QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

King's College Hospital NHS Foundation Trust (King's College Hospital)

Acute Care Common Stem

Risk-based Review (focus group and education lead conversation)

Quality Review report

20 June 2017

Final Report

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Quality Review details

Background to review	Due to less than favourable results in the General Medical Council National Training Survey (GMC NTS) 2016, the Head of London Academy of Anaesthesia requested an education status report from King's College Hospital NHS Foundation Trust, where education leads were asked to produce responses to a series of questions relating to the learning environment or learner experience. It was felt that the issues were predominantly at King's College Hospital. Due to a non-satisfactory response from the Trust, the Head of London Academy of Anaesthesia requested to delve into the issues further by conducting a risk-based review (focus group). The following pink outliers were highlighted in the GMC NTS 2016: • Overall supervision • Clinical supervision • Clinical supervision out of hours • Adequate experience • Supportive environment • Feedback The last review to King's College Hospital NHS Foundation Trust (Princess Royal University Hospital) had taken place on 24 May 2016 where acute care common stem (ACCS) was reviewed. There were two mandatory requirements still open from this review, relating to workload preventing trainees from attending mandatory training and relating to receiving feedback and signing off competencies.
Training programme / learner group reviewed	Acute Care Common Stem (King's College Hospital)
Quality review summary	The review team identified the following areas that were working well: • All the trainees attended a Trust induction with no issues reported around IT access. The local inductions to anaesthetics and the emergency department (ED) were particularly valued. • Anaesthetics training was well regarded with no issues reported and the trainees would recommend the placement. They particularly valued the buddying up and shadowing period prior to them joining the rota. Overall they felt extremely well supported. • In acute medicine (AM) the trainees recognised the tremendous case mix presented to them by working at King's College Hospital. • In the ED the trainees reported that there was no pressure for them to exceed their working hours despite the high workload pressure. The review team also identified the following areas of serious concern: • The review team heard that some ACCS trainees in AM had been pressurised to act up as medical higher trainees. The review team heard of at least three occasions during both the day and night where this had occurred.

- Trainees reported they had submitted DATIX reports but there was no feedback provided to any of them despite some trainees specifically requesting it.

The review team also noted the following areas for improvement:

- In intensive care medicine (ICM) it was reported that handover time was not incorporated within trainees' working time. The review team heard from trainees that they were spending at least one hour post shift handing over.
- In acute medicine the work was seen by trainees as predominantly service provision with limited teaching on ward rounds.
- The review team heard that there was confusion around the provision of supervisors in AM coupled with a lack of understanding of the ACCS curriculum.
- The involvement of ACCS AM trainees in local teaching opportunities was variable and not bleep free.
- ACCS AM trainees reported that there was a limited opportunity for performing procedures due to the intense competition with other grades. Despite coming in on their leave days there were occasions where trainees were still unable to complete them.
- There generally seemed to be a lack of engagement in AM in facilitating workplace-based assessments (WPBA) for trainees.
- The arrangements for the post-take handover in AM were not consistent and left the trainees confused as to their roles and responsibilities.
- In ED and AM it was reported that ACCS trainees were being disadvantaged in accessing training opportunities, for example shifts in the resuscitation (resus) area, and being moved to fill rota gaps. Overall the trainees in both ED and AM did not feel valued.

Quality Review Team			
HEE Review Lead	Dr Cleave Gass, Head of London Academy of Anaesthesia	**External Clinician**	Dr Roger Cordery, Training Programme Director for North Central and North East London ACCS, Barts Health NHS Trust
Trust Liaison Dean/County Dean	Dr Anand Mehta, Trust Liaison Dean, Health Education England	**External Clinician**	Dr Rocio Santamaria, Emergency Medicine Consultant, Guy's and St Thomas' NHS Foundation Trust
		Scribe	Matthew Howard, Quality Support Officer, Health Education England London and the South East

