QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

King's College Hospital NHS Foundation Trust (Princess Royal University Hospital)

Acute Care Common Stem

Risk-based Specialty Review

Quality Review report

Date: 24 May 2016

Final Report

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Quality Review details

Background to review	The Risk-based Specialty Review for acute care common stem (ACCS) to the Princess Royal University Hospital (PRUH) site of King's College Hospital NHS Foundation Trust sought to assess the education and training environment. The visit team wanted to investigate the effects of PRUH's merger with King's College Hospital NHS Foundation Trust in 2013. Especially the relationship between the anaesthetic intensive care medicine (ICM) departments and how trainees accessed support and supervision from both consultant bodies. The visit team was also interested in the planned changes to the ICM rotas and how this would impact on the ACCS trainees' rotations in ICM. This was a salient issue as the General Medical Council was mandating that ACCS rotations in ICM were six months in duration by 2017, not the three months, that was common in southeast London. Levels of workload and the structure of rotas would also need to be assessed in all four stems of ACCS: acute medicine, anaesthetics, emergency medicine, and intensive care medicine. The General Medical Council National Training Survey 2015 (GMC NTS) raised areas that required investigation by the visit team. There were pink outliers in 'clinical supervision out of hours', 'access to educational resources' and 'feedback'. There were also two red outliers, one for 'induction' and the other in 'local teaching'. Other areas that required investigation were: the structure and process in place for reporting serious incidents and how learning points were produced, the prominence of local faculty groups and any issues regarding bullying and undermining behaviour.
Number of trainees and trainers from each specialty	The visit team met with ACCS trainees, three of which had parent stems in anaesthetics and one whose stem was in emergency medicine. The trainees had combined experiences in emergency medicine, intensive care medicine, anaesthetics and acute medicine at the Princess Royal University Hospital site. The visit team met with trainers from acute medicine, anaesthetics, acute medicine, emergency medicine, and critical care.
Review summary and outcomes	The visit team would like to thank all those who attended the ACCS visit and to the Trust for accommodating the visit so effectively. The visit team found an ACCS programme that was running well and where trainees were well support. It was pleasing to find that all trainees would recommend PRUH for ACCS training. Trainees described an environment that was supportive, friendly, and well supervised. There were training opportunities, despite the high workload and it was noted that within the emergency department consultants were especially proactive to allow trainees to complete assessments and observe procedures. There were still issues regarding the attendance of local teaching on a regular basis and attending mandatory training days, because of the high workload and the gaps within the rotas. However, the visit team was pleased to see that since the merger anaesthetic teaching had become a joint venture across the Denmark Hill (DH) and PRUH sites, which the trainees really appreciated. The visit team found that with more development the teaching and training opportunities could be fully optimised.

	The visit team found that there were areas for improvement, especially the implementation of an ACCS local faculty group. The Trust should also ensure greater consultant leadership regarding the allocation of tasks for trainees within acute medicine and ambulatory care unit, this would allow the ACCS trainees to develop a degree of autonomy and allow for consultant feedback regarding clinical care within the acute admissions setting. It was also found that feedback from serious incidents was lacking and learning from these incidents could be enhanced, with better trainee engagement. The visit team found one serious concern, although this was not thought to warrant an Immediate mandatory requirement. This entailed the ratio of patients to trainees on the intensive care unit (ICU) when the satellite beds were open. Overall, the visit team found that the training environment was good and with adjustments, trainees would be able to optimise the teaching and training opportunities available.

