QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

North Middlesex University Hospital NHS Trust

Risk-based Review (Education Lead Conversation)

Quality Review report

19 September 2017

Final Report

Developing people for health and healthcare

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Quality Review details

Training programme	Medicine (acute internal medicine, core medical training, gastroenterology and endocrinology and diabetes mellitus)
Background to review	The Risk-based Review (education lead conversation) was proposed in response to the poor results received by the Trust in the 2017 General Medical Council National Training Survey (GMC NTS) across various medicine specialties. Within core medical training, the Trust received red outliers in relation to reporting systems, educational governance and educational supervision, and pink outliers for; clinical supervision, clinical supervision out of hours, teamwork and handover. For gastroenterology, red outliers were received regarding overall satisfaction, adequate experience and local teaching. Pink outliers were also received in relation to: reporting systems, work load, induction, curriculum coverage, educational governance and feedback. Acute internal medicine by post received red outliers for; clinical supervision, reporting systems, educational governance and educational supervision. Furthermore, pink outliers were received in relation to teamwork and handover. Within endocrinology and diabetes mellitus red outliers were received for; overall satisfaction, adequate experience, curriculum coverage, regional teaching and study leave. In addition, pink outliers were received regarding; work load, educational governance, educational supervision and feedback. Health Education England (HEE) therefore felt it was necessary to meet with the Medical Director, Director of Medical Education, Assistant Director for Education and the relevant educational and clinical leads in order to discuss and assess the actions the Trust was implementing to address the issues raised by trainees and also to ascertain whether there were distinct issues in each of the various specialties or whether the concerns raised by the trainees were a reflection of problems regarding the acute take.
HEE quality review team	Dr Jonathan Birns, Deputy Head of School for Medicine and Medical Specialties Dr Andrew Deaner, Trust Liaison Dean, Health Education England North Central London Elizabeth Dailly, Learning Environment Quality Coordinator, Health Education England London and the South East Ed Prager,

	Quality Support Officer, Health Education England London and the South East
Trust attendees	Medical Director Divisional Director for Medicine Endocrinology and diabetes mellitus educational lead Acute medicine educational lead Gastroenterology educational lead Assistant Director for Education

Conversation details

Ref No	Summary of discussions	Action to be taken? Y/N
1.	**Workload pressures** The Trust reported that they felt the negative results received in the 2017 General Medical Council National Training Survey (GMC NTS) were in part based upon how busy the medicine department had been over the winter months, which had been further exacerbated by significant rota gaps at the higher trainee level over this period. Due to the winter pressures, the quality review team was informed that 60 additional medical beds had been open during February 2017, which coincided with the trainees completing the GMC NTS, and had resulted in no elective surgery taking place within the Trust for two months. The review team heard that the Trust had been unable to close the winter escalation ward, due to delayed discharges of care. Although the Trust had attempted to ensure that they kept the number of patients on outlying wards to a minimum this had proved difficult and they recognised that additional demand had been put on the trainees as they were having to work across wards. When discussing how the Trust mitigated the effect of such a large number of rota gaps the review team was informed that the gaps were sometimes filled by a group of regular locums who had previously worked within the department. Furthermore, the Trust was extremely complimentary of the higher trainees within the department who had often undertaken extra shifts. The review team was informed that most of the extra shifts the higher trainees undertook were locum shifts and therefore did not displace their specialty training. However, it was recognised that if the locum shift was out of hours, the day off in lieu the trainees then took could have an impact upon the amount of specialty training they could then access. The review team was also informed that the consultants within the department regularly stepped down when there were no higher trainees available and undertook the necessary ward work and held the various bleeps. When discussing the rota gaps, the Divisional Director confirmed that at the time of the education lead conversation (ELC), although there were not many junior doctor gaps within the department, in relation to the higher trainees there were eight gaps in the 22 person rota. The Divisional Director confirmed that work was being undertaken to address the higher trainee gaps and that they were having regular meetings with the Human Resources department to try and resolve them. The review team was informed that the Trust had decreased the number of higher trainees on the rota, to try and reduce the impact of the gaps, and that three trust grades at a higher trainee level had been recruited. However, further work was still to be undertaken.	
2.	**Outlier wards** When discussing the handover systems in place for outlier patients, the Trust confirmed that a robust process was in place and that no serious incidents had been	

