QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

# St George's University Hospitals NHS Foundation Trust

## Risk-based Review (Education Lead Conversation)

## Quality Review report

**19 October 2016**

**Final Report**

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# Quality Review details

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| **Training programme / Learner group** | Rheumatology core and higher trainees |
| **Background to review** | The education lead conversation was initiated by the Head of School of Medicine at Health Education England.<br><br>The reasons behind this were threefold:<br><br>• To assess the interface between the general internal medicine post (GIM) with the rheumatology post, and understand how the GIM post had been incorporated into the rheumatology post<br>• To look at the balance between GIM and Rheumatology experience<br>• To explore rota design and the workload in Rheumatology<br>• Finally, to ascertain how much referral work trainees were dealing with in conjunction with their other responsibilities and how this was supervised. At the time of the review, there were three training posts at the Trust, two pure rheumatology and one high intensity GIM<br><br>The aforementioned issues formed the basis for the education lead conversation that was carried out between the Head of School, the training programme director for North West Thames (external) and the education leads at the Trust. |
| **HEE quality review team** | Dr Karen Le Ball, Head of School of Medicine, Health Education England<br><br>Dr Henry Penn, Training Programme Director, London North West Health NHS Trust<br><br>Nimo Jama, Quality Support Officer, Scribe |
| **Trust attendees** | Dr Jonathan Round, Director of Medical Education<br><br>Dr Patrick Kiely, Consultant Rheumatology Lead<br><br>Dr Virinderjit Sandhu, Consultant<br><br>Dr Katie Moss, Consultant<br><br>Dr Arvind Kaul, consultant<br><br>Dr Helena Robinson, Consultant<br><br>Dr Joao Albuquerque, Consultant in Acute Medicine Unit & Nephrology<br><br>Joseph Pavett-Downer, Medical Education Manager |

**Conversation details**

| GMC Theme | Summary of discussions | Action to be taken? Y/N |
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| | **Rheumatology interface with GIM**<br><br>The quality review team was given some documents outlining the responsibilities of the rheumatology trainees covering general internal medicine as part of their rotation. The workload in GIM was of reasonable intensity and it appeared it had been | |

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| | effectively incorporated into one of the rheumatology posts. The quality review team wanted to establish what this meant for the rheumatology trainees, and what structures were in place to support them. The consultant rheumatologists themselves no longer participated in the on-call GIM rota and their ward base was the domain of the geriatricians (on the whole).<br><br>The GIM/rheumatology post appeared to be working better and it was confirmed that the trainee had one educational supervisor for GIM and one for rheumatology. The quality review team was informed that the feedback from the trainees had been varied over the years often fluctuating from positive to negative. However, of late this had improved (according to the department) | |
| R1.12 | **Rota**<br><br>The distribution of the workload between GIM and rheumatology particularly in the post which was supposed to be low intensity medicine had historically been overloaded by GIM. This had now been removed entirely from that post so although that had solved the problem of intensity there did still need to be exposure to GIM. The consultants had developed some interesting training opportunities particularly in clinic where the trainees were supervised and had the opportunity to see new complex patients and on a large 'professorial' style ward round. In the months prior to the education lead conversation the timetables for the two pure rheumatology trainees had been reduced from five to four clinics which had brought about improvements and flexibility, freeing up some of the trainees' time. The quality review team was informed that there was no rheumatology service out of hours and the trainees were able to leave the Trust in good time as there was no habitual staying late in the department.<br><br>**Bleep System**<br><br>There was a rota of when the Rheumatology trainees carried the bleep for referrals. This task was supervised by a consultant and the consultant held the bleep if the doctor was away or had GIM/clinic responsibilities.<br><br>The educational leads emphasised that the referrals coming through bleeps were increasing in number (ranging from one to ten per day), many queries could be dealt with over the telephone. | |
| R2.11 | **Clinical Supervision**<br><br>The education leads informed the quality review team that trainees were all well supervised. There was a 'consultant of the month' system and the trainees could go to this consultant for advice with regards to patient care at any time.<br><br>In outpatient clinics, it was reported that there were clear lines of responsibility where consultants dealt with all new patient lists and trainees seeing new referrals had the opportunity to discuss them with the consultant in the clinic. Community clinics only ran when there was a consultant present. For general outpatient clinics some of the consultants reported that they had implemented a vetting process where they themselves would review every clinic list in advance to ensure that appropriate patients (and numbers) to be on the trainees' lists.<br><br>**Referrals system** | |