Quality Review Team			
Lead Visitor	Dr Claire Shannon, Head of London Academy of Anaesthesia	**External Representative**	Dr Angela Mcluckie, Joint ICM Training Programme London Regional Education Advisor
Deputy Lead Visitor	Dr Jonathan Birns, Deputy Head of London Specialty School of Medicine	**External Representative**	Dr Roger Cordery, Training Programme Director
Lay Member	Ryan Jeffs, Lay Representative	**Observer**	Dr Rachel Alder, Medical Education Fellow
Scribe	Lizzie Cannon, Learning Environment Quality Coordinator		

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
ACCS 1.1	**Patient safety** The attendees the visit team met with did not express any direct concerns relating to patient safety and all would be happy to have their family and friends treated at	

	the Trust. The visit team raised concerns regarding the number of trainees on the intensive care unit (ICU) out of hours and these trainees would be responsible for the care of eight patients but this could also be increased to 12 patients if the satellite beds were opened up. The visit team heard that this could be a frequent occurrence. This exceeded the maximum number of patients per trainee within an ICU by four. The visit team heard from the consultants that there was one higher trainee rostered on the ICU out of hours, overnight, which provided support for the acute care common stem (ACCS) trainee who was sometimes placed on intensive care medicine (ICM) overnight too. The visit team shared the concerns with the consultant body that without increased numbers of higher-grade doctors the ACCS trainees would not be sufficiently supported overnight on the ICM. This would be detrimental for patient safety and education and training. This was felt to be a salient issue as ACCS trainees would start to do increased overnight shifts on the ICU as their rotation was increasing by three months, to six months for ICM, with six months, instead of nine months of anaesthetics. The consultants reported that they had explicitly escalated these concerns to the medical director and the importance of increasing the number of higher-grade doctors within the ICU. The consultants stated they would like a workforce plan that allowed for 24/7 higher-grade presence in the ICU which could be provided through clinical fellows. The visit team fully supports the department's plan for the benefits of patient safety, education and training.	Yes, see below ACCS1.1
ACCS 1.2	**Serious incidents and professional duty of candour** The consultants informed the visit team that they actively encouraged the trainees to report serious incidents and would be provide trainees with the necessary support. The ACCS trainees corroborated this, stating, that they all knew how to report serious incidents through the Datix system and would feel comfortable reporting issues to their clinical supervisor, educational supervisor, college tutor, and department lead. The visit team heard from the consultants that there was an option on the Datix form to submit your email to address to ensure that you received feedback on the incident reported. However, the trainees stated that they did not receive feedback on the incidents they had submitted through Datix and they were unaware of any email submission option. The ACCS trainees stated that they did receive the anaesthetic department and acute medicine department's newsletter which gave an overview of serious incidents and learning points from them, but no personal feedback was given. There seemed to be a lack of learning and educational points taken from serious incidents, which could really benefit training and education. The consultants stated that for critical care they circulate the minutes of the clinical governance meetings, and the incidents were discussed at the ICU management meeting where a trainee representative was invited to attend. However, none of the ACCS trainees the visit team met with, mentioned this.	Yes, see TWR1.2 on the Trust Wide Review Report.
ACCS 1.3	**Appropriate level of clinical supervision** The trainees stated that overall, the support from consultants was good and they felt they received adequate clinical supervision. However, the trainees stated that if they were not in their parent stem specialty, they could quite easily feel lost and a little forgotten. The visit team heard that the rotas for anaesthetics and intensive care medicine for ACCS trainees were identical in routine and on call patterns. This allowed the ACCS trainee in ICM to run alongside the higher grade trainee (or trust-grade	