	reported. This comprised of a real-time online system, as well as daily meetings with the relevant nursing staff, who were asked if they were aware of any patient who had not been reviewed. Furthermore, the Trust reported that a fail proof mechanism was also in place, as each medical team had their own base ward and was also responsible for one outlier ward, where they would attend and review all their patients daily with the responsible consultant.	
3.	**Interaction with critical care** When discussing issues that had been previously highlighted by trainees at the Health Education England visit in March 2016 regarding their interaction with the Critical Care Unit, the Trust confirmed that there was now a better working relationship between the two teams and that no further concerns had been raised. The review team was informed that one of the acute medicine consultants also worked in the intensive care unit and that both teams were involved in the medical grand round, which had helped facilitate stronger relationships. Furthermore, the Trust stated that the outreach programme had become more settled and it was no longer as heavily dependent on locums.	
4.	**Physician assistants** The Trust reported that there were nine physician assistants employed across medicine who provided invaluable support, especially to the more junior trainees. The review team was informed that the assistants had been introduced following feedback from junior trainees regarding the high workload. The assistants supported the handover meetings and updated the electronic patient list, took bloods and undertook a lot of the administration work on the wards. The review team was informed that the Trust had employed prescribing pharmacists, who helped decrease the workload pressures and facilitate early discharge of patients.	
5.	**Endocrinology and diabetes mellitus** The educational lead for endocrinology and diabetes mellitus reported that they had only had one higher trainee, instead of two, within the department during the previous year and that they also had only three consultants as opposed to four. This had impacted upon the trainees' workload. Although the educational lead confirmed that trainees were able to attend their weekly, local teaching sessions and that the consultants often tried to cover them on the wards in order for the trainees to attend their regional teaching days, the review team was informed that as there had only been one higher trainee within the department in the year preceding the ELC, this may have impacted upon their ability to attend. The Trust confirmed that a large piece of work had been done to ensure the core medical trainees could access specialty clinics, as well as clinics within the ambulatory care unit. The review team was informed that the higher trainees accessed two clinics per week and that the core trainees attended one, which was similar to the clinic exposure offered within other Trusts. Furthermore, the review team heard that the trainees were encouraged to attend the specialty units at University College London Hospitals NHS Foundation Trust, which the trainees often took advantage of. When discussing the red outlier received for curriculum coverage, the Trust reported they were surprised by the result, as the trainees were exposed to a vast range of pathologies at the Trust and could access pump clinics, adolescent clinics and endocrine clinics. Furthermore, the review team was informed that when trainees started their placements within the department, they met with their educational	

	supervisor to create a clear training plan and address any training gaps they may have had. The review team was also informed that all trainees undertook an audit when completing their placement.	
6.	**Gastroenterology** When discussing the potential causes of the red flags in the 2017 GMC NTS, the educational lead reported that they had significant rota gaps in relation to the higher trainees which had a negative impact upon the core trainees and increased the workload pressures within the department. The Trust indicated that although they had advertised the positions, the gaps were predominantly being filled by the consultant body acting down to support the current team and providing more on the ground support. The review team was informed that since the GMC NTS results, changes to education and training had been made within the department. Whereas previously, there had been two ward consultants covering the base ward and all outlier wards, the department had moved to a system which involved one designated consultant being responsible for the base ward and the other for the outlier wards. Furthermore, the educational lead stated that they had 're-vamped' the local teaching provided to trainees. This included consultant led discussions of different learning points after each multi-disciplinary team meeting (MDT) and ward round, as well as the introduction of a journal club The review team heard that trainees received ample access to endoscopy training and that the higher trainees undertook one training endoscopy list and two service lists each week. The Trust further stated that the core trainees were also encouraged to attend the lists, but recognised that due to the higher trainee rota gaps and additional workload pressures that accompanied this, the core trainees may have found it difficult in practice to attend the endoscopy lists.	
7.	**Acute medicine** The review team was informed that although the dedicated acute medicine team did not have any core trainees, the core medical trainees from other specialties undertook shifts within the ambulatory care unit. The Trust confirmed that consultant supervision was always provided to the trainees, as there was a consultant present within the unit during the week and out of hours the trainees were supported by the consultant in the Acute Medical Unit, who would review patients in the ambulatory care unit if necessary. The unit also presented opportunities for the trainees to undertake clinics, with consultant supervision, which the trainees reportedly enjoyed. The educational lead reported that three consultants undertook separate post-take ward rounds every morning, which ensured that all trainees had the opportunity to present patients. Furthermore, the review team was informed that the morning handover meeting was robust and included a representative from each specialty, who was typically the most senior member of that team. This presented opportunities for referrals to be undertaken and fostered learning as well as continuity of care. The review team was informed that feedback given by the acute medicine trainees during the Local Faculty Groups (LFG) had been generally positive. The trainees indicated that they enjoyed the job, gained lots of experience and were able to access a lot of training opportunities and procedures.	

