongst the areas for improvement, it was highlighted that the hospital needed to improve its hand hygiene practices, especially by medical staff and that the hospital needed to ensure there was appropriate clinical equipment available in all areas.<br><br>The last visit conducted by Health Education England to Lewisham and Greenwich NHS Trust was on 31 March 2015 and before that there was a visit on 6 March 2014 where general surgery was reviewed. At the time of the visit, the University Hospital Lewisham (UHL) site had four open visit actions from earlier visits. |
| **Specialties / grades reviewed** | The visit team had the opportunity to meet with a number of trainee representatives, trainees and trainers from a variety of specialties at the ULH site during the Trust-wide Review sessions. |
| **Number of trainees and trainers from each specialty** | The TWR team met with a total of 20 trainees including foundation, core and higher trainee representatives and trainees from anaesthetics, paediatrics, emergency medicine, core medical training, renal medicine, gastroenterology, geriatric medicine and general medicine.<br><br>Furthermore, the visit team met with the chief executive, the interim medical director, the director of workforce and medical education, the director of medical education, the assistant director of workforce and medical education, the associate director of finance, the head of medical education and staffing and the deputy director of medical education. |
| **Review summary and outcomes** | The visit team thanked the Trust for accommodating the visit and for ensuring that attendance was good.<br><br>Overall, in the Trust-wide Review session, the visit team noted the following positive areas:<br><br>• Consultants were reported to be very supportive, always available and aware of the problems faced by the trainees. Particular positive feedback was received for Dr Mansfield and Dr Patel.<br><br>• The pilot of the two additional core medical trainees in the acute medical rota was seen as beneficial in terms of reducing workload and enabling training to happen.<br><br>• The obstetrics and gynaecology and anaesthetics ITU trainees were complimentary about their training and experience in general.<br><br>However, the visit team uncovered the following serious concerns:<br><br>• The limitations of the portering service was impacting on patient care and training. The visit team suggested that this needed to be improved so that |

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| | clinical priorities were taken into account.<br>• Trainees were undertaking inappropriate duties on a regular basis including portering bloods, portering patients and delivering paper-based referrals.<br>• Various IT systems did not network with each other. The iCare system in particular posed problems as patients were not entered into system for variable hours following transfer from the emergency department. Locum nurses may not be trained to upload patients onto the system out of hours.<br>• The rota in medicine needed urgent review as the current system could leave an F1 doctor undertaking unsupervised ward rounds. The visit team was keen to hear more about the plans in place to address this, including timescales.<br>• The environment in the emergency department was not conducive to training: space issues, workload issues, nursing issues. This meant that trainees were not able to be released for training opportunities.<br>Overall, most of the trainees interviewed reported that they would not feel happy about having their friends and family treated at the Trust. However, most reported that they would recommend their posts if their rotas were fully staffed. |

**Educational overview and progress since last visit – summary of Trust presentation**

The director of medical education (DME) gave a presentation regarding medical education to the visit team which included details of the medical education structure, notable practices, achievements and progress made since the last Trust-wide Review. He reported that a governance structure and process was now in place and that business as usual had exponentially increased.

The visit team heard that the junior doctor contract issues and low morale had significantly impacted on staff in the Trust. In addition, at the University Hospital Lewisham (UHL) site, the Trust had been struggling to recruit to rota gaps which had led to increased workload for staff members at all levels. These rota gaps had not previously been a problem at this site.

The DME highlighted a number of projects which had been developed and sponsored by Health Education England South London (HEE SL) to try and address some of the problems:

- Living our values – aimed at aligning organisational cultures established previously at UHL, Queen Elizabeth Hospital (QEH) & LCCS services, thereby maintaining and attracting a good workforce, whilst instilling organisational and national values
- Acute medical models at UHL / QEH – aimed at changing demands, increasing frail elderly, patient expectations, new technology in order to deliver a desired quality of care in line with best practice

The DME reported that the national agency caps had also affected staff morale and the availability of skilled workforce at the Trust. However, the director of workforce remarked that although the rota gaps had been harder to fill in the previous two months, overall the fill rate for the Trust was good (81%).