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| | The education leads confirmed that there had been a significant increase in in patient referrals to the department which had been largely dealt with by the higher trainees. This involved a lot of telephone calls where the higher trainees were expected to give advice over the phone; for urgent cases; they were expected to see the patient within 24 hours.<br><br>The cases that were presented were variable in complexity and quality but it but nonetheless if trainees needed advice consultants were available. The education leads noted their availability to the trainees in this respect as well stating that they often dealt with questions from core trainees who were less confident and wanted to seek consultant advice. Higher trainees were reported to be more confident but the education leads emphasised that it was often the clinical supervisors themselves who approached the trainees to ensure that they had no concerns.<br><br>**Educational Supervision**<br><br>The quality review team heard that there was a 'rolling system' in place in terms of educational supervision responsibilities. Each of the consultants in the department would take it in turn to be an educational supervisor to the three trainees in post. There were no concerns reported in this respect and it was noted that there were adequate measures in place to carry out educational supervision due to the low number of trainees in the rheumatology department. They were trained in educational supervision but some said they had no specific blocks of time allocated in their job plan for this role. | |
| R1.6 | **Local faculty group meeting and feedback**<br><br>The education leads informed the review team that they had received feedback from trainees via different channels, such as the annual review competency progression (ARCPs) and from local faculty group (LFG) meetings in regards to their training at the Trust, therefore the results of the GMC NTS were not unexpected. The faculty meeting had been embedded for two and a half years.<br><br>Of late in the feedback it had become apparent that the trainees expressed desire for their post to be rheumatology focused and less focused on general internal medicine. This had been listened to and addressed but there still needed to be some exposure to GIM in one of the pure rheumatology posts.<br><br>The education leads reported that there had been a service reconfiguration within the department three to four years earlier. At this time decisions had been made to make one of the trainee posts purely rheumatology focused and the other two posts un-banded. | |
| | **AOB**<br><br>The HEE quality review lead gave the educational leads the opportunity to feedback on what they thought could be improved in the department in terms of education and training.<br><br>The leads stated that there already had been many improvements, including the phasing out of one clinic per week from the beginning of October 2016 which had been fundamental as it allowed the trainees to free up some time, giving them the opportunity to complete projects.<br><br>Three other areas were highlighted: the educational leads cautioned that the quality of the training could deteriorate if trainees were not rotating to GIM. Firstly, they felt that trainees would lose the benefit of dual accreditation which they felt was required in many medicine jobs. Considering that clinics had been reduced, the education leads felt that future trainees would struggle if they progressed to consultant positions where | |

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| | the first years of their post required taking responsibility for five clinics a week. They shared a concern that as a result of a reduction on workload it was feasible that it would be a shock to them when they became consultant as to what was actually required it.<br><br>The education leads suggested that the training programme director (TPD) should carefully consider the strengths of the department when deciding where to place trainees. It was stated that St George's Hospital University Hospitals NHS Foundation Trust could be an excellent training ground provided that the 'right type' of trainee was placed in the rheumatology post. The review team heard that more junior trainees at (year three trainees for example )may not be in a position to gain the most from being in a complex rheumatology posts at the start of their higher specialty training<br>The review team explained to the department that the TPD was carefully selective about where the trainees in the region were placed but occasionally due to logistical reasons with many influences such as OOPs recruitment, maternity and accommodation of KSS trainees more junior trainees would need to be placed at the Trust. The Head of School was of the view, however, that trainees should be placed in a post which was most likely to meet with their training needs but due to the logistic issues listed above there could not always be a perfect alignment and it was up to the training site to ensure they met the trainees' needs the best way they could.<br><br>At the time of the review, the quality review team heard that there were six consultants providing 4.8 WTE sessions in post, though some were part time. The education leads stated that the department could benefit from an extra consultant. | |

**Next steps**

| Conclusion |
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| The quality review team felt that the rheumatology department at the Trust offered good training opportunities in rheumatology and GIM. Since concerns had been raised about the intensity of work (both in GIM and rheumatology) the department had been making efforts to address these with good effect. However, there did still need to be some exposure to GIM for one of the higher trainees which currently did not occur; therefore, the quality review team suggested that measures needed to be taken to consider how to implement this without jeopardising the considerable progress the Trust had already made. |

**Requirements / Recommendations**

| Mandatory Requirements | | | |
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| **Req. Ref No.** | **Requirement** | **Required Actions / Evidence** | **GMC Req. No.** |
| 1.12 | Consider measures to introduce some low intensity GIM to one of the higher specialty posts | Submit an action plan explaining how the Trust intends to address this issue. We suggest that some discussion with the TPD would be helpful. | |

| Other Actions (including actions to be taken by Health Education England) | |
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| **Requirement** | **Responsibility** |

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| **Signed** | |
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| **By the HEE Review Lead on behalf of the Quality Review Team:** | *Dr Karen Le Ball* |
| **Date:** | *16 November 2016* |

**What happens next?**

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.