	equivalent doctor) in anaesthetics, as a mentor or buddy during the on call. This was an excellent initiative. The trainees did state that they felt fully supported by the plethora of consultants in the ICU. The consultants stated that all consultants on the ICU were anaesthetists by background and now worked in ICU, which meant all consultants had advanced airway skills. The consultants also assured the visit team that there was always someone on the unit who was airway skilled.	
ACCS 1.4	**Responsibilities for patient care appropriate for stage of education and training** The visit team was concerned to hear the core training grade one (CT1) ACCS trainees in acute medicine were managing the allocation of tasks for acute medicine and the ambulatory care unit.	Yes, see below ACCS 1.4
ACCS 1.5	**Rotas** The visit team heard that the workload within acute medicine was very variable. The ACCS trainees stated that some days there would only be six patients with numerous doctors on the wards. However, on other days there would be 22 plus patients and the foundation doctors would go to their teaching and the workload would become very high. The trainees stated that the consultants were aware of this issue and had begun to reallocate trainees to ensure there was a more equitable workload, through twice-daily ward rounds. The ACCS trainees raised no issues regarding the other specialty rotas, although all stated that the workload was high.	
ACCS 1.6	**Induction** The ACCS trainees stated that there was no issue with the local inductions they received. However, both the trainees and consultants stated that there were delays in receiving passwords and the information technology (IT) systems were not particularly efficient or effective. This was corroborated by other visit teams on the day of the visit.	Yes, see TWR1.5a on the Trust Wide Review report.
ACCS 1.7	**Handover** The visit team heard that when the post-take in acute medicine was very big, with patients still located in the emergency department, they had lost patients on occasions. The visit team heard that there was a large board round at 11am every day and this allocated consultants to each patient, which tried to ensure that all patients were tracked. The trainees stated that this was not always the case but that nurses on the wards were very good at phoning up and reporting lost patients. The other visit teams on the day heard similar issues of losing patients due to the lack of an electronic patient record system. The Trust senior management team stated that this would be implemented in October 2016. This item has been addressed in the Trust Wide Review report.	Yes, see TWR1.1 on the Trust Wide Review report.
ACCS 1.8	**Protected time for learning and organised educational sessions** The visit team heard that the workload in all specialties was preventing trainees from regularly attending the mandatory training days and local teaching. The visit team heard that the ACCS trainees who had a stem in anaesthetics really appreciated the one full day of local anaesthetics teaching twice a month, which alternated between the Denmark Hill (DH) site and Princess Royal University Hospital (PRUH) site and incorporated all anaesthetic trainees across the two sites. However, unlike the trainees at DH, this was not protected for the PRUH trainees	Yes, see below ACCS1.8

	and so when on call and post-nights there were minimal opportunities to attend. The trainees stated that during the initial training period, the teaching was intensive as the trainees completed the initial assessment of competencies but since October 2015 to the time of the visit, the trainees had only been able to attend four out of 14 teaching sessions. The visit team heard that while working within the emergency medicine department the ACCS trainees who had a stem in anaesthetics found it even more difficult to attend the anaesthetics fortnightly teaching because of the nature of the work of the emergency department. The visit team heard that the on-site teaching in the emergency department was not protected either but that all the consultants liked to attend teaching and this prevented it from being an issue with the nursing staff and non-training grades covering the shop floor. The visit team heard that there was weekly teaching within acute medicine, which was mainly aimed at core medical training trainees, but it was still appropriate. There were issues for the ACCS trainees in acute medicine attending the ACCS regional training days if the trainees had been working the night before. The ACCS trainees in anaesthetics reported that they could attend the novice anaesthetist course or the Membership of the Royal College of Physicians (MRCP) course and encountered no problems acquiring study leave for this. The consultants also stated that PRUH trainee attendance at teaching at DH could be increased if the Tina Chan room had video conferencing facilities to link with the facilities at the DH site.	
ACCS 1.9	**Adequate time and resources to complete assessments required by the curriculum** The visit team heard that the trainees did not think the PRUH site would not be able to offer all of the opportunities to sign off on certain criteria on the ACCS checklist because of the nature of the work at the site. The ACCS trainees stated that within acute medicine it could be difficult to sign off directly observed procedures (DOPs) in the evening because they could be the most senior doctor within the department. There were also issues with attaining acute care assessment tools (ACATs) and case based discussions (CbDs) in acute medicine because of the set-up of the acute take. However, the trainees reported no problems achieving sign off for ACATs and CbDs in the other three ACCS specialties. The emergency medicine department was described by the ACCS trainees as being very amenable and accommodating with competency sign-offs. The ACCS trainees stated that the consultants would make time to observe trainees undertaking procedures, clerking patients and assessments. The visit team was also pleased to hear that if the department was too busy, there would be time set aside afterwards to ensure sign off of assessments.	Yes, see below ACCS 5.1.

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.

