QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

King's College London NHS Foundation Trust

Neurology and Stroke

Risk-based Review (on-site visit)

Quality Review report

2 March 2017

Final Report

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Quality Review details

Background to review	The purpose of the risk-based review (on-site visit) to neurology and stroke at King's College Hospital NHS Foundation Trust was manifold. Firstly, the quality review team was keen to explore the red outliers generated within neurology in the General Medical Council National Training Survey (GMC NTS) in 2016 for 'overall satisfaction', 'reporting systems', 'handover' and 'supportive environment'. Additionally, the quality review team wanted to review the following areas: • Explore if trainees had adequate experience in the department and received access to varied learning opportunities. • Determine if there was sufficient on-call cover during the weekends and explore potential rota gaps. • Explore if there was sufficient consultant supervision for all trainees within the department. Regarding stroke, the quality review team was keen to follow up on the areas of improvement required from the review of stroke medicine that took place in May 2016 and review the Trust's progress with open actions. Moreover, the quality review team was keen to explore the following areas: • Explore the issues highlighted within the Health Education England (HEE) Pan-London stroke survey. • Determine if trainees were able to complete their workplace-based assessments (WPBAs).
Training programme / learner group reviewed	Neurology and Stroke
Number of learners and educators from each training programme	The quality review team met with eleven trainees in neurology, at the following grades: • Core training year 1 (CT1), • Core training year 2 (CT2), • Specialty training year three (ST3), • Specialty training year four (ST4), • Specialty training year five (ST5), • Specialty training year seven (ST7), • Clinical fellows. The quality review team also met with thirteen trainees in stroke, at the following grades: • Core training year 1 (CT1), • Core training year 2 (CT2), • Specialty training year three (ST3), • Specialty training year four (ST4), • Specialty training year five (ST5), • Specialty training year six (ST6), • Specialty training year seven (ST7), • Junior clinical fellows. The quality review team met with the following educators: • Deputy director of operations, • Clinical Lead for stroke,

	• Clinical lead for Neurology, • Training programme director (TPD) for neurology, • TPD for core medical training (CMT), • Education lead for CMT, • Education lead for stroke, • Education lead for neurology, • Educational supervisors.
Review summary and outcomes	Health Education England would like to thank the Trust for accommodating the risk-based review. During the course of the review, areas that were working well with training at the Trust were identified as follows: • The quality review team heard that a daily stroke post-take handover meeting had been introduced at 8.30am, which was attended by radiologists and hyperacute stroke unit (HASU) consultants. • The trainees in stroke reported that consultant-led teaching had recently been introduced on Tuesday lunchtimes. • There was a combined neurology and stroke local faculty group (LFG) meeting, which included trainee representation. • The quality review team heard that the training programme director (TPD) for neurology had sought trainee involvement in trying to resolve the issues identified in the 2016 GMC NTS. • The trainees reported that supervision within the motor neurone disease (MND) and muscle clinics, and a general neurology clinic at the Princess Royal University Hospital site was very good. Additionally, a consultant was complimented on their enthusiasm and dedication to training when completing workplace-based assessments (WPBAs) on the epilepsy unit. However, various concerns were raised regarding the neurology and stroke training at the Trust, including one area of serious concern as the quality review team was made aware of outpatient clinics being run by higher trainees with no consultant supervision or attendance. Of particular note, the panel was informed of an acute neurology clinic run in this fashion that required immediate rectification. Additional concerns were identified as follows: • The quality review team heard that the local induction for both neurology and stroke was insufficient for their requirements. The trainees in stroke reported that the thrombolysis out-of-hours arrangements were not covered adequately in the induction. • The trainees reported that they had no opportunity to attend stroke clinics at the site. • The trainees informed the quality review team that whilst a pathway for the management of stroke mimics had been introduced, adherence to it was sporadic and could increase their workload substantially and inappropriately. • The stroke trainees reported that at times, their workload could be overwhelming. • Some of the trainees advised that they had had to share login details with other trainees to access the online referral system, which appeared to have been resolved by the time of the review. The Trust must ensure that this is not still happening. • The quality review team heard that some of the core trainees in neurology were asked to undertake lumbar punctures for private patients when they should have been attending teaching sessions.