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
A1.1	**Patient safety** No specific examples of patient safety concerns were reported and trainees stated that they were aware of where to find the information should they require an incident to be reported.	
A1.2	**Serious incidents and professional duty of candour** Several trainees reported that they had submitted DATIX reports both via their clinical supervisor and local consultant but there was no feedback provided to any of them despite some trainees specifically requesting it. The review team heard from one of the core year one anaesthetics trainees that they were on the serious incident (SI) committee as a trainee representative and that the committee, which would meet twice a month, would be launching an SI newsletter to be distributed to the 'junior doctors'. This was in conjunction with the head of patient safety and although this would not feedback on individual DATIX incidents, it would provide general learning points. This information would be cascaded via the Trust intranet initially on a quarterly basis and then subsequently by e-mail.	Yes – see A1.2 below
A1.3	**Responsibilities for patient care appropriate for stage of education and training** It was reported by one of the AM trainees that, only six weeks into the rotation, they had been actively pressured into acting up as a medical higher trainee. The review team heard of at least three occasions during both the day and night where this had occurred. One of the anaesthetics ACCS trainees reported that they had been asked to cover the clinical decision unit (CDU) being reallocated from majors and resus shifts on a regular basis whilst on the emergency medicine (EM) which was felt by the trainee to be an unreasonable request, as the perception was the other doctors in the emergency department (ED) were not being asked to do this on such a frequent basis.	Yes – see A1.3 below
A1.4	**Rotas**	

	The trainees stated that they acted in a supernumerary capacity in their initial 'novice' period with good consultant supervision in anaesthesia. During the first three months, the review team heard that when on call they would be buddied up with a higher level trainee. The trainees also reported that prior to starting night shifts they were provided the opportunity to shadow colleagues over a number of night shifts before being taken off the 'novice' rota which they felt was extremely useful. The trainees in AM agreed that during their first year the level of service provision was heavy and consequently this resulted in them have a limited opportunity for learning. One of the ED trainees reported that during their time in AM post-acute care, they had been allocated to both a diabetic foot and a medical outlier ward which they did not consider offered a training experience particularly relevant to their curriculum, but they did state that the respiratory experience they had received had been very useful. The review team heard from the trainees working in the ED that as there was no differentiation between them and the trust clinical fellows, they would find that they were just incorporated into the junior clinical fellow (JCF) and Trust grade doctor rotas, with little recognition of their roles and expectations.	
A1.5	**Induction** All the trainees attended a Trust induction with no issues reported around IT access. The local inductions to anaesthetics and the ED were particularly valued. The ED induction was particularly singled out by trainees, having taken place over three days, with trainees split out by training levels, and was very well organised and thorough in nature with a really good tour of the department. SIs were highlighted and it was explained to trainees how protocols had changed as a result of the lessons learnt.	
A1.6	**Handover** In intensive care medicine (ICM) it was reported that handover time was not incorporated within trainees' working time. The review team heard from trainees that they were spending at least one-hour post shift handing over and this could increase to one hour and 30 minutes during the consultant-led handovers on a Monday and Friday. The arrangements for the post-take handover in AM were not consistent and left the trainees confused as to their roles and responsibilities. One example provided by the trainees related to a lack of clarity around what time they were required to take responsibility for patients transferred to an outlying ward and this in turn could ultimately lead to a lack of ownership.	Yes – see A1.6 below
A1.7	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The review team heard from one of the specialty training year one (ST1) trainees in EM that during their AM rotation they had been allocated to the cystic fibrosis ward which they felt was too niche an area and it did not deliver much in terms of a learning experience; they stated for example, that much of the work was of a heavy administrative nature such as trawling through historical results and this was coupled with a lack of direction from the supervising consultants.	Yes – see A1.7 below
A1.8	**Protected time for learning and organised educational sessions** Trainees in acute medicine stated that local teaching did take place and this was carried out on a Friday lunchtime between 13.00 – 14.00 but this was not protected or bleep free. It was also reported to the review team that full day training sessions took place every two weeks for anaesthetics trainees, alternated between King's College Hospital and the Princess Royal University Hospital (PRUH) and all trainees had the opportunity to attend. After the initial 'novice' themed sessions, the training sessions would subsequently be offered as a joint teaching opportunity with the higher level trainees.	

A1.9	**Access to simulation-based training opportunities** The review team heard from one of the ST2 trainees that in anaesthetics there were multiple opportunities to access simulation training and the exposure was of a very good quality.	

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.

A2.1	**Organisation to ensure access to a named educational supervisor** All trainees stated to the review team that their educational supervisors (ES) were known to them and in the main, they would meet at least twice during their six-month rotation, usually at the beginning and end. In acute medicine, one of the trainees reported that they had met up to four times but in the intensive therapy unit (ITU) the review team heard this fell to one meeting only. One of the ICM trainees did report to the review team that they had had difficulty in finding out who their ES was in the early months of their placement.	

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.