ACCS 2.1	**Effective, transparent and clearly understood educational governance systems and processes** The ACCS trainees stated that there was an ACCS lead on the PRUH site but the trainees were unable to name them. The visit team heard from the trainees that there were a number of different conduits for trainees to express concerns and raise issues regarding their training and education. The trainees stated that they could attend the core medical training trainee forum to raise issues. However, the visit team was disappointed to hear that there was no specific ACCS local faculty group (LFG) either for the PRUH site or across both sites within the Trust. The visit team would strongly encourage the implementation of an ACCS LFG to ensure that specific ACCS training issues could be raised and discussed amongst trainees and consultants involved with the training programme. This would also allow a forum to share good practice and address inequities across the two sites.	Yes, see below ACCS 2.1.

GMC Theme 3) Supporting learners

Standards

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

ACCS 3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The ACCS visit team heard of no instances of behaviour which was or could be perceived as bullying and undermining, from the ACCS trainees they met in the morning of the visit. However, the visit team for the Trust Wide Review in the afternoon visit heard that although the trainees in anaesthetics, ICM and the ACCS trainees were not being bullied or undermined there was still a schism between the consultant bodies of the anaesthetic and ICM departments. This was thwarting an optimal relationship and interaction between the two departments. The visit team was concerned that it also made the trainees reticent of asking for support and help from the department's consultants they were not working in.	

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.**		
ACCS 4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The consultants confirmed that they received an allowance of 0.25 programmed activities (PAs) per trainee for their educational supervision responsibilities. College tutors were given an additional one PA for this role, but this normally entailed the consultant decreasing their clinical work accordingly. The consultants stated that they normally undertook responsibilities for education within their own time but that this was an accepted reality, which they did not mind.	
GMC Theme 5) Developing and implementing curricula and assessments		
Standards **S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.** **S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good Medical Practice and to achieve the learning outcomes required by their curriculum.**		
ACCS 5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The ACCS trainees stated that while they were in anaesthetics for nine months, they were not allowed on the on-call rota until they had completed the necessary competencies. This allowed for a lot of training opportunities, however the trainees stated that as soon as they were on the on call rota the balance between training and service took on a service bias, which was detrimental to optimising the training and teaching opportunities available. However, the rotation in anaesthetics was said to be good for training opportunities because the ACCS trainees the visit team met (three of which had parent stems in anaesthetics) stated there was little competition for training opportunities as they were commonly the most senior trainee within the department. The ACCS trainees reported that because of the nature of both emergency medicine and acute medicine there was always difficulty balancing training with service. The trainees stated that in emergency medicine, although the teaching was good, there was more emphasis on service delivery and there were not always opportunities to receive feedback on specific patients, but they did receive opportunities for the sign off of assessments. The visit team heard that within acute medicine, receiving feedback from consultants on specific patients was difficult as was presenting five patients to the same consultant for the sign-off of competencies. This was because of the structure of the acute medicine take where the large number of patients was distributed amongst five consultant ward rounds. The trainees were allocated to the consultants but because of the large number of consultants now in acute medicine there was no continuity of consultants following on from each day. ACCS trainees also reported that although they could receive good training opportunities in acute medicine 48 hours after post-take, the rest of the time they	Yes, see below ACCS 5.1.