Quality Review Team			
HEE Review Lead	Dr Jonathan Birns, Deputy Head of London Specialty School of Medicine	**External Clinician**	Dr Anthony Pereira, Consultant Neurologist, St George's University Hospitals NHS Foundation Trust
Trust Liaison Dean/County Dean	Dr Anand Mehta, Deputy Postgraduate Dean, Health Education England	**Trainee Representative**	Dr Samuel Shribman, Neurology Trainee and Member of British Association of Stroke Physicians Trainee Committee, St George's University Hospitals NHS Foundation Trust
Lay Member	Ryan Jeffs, Lay Representative	**Scribe**	Kate Neilson, Learning Environment Quality Coordinator, Health Education England

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services.

1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.

Ref	Findings	Action required? Requirement Reference Number
N&S1.1	**Patient safety** The quality review team heard from all of the trainees in both neurology and stroke that they did not have any concerns regarding patient safety.	
N&S1.2	**Serious incidents and professional duty of candour** Neurology	

	The quality review team was informed by the trainees in neurology that they were aware of how to report incidents and that they had completed an online training module which covered this. However, these trainees noted that they did not receive formal feedback following reporting incidents but that there was a monthly neuroscience governance meeting, where all reported serious incidents were discussed. Following these meetings, the minutes were disseminated to the department. However, it was noted that whilst incidents were discussed, there did not appear to be a drive to resolve recurrent issues. Stroke The trainees in stroke advised that they were aware of how to escalate concerns.	Yes. See ref N&S1.2 below.
N&S1.3	**Appropriate level of clinical supervision** Neurology The quality review team heard from the higher trainees in neurology that regarding outpatient clinics, consultant supervision was sometimes lacking and consultants did not regularly review patients. These trainees noted that this was a lost learning opportunity for them. Furthermore, there was no consultant supervision or attendance at some clinics, including acute neurology clinics. It was noted that whilst the deep brain stimulation (DBS) clinics were consultant-led and consultants saw every patient in these clinics, the follow-up movement disorder clinics were completed by the higher trainees without consultant oversight. The higher trainees advised that during these clinics, the senior clinical fellow was available to provide advice, if required. However, some of the higher trainees expressed concern that they would not be able to complete adequate numbers of WPBAs for sign-off regarding movement disorder clinics. It was noted that it was possible that trainees could complete an attachment in clinic without ever meeting the supervising consultant. Stroke The higher trainees in stroke advised that there was always a consultant available to provide advice, either face-to-face or over the phone. Regarding transient ischemic attack (TIA) patients, the higher trainees advised that their training around this was informal in nature. The service was well organised and that there were never too many patients to review at any one time but the higher trainees reviewed TIA patients alone without Consultant supervision. Trainees knew that consultants were always available to provide advice, if needed. It was noted by the trainees that they knew who the responsible consultant was as it was the consultant covering the HASU. There was a daily consultant ward round on the HASU. The core trainees in stroke covered the TIA service when the higher trainees were busy. The quality review team was informed that all trainers in neurology and stroke had completed appropriate accreditation to be educational and clinical supervisors and that the Trust would provide evidence of this to HEE.	Yes. See ref N&S1.3a below. Yes. See ref N&S1.3b below.
N&S1.4	**Responsibilities for patient care appropriate for stage of education and training** Neurology The higher trainees in neurology reported that there were times when they felt out of their depth due to the lack of regular consultant presence. The higher trainees in neurology advised that when on the out-of-hours rota, they cross-covered stroke and that there was always a consultant available to provide support. Regarding thombolysis, these trainees reported that they did not have a formal induction or specific training (unless they had done the stroke job) before doing their first on-call shift. Stroke The quality review team heard from the higher trainees that there did not appear to be a comprehensive system in place for checking trainees' competence in	Yes. See N&S1.4 below.