A4.1	**Sufficient time in educators' job plans to meet educational responsibilities** It was reported by trainees in AM that it was felt that there were not enough supervisors who had time in their job plans to actively engage with teaching or educational supervision arrangements.	Yes – see A4.1 below

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.**		
A5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The review team heard that there was confusion around the provision of supervisors in AM coupled with a lack of understanding by the supervisors of the ACCS curriculum. The trainees highlighted as an example that the supervisors did not understand the differences between the acute care assessment tool (ACAT) forms for ACCS and core medical training (CMT).	Yes – see A5.1 below
A5.2	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** Trainees reported that there was a limited opportunity for performing procedures due to the intense competition with other grades. The review team heard from the ACCS trainees as a whole that they felt that they were at a disadvantage when it came to accessing clinics, for example. Owing to the well understood requirement for CMT trainees to attend 40 clinics during their two-year training programme, it would not be unusual for ACCS trainees to attend a plural clinic, in an effort to gain experience in plural taps, only to find that there was a higher level trainee and two CMT trainees already waiting to carry out the procedure. Another factor mentioned to the review team was due to the high number of trust grade F1s who required more senior support, one of the ST1 trainees in EM reported that they were more reluctant to attend plural clinics as they did not want to leave the ward without sufficient cover. Despite coming in on their leave days there were occasions where trainees were still unable to complete them. There generally seemed to be a lack of engagement in AM in facilitating workplace-based assessments (WPBA) for trainees.	Yes – see A5.2 below
A5.3	**Appropriate balance between providing services and accessing educational and training opportunities** In acute medicine the work was seen by trainees as predominantly service provision with limited teaching on ward rounds. One of the core trainee year one (CT1) trainees reported that they had spent six months on the acute medical unit (AMU) and this was felt to have been a very arduous experience due to workload pressures. They cited as an example the requirement to see 18 patients before 12.00 in the AMU, and work patterns such as these resulted in very limited opportunities for teaching. The review team heard from several trainees in EM how challenging it was to obtain exposure to shifts in the resuscitation area though they agreed that the ten bed unit offered a fantastic learning environment. One trainee reported that they had only managed four shifts in a six-month period which was disappointing and seemed to be a wasted training opportunity but stated that they were aware that even at consultant level these shifts were in high demand and hard to access.	

Good Practice and Requirements

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
A1.2	The Trust is required to ensure that all trainees who submit Datix reports receive feedback, including details of how the issue has been dealt with.	The Trust should review and strengthen its serious incident policy to ensure that trainees receive feedback on incidents they have raised. This should be a standing item on the LFG agenda and if trainees are not receiving feedback, then this should appear as a clear action following the meeting and should be acted upon.	R1.3
A1.3	The Trust must ensure that the practice of actively pressurising acute care common stem (ACCS) trainees in acute medicine (AM) to act up as medical higher trainees, beyond their competency level, should cease and any rota gaps be covered appropriately.	The Trust to submit copies of its revised rotas, as evidence. Compliance with this action should be monitored through LFG meetings, with trainee feedback and copies of minutes submitted as evidence.	R1.9
A1.6	The Trust should examine the rotas in respect of intensive care medicine (ICM) to ensure that handover time is incorporated within working time, this will be especially relevant once the new junior doctor contracts are effective from August 2017.	The Trust to submit copies of its revised rotas, as evidence. Compliance with this action should be monitored through LFG meetings, with trainee feedback and copies of minutes submitted as evidence. The Guardian of safe working in the Trust should ensure that the rotas are compliant with the new contract.	R1.12
A5.2	In ED and AM the Trust should ensure that ACCS trainees are provided with sufficient opportunities to meet curriculum requirements and are prioritised over non-training grades in terms of accessing training opportunities, for example resuscitation shifts or access to clinics. It would be useful for the ACCS trainees to have their own designated local faculty group so that they can raise concerns about their own training needs (rather than these being discussed as part of a larger EM LFG).	This item should be monitored at LFG meetings, with the submission of minutes and associated ongoing trainee feedback as evidence. Please submit details of any plans to have an ACCS-specific LFG.	R1.15

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
A4.1	The Trust is required to provide evidence that all consultants in AM have job plans	The Trust is required to provide evidence that educational supervisors have adequate	R2.10

	and that these job plans reflect all educational roles, specifically the roles of clinical and educational supervisors.	time in their job plans to undertake educational activities.	
A1.7	The Trust should consider the relevant curriculum requirements of the ACCS trainees when deciding on rota allocation as it was felt that certain specialty areas such as respiratory medicine provided a greater learning experience than time on the cystic fibrosis ward for example.	The Trust to submit copies of its revised rotas, as evidence.	R1.12
A5.1	The Trust should ensure that the educational supervisors are familiar with the ACCS curriculum and portfolio requirements.	The Trust should provide a plan of action to address this issue.	R3.7

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Cleave Gass
Date:	07 July 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.