The DME reported that the Trust had investigated the red outliers generated in the GMC National Training Survey 2015. Diary card exercises had been carried out to try and investigate further the workload issues particularly in general and geriatric medicine. The DME admitted that there had been some delays in providing feedback to the trainees about this exercise.

To tackle the workload issues in general medicine, the following steps had been or were being taken:

- Introduce an acute medical model (quasi-ward based system)
- Encourage time management, prioritisation and efficiency
- Appoint Trust fellows
- DME session with clinical director regarding physician assistants, advanced nurse practitioners and Trust fellows

- Rota co-ordinator appointment
- Band 7 - service manager for trainees (approved to appoint)
- Trainee-led weekend handover

The DME reported that the deputy CEO and the DME had organised monthly training days on both sites to try and meet with the trainees so that they had the opportunity to raise any issues. Unfortunately at the time of the visit, the attendance at these fora had not been satisfactory.

| **Quality Review Team** | | | |
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| **Lead Visitor** | Dr Chandi Vellodi, Trust Liaison Dean, Health Education England North West London | **Local Office Representative** | Teresa Collins, Quality and Performance Manager |
| **Trust Liaison Dean** | Dr Helen Massil, Trust Liaison Dean, Health Education England South London | **Lay Member** | Jane Gregory, Lay Representative |
| **Scribe** | Jane MacPherson, Deputy Quality and Visits Manager | | |

# Findings

## GMC Theme 1) Learning environment and culture

**Standards**

**S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.**

**S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.**

| Ref | Findings | Action required? Requirement Reference Number |
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| TWR 1.1 | **Serious incidents and professional duty of candour**<br>The interim medical director informed the visit team that there was a robust serious incident policy in place and that if trainees were involved in any incidents, the director of medical education (DME) would be notified.<br>The visit team heard that afternoon learning sessions took place where incidents and never events were discussed, and where trainees had the opportunity to present.<br>The senior management team admitted that the feedback loop still posed problems but commented that discussions were taking place between members of the patient safety team and the IT department to address this. The visit team heard that the Trust used a paper-based incident reporting system rather than the Datix system.<br>The trainees reported that they were informed about how to report incidents during their induction session. They stated, however, that the serious incident reporting system was not user-friendly. As a consequence of the high workload and the long- | Yes – see Ref 1.1a below. |

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| | winded serious incident form, trainees were often reluctant to report incidents, apart from in really serious cases.<br><br>Some trainees commented, however, that when they had reported incidents, they had been thoroughly investigated. This was particularly evident in paediatrics where trainees also commented that they had received appropriate feedback on incidents that they had reported.<br><br>In general, the trainees felt that they had not been invited to clinical governance meetings and did not think that they had been given sufficient teaching in 'lessons learned'.<br><br>Some trainees commented that when they had emailed their consultant supervisor to raise an issue, this had led to a speedier resolution than if they had reported an incident on the system. For example, when in medicine, there had been 85 patients to look after one particular evening, following an email, a consultant had piloted a new system whereby an extra core-level trainee was introduced to cover the take team. This had enormously helped the other trainees on duty with managing their workload whilst also being able to access training.<br><br>The trainees expressed to the visit team their concerns regarding Hawthorne Ward. It was reported that Hawthorne Ward was not 'medically ready' due to its paucity of equipment and medication. Trainees were also unclear on the process of referral to this ward. The visit team heard that the ward had been opened in January 2016 as an escalation ward but that it had stayed open and was now used as a type of discharge lounge. No trainees were allocated to this ward. As a result, the visit team felt that the process of referral and the facilities to support clinical care within Hawthorne Ward needed to be reviewed.<br><br>Although the trainees also expressed some concern about the Sapphire Ward, the visit team subsequently received reassurance from the educational lead responsible for this ward. A competent nurse was based on this ward and a core-level doctor was designated there each week.<br><br>The trainers interviewed by the visit team indicated that the Hawthorne Ward was a low intensity ward which had been opened for less acute patients who were ready for discharge. Patients were reportedly looked after by the different firms. The Sapphire Ward, on the other hand, was a commissioned 20 bed 'community' ward under the management of one consultant. | Yes – see Ref 1.1b below. |
| TWR 1.2 | **Appropriate level of clinical supervision**<br><br>The trainees reported that they felt well supported by their consultants but did not feel well supported by service managers, particularly when discussing rota issues and diary card exercises. | |
| TWR 1.3 | **Rotas**<br><br>Overall, the visit team heard that there were rota issues in medicine and paediatrics. Trainees reported that 109 of the 193 trainees at UHL who had completed diary card exercises had found that their rota was not compliant because of the extra hours that they had to complete on a regular basis; the Trust had agreed to reimburse the trainees for these regular, extra hours.<br><br>**Medicine**<br><br>The visit team heard that the trainees working in medicine felt over-worked on a regular basis. They stated that they had to frequently start early and stay late. They cited the gaps in the rota and the clumsy IT and paper-based systems as the main reasons for their onerous workload, and the subsequent negative impact on their training experience.<br><br>Many trainees felt that the rota was unsafe. The firm-based structure of the rota in medicine meant that the foundation doctor could be expected to conduct a ward round of 15 to 20 patients singlehandedly while the other members of the team were on call. | Yes – see Ref 1.3a below |