	providing thrombolysis and this was not adequately covered within the local induction. Regarding the HASU, whilst trainees received good experience within emergency aspects of stroke, their training was much poorer in learning how to discharge plan.	
N&S1.5	**Rotas** Neurology The core trainees in neurology advised the quality review team that their responsibilities were largely ward-based and that during the day, there was a stroke as well as a neurology trainee on the rota but at night, there was only one core trainee. It was noted that the busiest time for these trainees was between 5pm and 8.30pm when patients were admitted. The nightly workload was reported to be manageable. Furthermore, the core trainees in neurology advised that their training experience could have been improved if there was more of a balance between their responsibilities for stroke and acute neurological patients. Moreover, as the majority of neurology patients were stable, these trainees felt that they were not getting sufficient experience of managing acutely unwell patients. The quality review team heard from the higher trainees in neurology that they had recently submitted a proposal to change the structure of their rota as the substantial lack of continuity from one week to the next had become problematic. These trainees advised that whilst the team structure worked well on the wards, there was little continuity in terms of outpatient clinics. Furthermore, the higher trainees in neurology noted that the acute neurology workload was often heavy and that when covering the emergency department, they covered an emergency neurology clinic based in the admissions unit on Tuesday and Thursday afternoons. Whilst the on-call consultant was reported to be available on the phone, the higher trainees otherwise completed the clinic unsupervised. Furthermore, these trainees advised that although there were only four clinic slots at this clinic, it could be difficult to complete it without being interrupted by telephone calls. Regarding other clinics, the higher trainees in neurology reported that there were good training opportunities available, especially in the MND, muscle and multiple sclerosis clinics. However, when there were rota gaps or other trainees on annual leave, this specialist clinic experience was compromised and as a result, they felt that their sub-specialty experience was being diluted by the acute neurology workload. These trainees noted that they had raised this issue at a recent meeting. Regarding reporting of stroke scans overnight, the higher trainees advised that the higher trainees in radiology reported on these if urgent. Otherwise scans were sent to Medica and usually received a response within an hour. Furthermore, scans were discussed at the daily 8.30am meeting which was attended by the radiology team as well as HASU consultants. Stroke The quality review team heard from the higher trainees in stroke that there were three trainees on the rota and their duties included covering the wards, as well as the TIA service and the acute referrals within the emergency department (ED). Whilst there was meant to be a third higher trainee on the rota whose duties included attending clinics and surgical lists, this rarely happened in practice due to nights, post-nights and annual leave. As a result, these higher trainees reported that as the ward and ED duties (especially when carrying the thrombolysis bleep) were so time-consuming, they were rarely able to attend clinics or meetings. Furthermore, there were no stroke clinics rostered on the higher trainee rota. Regarding the out-of-hours rota, the higher trainees in stroke advised that there were regular rota gaps, which they felt they had identified sufficiently in advance to allow suitable action to be taken. However, the rota was subsequently distributed with gaps on it and these trainees were frequently asked to cover shifts at short notice. The situation had been going on for over a year and had been brought to the attention of consultants and managers. This issue had been discussed at departmental meetings and the clinical director subsequently agreed to pay for	Yes. See N&S1.3a below. Yes. See N&S1.5a below. Yes. See ref N&S1.5b below

	locums to cover these shifts. However, the locum rate was relatively low so it was hard to find locums willing to cover the shifts. The core trainees were required to provide thrombolysis cover when higher trainees were unavailable. From a previous visit, the Trust had been mandated to provide a clear and robust pathway for patients who were identified in the ED as having a non-stroke pathology. The trainees advised that the Trust had produced a pathway but that it was not always adhered to and could not be considered as robust. It was noted that when working out of hours, dealing with stroke calls, mimics and receiving phone calls from other EDs were the duties that were most time-consuming.	
N&S1.6	**Induction** <u>Neurology</u> The quality review team heard that whilst the majority of trainees at all levels received a Trust induction, in most cases there was no local induction. Moreover, those trainees who had received a local induction advised that it did not adequately cover practical considerations such as access to the electronic referral system. It was noted that some of the trainees had to share logins to this system when they first started the placement, as they were not given their own logins. Whilst trainees had provided feedback regarding the local induction and how it could have been improved, these changes had not been implemented. <u>Stroke</u> The higher trainees in stroke advised that those who had commenced placement more recently had received a local induction but they were not given the relevant handbook, although it was noted that this was available on the Trust's intranet. In other words, the information was available but had not been adequately disseminated or signposted to the new employees. However, it was noted by the trainees that the out-of-hours thrombolysis arrangements were not covered sufficiently in the induction and that those who had not done it before did not feel prepared to cover it unsupervised at night. This had been identified as a significant issue in the previous visit. It was not clear at the time of the risk-based review (on-site visit), whether it had been tackled successfully.	Yes. See ref N&S1.6 below. Yes. See ref N&S1.4 below.
N&S1.7	**Handover** <u>Neurology/Stroke</u> The quality review team heard that a daily post-take handover meeting had been introduced at 8.30am, which was attended by radiologists and HASU consultants. This was a clear improvement from the previous visit and whilst it had not been in place for very long, was seen by the trainees as a success already.	
N&S1.8	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** <u>Stroke</u> The core trainees in stroke reported that the teaching opportunities were good on the stroke unit and that they received appropriate supervision and autonomy there, as well as opportunities to gain experience on the HASU.	
N&S1.9	**Protected time for learning and organised educational sessions** <u>Neurology</u> The core trainees in neurology informed the quality review team that on the whole, they were able to attend the teaching sessions and that they could give their bleeps to another member of staff (although they did not all do so). However, some of these trainees noted that they could be asked to undertake lumbar punctures for private patients prior to the teaching sessions, which meant that they were not able to attend the teaching. The quality review team heard from the higher trainees in neurology that their teaching sessions did not always take place due to the issues with the rota. <u>Stroke</u>	Yes. See ref N&S1.9 below.