	felt that they were treated just as a ward doctor. The majority of work they felt was purely service. The trainees stated that the high number of consultants in acute medicine was good for patient care and managing the very high number of patients who went through the department. However, it meant that the trainees were not able to access as many training opportunities and instead just followed the consultants around. The trainees stated that they got to lead ward rounds but only at the weekends and would like to be able to do more of this, like the core medical training trainees. The consultants stated that the trainees did lead on ward rounds and provided an initial patient management plan that was then reviewed by a consultant; this was the same practice for core training grade two trainees. The visit team heard from the consultants that to develop the ACCS trainees' leadership and management skills while in acute medicine they were mainly responsible for the trainee rotas. The trainees confirmed this, but stated that this involved a lot of administrative work and allocating foundation doctors to patients to cover the workload and this was inhibiting their ability to access training opportunities, such as presenting patients to consultants. The ACCS trainees reported that the ambulatory clinics were becoming increasingly busy. The clinics were supposed to close at 5pm but trainees would often stay until 7-8pm. The visit team heard from the trainees that although it was nice to patients who had, 72 hours previously, been in the acute medicine department, therefore closing the patient management loop, it was just too busy within the clinics to train, and instead felt like fire fighting cases. The consultants stated that there was always a consultant present in the clinics and that it was a useful opportunity for trainees to be exposure to outpatient management. The ACCS trainees stated that they only spent three months in the intensive care medicine and would appreciate more time within in the ICU. The time that they did spend there, they stated was good and applicable to training. The visit team was pleased to hear that there would be a change in the rotations for the ACCS trainees in southeast London so that it aligned with the other ACCS rotations in London. This would mean six months in ICM and six months in anaesthetics in the second year of the ACCS training programme. Overall, all the ACCS trainees the visit team met with would recommend the posts for training.	
ACCS 5.2	**Regular, useful meetings with clinical and educational supervisors** The visit team heard from the consultants that the educational supervisors from the trainee's parent stem would oversee the trainees' educational progress throughout the two years, but there would also be a local educational supervisor for the specialty the ACCS trainee was rotating into for the six months. The consultants stated that it was not always easy to understand the requirements of the ACCS curriculum especially in the specialties that they were not consultants in. They stated that they went to ACCS training days, but that it was still quite complex. The visit team would strongly suggest a discrete ACCS LFG where the curriculum requirements and practice can be shared amongst the faculty. All the ACCS trainees the visit team met stated that the ACCS handbook provided very useful information on the intricacies of the ACCS curriculum and navigating the online e-Portfolio. The visit team heard that the level of knowledge and understanding of the ACCS curriculum varies amongst educational supervisors and that it trainees would often rely on the previous year's cohort of trainees to better understand the requirements. The educational supervisor in emergency medicine was highlighted to the visit team as being particularly au fait with the ACCS curriculum requirements. It was reported that when ACCS trainees started their six-month rotation within the emergency department this educational supervisor would seek the ACCS trainee out and provide specific support, even if the ACCS trainee was not an EM stem. This was much appreciated by the trainees.	

Good Practice and Requirements

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
ACCS 1.1	The Trust is required to ensure that the ratio of eight patients to one trainee is maintained within the ICU, especially when the satellite beds are opened.	The Trust is required to provide a review of the number of doctors allocated to the ICU over a 24/7 hour period. This review should include a plan for increasing the number of doctors within the ICU.	R1.2
ACCS 1.4	The Trust is required to ensure that ACCS trainees are not responsible for the allocation of tasks within the acute medicine department and the ambulatory care unit.	The Trust is required to provide the ACCS LFG minutes which demonstrate that trainees are no longer undertaking inappropriate tasks.	R1.9
ACCS1. 8	The Trust is required to ensure that ACCS trainees are able to regularly attend local teaching and mandatory training days. This should be protected time within their timetables.	The Trust is required to provide all of the ACCS trainees' timetables, which show the protected time for teaching, the attendance registers for applicable teaching, and the minutes of the ACCS LFG which demonstrate trainees are able to access training and teaching regularly.	R1.16
ACCS 2.1	The Trust is required to ensure that an ACCS LFG is implemented. This could be across both sites, but must involve all trainers and trainees involved with the ACCS training programme and be held every three months, with minutes and register taken. Action points should be developed from these meetings, if issues are raised.	The Trust is required to provide the minutes, action points and register of the ACCS LFG over a 12 month period.	R2.7
ACCS 5.1	The Trust is required to ensure that ACCS trainees are able to complete adequate numbers of assessments within acute medicine and are able to develop a degree of autonomy of clinical care, patient management plans and receive regular feedback.	The Trust is required to provide an audit of the number of assessments ACCS trainees are undertaking in acute medicine and provide the minutes of the ACCS LFG which demonstrate trainee feedback, which indicates the number of assessments and quality of feedback the trainees' receive is adequate.	R5.9

Signed

By the Lead Visitor on behalf of the Visiting Team:	Dr Claire Shannon, Head of London Academy of Anaesthesia Dr Jonathan Birns, Deputy Head of London Specialty School of Medicine
Date:	12 July 2016