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| | Each team covered a 24 hour period. The trainees reported that they could have up to 85 patients on a firm with only three people looking after them. Some highlighted that on occasions two firms (with only three doctors) had had to look after 120 patients. The trainees commented that the firm-based structure was positive for continuity of care but only worked if there were no rota gaps.<br><br>Some trainees were aware of the two-week pilot that had taken place in acute medicine which involved two additional core-level medical doctors being added to the acute medicine rota. This was seen as beneficial in terms of reducing workload and enabling training to happen.<br><br>The trainers in medicine reported that they were concerned about the trainees' morale particularly as the schism between training opportunities and service work was widening, as a result of the ever-increasing workload. The trainers reported that the department was trying to address the workload and rota gap issues. As previously mentioned in the DME's presentation, the trainers reported that a band 7 service manager was being appointed to try and help with the rota gap issues. A rota coordinator was also due to be appointed who would be responsible for trying to foresee the gaps in advance so that contingency plans could be put in place to fill the gaps in a more timely fashion. The visit team also heard that the Trust was considering a new model to try and address the peak and trough situation (where some teams had 70 patients under their care whilst other days this could be as low as 15 patients).). The Trust was keen to try and rationalise these numbers so that a similar number of patients needed to be looked after each day. The visit team heard that the Trust was also in the process of recruiting to the junior non-training grade vacant posts and that funding was also available for senior clinical fellow posts. The Trust was also keen to employ physician associates to take over some of the trainees' tasks. Clinical technicians would also be retained.<br><br>The consultant trainers reported that they were acutely aware of the issues faced by the trainees but reiterated that the aforementioned programme of attempted improvements was intended to help resolve the issues.<br><br>**Paediatrics**<br><br>In paediatrics, many trainees had to work locum shifts in addition to their normal shifts because there were only three middle grade doctors in post and it was impossible for them to cover a 24 hour service. The visit team heard that seven doctors should cover the rota, but that the Trust had struggled to fill the other gaps.<br><br>As a result of the rota gaps, when working the dayshift the trainee on duty had to carry the bleep and undertake the baby checks and other service-related tasks on the postnatal ward in neonatology, whereas normally (on a full rota) this workload would be covered by two trainees. Therefore, rarely did the trainees covering this post receive any appropriate training for their curriculum needs. Although their timetabled hours were 8am to 4pm, rarely were they able to leave until after 7pm. This had huge implications for compliance with the European Working Time Directive. The trainees commented that their consultants tried to help them where possible, but were also over-worked and covering night shifts. One trainee who had been in this post for six months when the rota was fully staffed reported that the job had been 'amazing'. Once again, it was clear to the visit team that the rota gaps were having a detrimental effect on the trainees' training experience.<br><br>The paediatrics trainers agreed that there had been staffing issues since March 2016 with rotas less than half-filled. They reported that they were doing everything they could to address the issues.<br><br>The visit team heard that the anaesthetics rota was satisfactory. Similarly, the obstetrics and gynaecology rota issues at the start of the year had been resolved and the trainees now had a full complement of staff and as a result, were able to take advantage of training opportunities. | Yes – See Ref 1.3b below |
| TWR 1.4 | **Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience**<br><br>The visit team heard from staff members at all levels that there were issues with | |