	The quality review team heard that in the previous few weeks prior to the risk-based review, there had been consultant-led teaching on Tuesday lunchtimes. It was noted that a training lead within stroke had recently been appointed.	
N&S1.10	**Adequate time and resources to complete assessments required by the curriculum** Neurology The quality review team heard from the core trainees in neurology that whilst they were able to get WPBAs signed off by higher trainees, it was harder to obtain sign off from consultants. These trainees also noted that that it was sometimes difficult to get acute care assessment tool (ACATs) signed off. The higher trainees in neurology reported that it could be difficult to get ticketed assessments signed off and that they often had to send them to some consultants more than once, which they noted was time consuming. Stroke The core and higher trainees in stroke advised that they were able to get WPBAs signed off.	Yes. See ref N&S1.10 below.

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity.

2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.

2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.

N&S2.1	**Effective, transparent and clearly understood educational governance systems and processes** The quality review team heard that there was a local faculty group (LFG) meeting which included representation from neurology and stroke trainees. However, it was not well advertised and it was noted that not all stroke trainees were aware the LFG existed.	
N&S2.2	**Impact of service design on learners** Neurology The quality review team was informed by the trainees in neurology that they would be happy for their family to be treated for neurological disorders at the site. Stroke The trainees in stroke advised that although there was a stroke mimic pathway for patients within the ED, this was not always adhered to. Furthermore, relations with ED colleagues could be difficult and ownership of these patients was often an issue. It was noted that if triage for stroke calls was improved, it would make the trainees' workload more manageable. The quality review team was informed by the trainees in stroke that they would be happy for their family to be treated at the site. Furthermore, whilst they would	Yes. See ref N&S2.2 below.

	recommend the post to a colleague at core trainee level, some of the higher trainees would not do so due to the lack of clinic experience at the site.	

3. Supporting and empowering learners

HEE Quality Standards

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.

3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.

N&S3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The quality review team heard from the trainees in neurology that there had been instances of obstructive and sometimes undermining behaviour from colleagues within the emergency department (ED). However, it was noted that the situation had recently improved due in part to the appointment of a consultant liaison. The trainees in stroke concurred that interactions with ED colleagues could be difficult but they did not raise any issues with undermining behaviour.	

4. Supporting and empowering educators

HEE Quality Standards

4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.

4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.

N&S4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The educational supervisors confirmed that they received time within their job plans for their supervision duties. It was noted that the education leads did not have educational supervision responsibilities for trainees.	
N&S4.2	**Access to appropriately funded resources to meet the requirements of the training programme or curriculum** The quality review team heard from the educational supervisors that whilst they had not had a meeting to discuss their responsibilities for the new junior doctors' contract, some had completed an on-line training module on this.	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.

5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.

5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.

5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.