	The educational lead further reported that trainees were released in order to attend their regional teaching.	
8.	**Educational supervision** All of the supervisors the review team met with confirmed they had adequate supporting professional activity (SPA) time, and that the Trust allocated 0.25 PAs per trainee. The Director of Medical Education (DME) informed the review team that they had presented to the board the HEE: Junior Doctor Morale paper and were in the process of attempting to timetable sessions for educational supervisors with their trainees on a weekly basis. Although the Trust confirmed that supervisors had the requisite SPA time, it was recognised that often it was difficult in practice to fit this into their job plans, and it was felt that by timetabling the sessions, this would ensure they became more embedded and occurred more frequently. The review team was informed that the Trust was in the process of creating a system whereby a weekly Doodle Poll was sent to all educational supervisors, asking whether they had met with their trainee that week.	
9.	**Teaching opportunities** The review team was informed that a weekly bulletin email was disseminated amongst all trainees, which informed them of teaching opportunities they could access that week, such as Schwartz rounds and radiology meetings.	
10.	**Reporting and governance systems** When discussing the breakdown of the questions behind the GMC NTS red outliers, the DME noted that although trainees indicated they were aware of the reporting systems in place, the Trust often scored poorly in relation to trainees feeling that reports instigated change and addressed the issues raised. The Trust confirmed that when a Datix form was submitted, the individual in question received a provisional report outlining how the issue was dealt with and that if they felt the response was inadequate, they could raise it with the patient safety lead. Furthermore, following each report that was submitted, a Datix meeting took place the next day during which the incident was discussed. Although the trainees were informed of the escalation policy during their induction, the DME stated that once a Datix had been submitted, trainees would subsequently be invited to the Datix meeting the following day and would be reminded that if they were unsatisfied with the response they received, they could escalate this to the patient safety lead. The DME further stated that the Trust was in the process of determining whether each time a trainee submits a Datix form a report could be sent to the education team, outlining the details of the incident and the trainee involved, so the trainee's educational supervisor could then be informed. The Trust hoped this would ensure that educational supervisors discussed any serious incidents reported with their trainees. Furthermore, the quality review team was informed that trainees were encouraged to attend both the patient safety outcome committee and the serious incident outcome assurance meetings. The Divisional Director informed the review team that they met with three trainee representatives on a monthly basis in order to discuss issues and how improvements can be made in the department. Although previously, the trainee representatives had	

	all been higher trainees, the review team was informed that a core medical trainee was also due to take up one of the positions.	
11.	**Respiratory medicine** The review team was informed that two new consultants had been appointed within the department, who both had an interest in education and the Trust anticipated this would improve the learning and education environment within the department. The Trust further stated that the consultant model in place in gastroenterology, whereby one consultant had responsibility for the base ward and the other for any outlier wards at the time of the review was being considered for respiratory medicine.	

Next steps

Conclusion
The review team recognised that the medical teams had been working under a great deal of pressure due to a high workload. The workload was made more difficult to cope with due to a significant number of rota gaps and a number of unfilled consultant posts. However, the review team were pleased that the lead consultants for the various medical specialties were fully aware of the issues of concern and were making appropriate positive and proactive decisions in order to improve the learning and training environment across medicine for trainees and address the issues highlighted in the 2017 General Medical Council National Training Survey. The review team decided that in order to measure the success of the measures the Trust was implementing they would undertake a survey of the relevant trainees in December of this year. The results of the survey will be used to inform HEE if a formal visit is required in early 2018.

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:	29 September 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.