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| | information technology (IT) systems at the Trust; the IT systems in use were reported to be laborious, clumsy and difficult to manipulate particularly as many did not network with each other. The iCare system in particular posed problems as patients were not entered into the system for hours and occasionally two days, following transfer from the emergency department (ED). The visit team heard that patients needed to be entered onto the iCare system so that tests could be ordered. However, at the time of the visit, there were often delays with entering patients onto the system and many nurses did not know how to do this, particularly locum nurses who were not permanently employed at the Trust.<br><br>The trainees reported that the above issue had been raised at faculty meetings; they felt that it was a work in progress. However, given that the iCare system had been in place for seven months, the visit team suggested that quicker progress needed to be made to streamline the systems.<br><br>Although the educational and clinical leads interviewed during the visit agreed that the systems were frustrating, they did not feel that patients suffered delays in treatment as a result.<br><br>The visit team heard that agency staff members were expected to undertake a three hour training session on iCare prior to obtaining their smartcard.<br><br>The visit team heard that trainees were undertaking inappropriate duties on a regular basis including portering bloods, portering patients and hand-delivering paper-based referrals. The visit team felt that this added an administrative burden onto the already very busy trainees. The trainees reported that there was no portering service between 5pm and 7pm and that the service was also limited at weekends and nights. The trainees felt that the impact on training was immeasurable not to mention the potential impact on patient safety when delays occurred.<br><br>Although the trainers interviewed did not think that the Trust's portering service was ideal, they did not think that this was a major issue and they felt confident that if trainees had to porter patients they would be able to prioritise their patients so that the ones left behind were not neglected.<br><br>The visit team heard that there was a lack of discharge coordinators and therefore the trainees were often expected to complete the forms themselves, thus undertaking tasks of little educational relevance. | Yes – see Ref 1.4a below<br><br>Yes – see Ref 1.4b below |
| TWR 1.5 | **Protected time for learning and organised educational sessions**<br><br>The visit team heard that the sheer volume of patients in the emergency department combined with inadequate numbers of nursing staff as well as a lack of beds had a huge impact on the trainees' overall training experience. The trainees reported that although their trainers were keen to train and supervise them, they regularly felt that they missed out on training opportunities as a result of the busy workload. | Yes – see Ref TWR 1.5 |
| TWR 1.6 | **Access to simulation-based training opportunities**<br><br>The visit team heard that when the Trust merged, there was an education centre at both sites, which the Trust decided to maintain. As a result, simulation opportunities were available at both sites, and all simulation training offered was multi-disciplinary in nature. | |

## GMC Theme 2) Educational governance and leadership

**Standards**

**S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.**

**S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.**

**S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.**

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| TWR 2.1 | **Appropriate system for raising concerns about education and training within the organisation**<br><br>The DME reported that faculty meetings were taking place regularly but admitted that the structure was less embedded in some specialties, for example, surgery. The postgraduate medical education team had tried hard to improve attendance at surgical local faculty group (LFG) meetings e.g. changing the times of the meetings and holding meetings at both sites, but despite these efforts, little had improved. The divisional education lead was reportedly trying to promote the benefits of LFGs. The LFG in otolaryngology had made some progress.<br><br>The DME reported that LFG meetings had agenda templates, and that any issues raised during LFG meetings were discussed at the medical education committee meeting.<br><br>The DME reported that faculty meetings took place at a cross-site level, apart from in acute medicine where there were too many trainees whose issues were very different which meant that a cross-site meeting would be ineffective.<br><br>The visit team heard that in general trainees worked on one site only. Some higher surgical trainees travelled with their consultants to other sites for training opportunities but never for service provision.<br><br>In general, the trainees interviewed seemed unaware of the term local faculty group, but they were aware of faculty meetings taking place. They felt that they worked well and had trainee rep attendance.<br><br>The trainee reps reported that they collated concerns from their peers prior to the meetings. Some positive changes had occurred as a result of the meetings, e.g. clarification on portfolio requirements and changes to the rota. | |