N&S5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** Neurology The trainees in neurology advised that whilst they completed a professional development plan at the beginning of their placement, their progress against the plan had not been reviewed since that time. Whilst these trainees noted that their educational supervisors were helpful for signposting them to opportunities within their specialist area, it was harder to obtain similar information about other sub-specialty opportunities in the department. It was noted that at the time of the risk-based review, the core and higher trainee hand books had been updated but had not been circulated to the trainees as they were awaiting review by a higher trainee.	

Good Practice and Requirements

Good Practice
N/A

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
N&S1.3a	The quality review team was made aware of outpatient clinics being run by higher trainees with no consultant supervision or attendance. Of particular note, the panel was informed of an acute neurology clinic run in this fashion that requires immediate rectification.	Plans to be put in place within five working days to rectify the situation.	R1.8

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
N&S1.2	The Trust is required to review and strengthen the engagement of the trainees in the serious incident process. The Trust to ensure that all trainees who submit Datix reports receive feedback, including details of how the issue has been dealt with.	Trust to provide summary of feedback to trainees versus a log of Datix forms submitted by trainees. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where feedback from Datix reports is discussed.	R1.3
N&S1.3b	The Trust must ensure that all trainers in neurology and stroke have completed appropriate accreditation to be educational and clinical supervisors and are conversant	Trust to provide evidence that all trainers in neurology and stroke have completed appropriate accreditation to be educational and clinical supervisors.	R4.1

	with their responsibilities regarding the new contract.		
N&S1.4	The Trust is required to formalise the thrombolysis training for trainees in both neurology and stroke, prior to their first on-call shift where they will have responsibilities for thrombolysing patients. Additionally, thrombolysis should be covered in the local induction.	Trust to confirm how they plan to formalise the thrombolysis training. Furthermore, the Trust should provide updated induction material, which clearly shows that thrombolysis arrangements will be covered within the local induction.	R1.12
N&S1.5a	The Trust is required to revise the rotas to ensure that trainees in stroke attend regular clinics, relevant to their stroke training.	The Trust to submit copies of the revised rotas for stroke trainees, which clearly indicates access to clinic lists. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings, at which there is trainee representation, where access to clinics is reported over a three-month period.	R1.12
N&S1.5b	The Trust must provide evidence of up-to-date out-of-hours on-call stroke/neurology rotas without gaps.	Compliance with this action should be demonstrated through provision of three consecutive months of out of hours on-call stroke/neurology rotas without gaps and LFG meeting minutes and trainee feedback documenting that the process has been adhered to.	R1.12
N&S1.6	The Trust must ensure that a local induction is provided for any trainee starting any post at any time of year. The departmental induction must be sustainable, of high quality and must include: • orientation and introductions, • details of rotas and working patterns, • clinical protocols, • working computer logins.	Trust to confirm, via a survey of trainees, that each trainee has received an induction and that this was considered fit for purpose. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where induction is discussed.	R1.13
N&S1.9	The Trust must ensure that core and higher trainees are able to attend teaching sessions and should not be required to complete other duties; including attending to private patients at the same time as these sessions.	Trust to submit copies of communications sent to the consultant body advising them that trainees should be able to attend teaching sessions. (I think there is a paper on our expectation of trainee involvement in managing private patients) Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where attendance at teaching sessions is discussed.	R1.12
N&S1.10	The Trust must ensure that core and higher trainees in neurology receive timely sign-off of WPBAs from consultants.	Trust to submit copies of communications sent to the consultant body confirming their responsibilities for signing off WPBAs. Compliance with this action should be monitored through LFG meetings. The	R1.18

		Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where sign-off of WPBAs is discussed.	
N&S2.2	The Trust is required to ensure that the new policy of managing non-stroke pathology in ED is adhered to. There should be a reporting system in place so that trainees can let their supervisors know when they have faced difficulties with implementing these policies and the supervisors should deal with this issue at a higher interdepartmental level. There should be some formal monitoring of the workload of trainees especially when two of the three ward stroke higher trainees are away, to avoid the remaining trainee being overwhelmed.	Compliance with this action should be monitored through LFG meetings and trainee feedback. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where evidence of a robust stroke mimic pathway and stroke trainee workload is reported.	R2.3

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
	N/A		

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

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Jonathan Birns
Date:	28 March 2017

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.