## GMC Theme 4) Supporting educators

**Standards**

**S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.**

**S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.**

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| TWR 4.1 | **Access to appropriately funded professional development, training and an appraisal for educators**<br><br>The DME reported that appraisals for trainers took place every three years and confirmed that every educational supervisor in the Trust had completed the required training (apart from one trainer who had been contacted by the chief executive about this issue). | |

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| TWR 4.2 | **Sufficient time in educators' job plans to meet educational responsibilities**<br><br>The DME reported that the Trust intended to move towards an electronic job planning system but that at the time of the visit an Excel version was in use. Funding was reportedly given directly to each division, and efforts were made to quantify teaching and other educational activity to ensure that the right people received the right funding.<br><br>In some areas, where there were insufficient numbers of consultants and an excessive number of trainees, the Trust had asked some of the radiologists and microbiologists to supervise some of the foundation trainees to reduce the burden on the emergency medicine consultants. There was a trust-wide recommendation in place of no more than four supervisees per supervisor. | |

# Good Practice and Requirements

## Mandatory Requirements

| Req. Ref No. | Requirement | Required Actions / Evidence | GMC Req. No. |
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| TWR1.1a | Review and strengthen the clinical incident reporting system so that it is user-friendly. Encourage trainees to report incidents. Continue efforts to strengthen the feedback loop to ensure learning from incidents. | Evidence must be provided in the form of minuted discussion at the LFGs. Provide details of new electronic incident reporting system. | R1.3, R1.4 |
| TWR1.1b | The process of referral and the facilities to support clinical care within Hawthorne Ward needs to be reviewed and communicated to trainees. | Provide outcome of review and details of new referral process. Provide evidence of improvement in patient pathway through minutes of discussion at LFGs. | R1.2 |
| TWR1.3a | The current rota in medicine needs urgent review as the current firm-based system can leave an F1 doctor undertaking unsupervised ward rounds. | The visit team is keen to hear more about the plans in place to address this, including timescales. Interim arrangements need to be implemented to support unsupervised ward rounds. This should be corroborated with trainee feedback in the form of LFG minutes. | R1.12 |
| TWR1.3b | Trainees must not be expected to undertake duties which can be safely undertaken by other staff (e.g. midwives doing baby checks) so as to release time for training activities. | The Trust is required to provide a review of duties undertaken by the trainees including the baby check system and develop solutions to be implemented. This review should contain evidence of roles and responsibilities for trainees, midwives and healthcare assistants, the organisation of the baby checks and a timeline for full implementation of midwife-led baby checks. | R1.9 |
| TWR1.4a | Review and revise the current IT systems, in particular the iCare system to ensure that they are fit for purpose and do not negatively impact on staff workload or patient safety. | Provide timeline regarding when the multiple IT systems will network with each other appropriately. This should be corroborated with trainee feedback in form of LFG minutes. | R1.1 |
| TWR1.4b | Portering needs to be reviewed so that clinical priorities are taken into account and trainees are not required to undertake | Provide outcome of review of portering service, including any plans to increase the service. Provide evidence that | R1.15 |

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| | tasks of no educational value. | trainees are not undertaking excessive portering duties. This should be corroborated with trainee feedback in form of LFG minutes. | |
| TWR1.5 | The environment in the emergency department is not conducive to training: space issues, workload issues, nursing issues. This means that trainees are not able to be released for training opportunities. | Provide update on Trust's plans to address these issues, including evidence of minuted discussions at LFG meetings. | R1.15 |

| **Signed** | |
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| **By the Lead Visitor on behalf of the Visiting Team:** | Dr Chandi Vellodi, Trust Liaison Dean, Health Education England North West London |
| **Date:** | 21 June 2016 |