QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Barking, Havering and Redbridge University Hospitals NHS Trust

Risk-based Review (education lead conversation)

Quality Review report

17 October 2017

Final Report

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Quality Review details

Background to review	Before the various Risk-based Reviews (focus groups) that took place at Barking, Havering and Redbridge University Hospitals NHS Trust of core medicine, higher medicine, foundation medicine, foundation surgery and emergency medicine, the Deputy Postgraduate Dean met with the Medical Director, Director of Medical Education, Medical Education Manager and Foundation Training Programme Director. This was in order to discuss the work the Trust was undertaking in the various departments and to see what progress had been made.
HEE quality review team	Deputy Postgraduate Dean – Dr Indranil Chakravorty Deputy Quality and Reviews Manager – Elizabeth Dailly Learning Environment Quality Coordinator – Ed Praeger
Trust attendees	Medical Director – Dr Nadeem Moghul Director of Medical Education – Professor Jayanta Medical Education and Training Manager – Caroline Curtin Foundation Training Programme Director – Dr Peter Walker

Conversation details

Ref No	Summary of discussions	Action to be taken? Y/N
1	**E Portfolio** The Trust informed the review team, that there had been significant issues with the new e-portfolio system (HORUS) that had been introduced. The review team was informed that when it was introduced for the new cohort of trainees in August 2017 it was not fully completed and fit to be used by trainees. The Trust was surprised that the finished product was not complete before it was implemented, especially considering that its launch had been postponed an additional year, in order to ensure it was fully functional. The review team was informed that at the time of the review, they could still not access the curriculum aspects of the e portfolio system and that trainees were unable to record or link supervised learning events. Furthermore, the archive had not been uploaded to the system until two months, after the trainees had begun their placements. The Trust reported that they had received generic updates from Health Education England (HEE) about the problems relating to the system, but that communication had been difficult and that they had often struggled to get a timely response from HEE on these issues. It was reported that the system had created a lot of additional stress for the administration team, educational supervisors and the trainees. The review team was informed that an additional burden had been placed on trainees and trainers as they were attempting to navigate a system that was not fully functional.	
2	**Rotations** The Trust reported that they had not been able to provide trainees with their contracts 8 weeks before they were due to start their posts, as they had not received the information from Health Education England.	
3	**Foundation School**	

	The Trust reported that they had had difficulties in their communication with the foundation school as their emails were sent to an generic inbox and they often did not receive a response, or if they did it was from a range of different people and there was no continuity. However, the Trust reported that they could always get hold of the Director of the Foundation School directly if necessary, but that they were mindful of her clinical duties and did not want to over burden her. The Trust indicated that a foundation training programme director meeting took place on a monthly basis, where issues were discussed and subsequent actions agreed. They commented that they then raised the issues with the Director directly, as they did not think they would get an adequate response from the foundation school mail box. It was suggested whether a regular meeting on a two-month basis with the Director would be beneficial. The review team was informed that they only received the rotations and posts they would be receiving for foundation trainees very late, and that a huge amount of work had been undertaken to work out that they were receiving the correct posts. The foundation programme director indicated that they had spent up to an additional 30 hours trying to complete this piece of work. The Trust also commented that in relation to the foundation surgical posts at Queen's Hospital, they had previously been informed that there would be only 11 posts in the department and that they had informed the surgical department of this which had resulted in difficult discussions. However, in August 2017 the Trust received 12 posts.	
4	**Foundation Training at King George Hospital** The Trust reported that they felt the main issues faced by the foundation trainees based at King George Hospital, was due to the lack of educational supervision they received. The review team was informed that many of the consultants based at King George Hospital were locums and not permanent members of staff, which meant that trainees felt less supported. This was especially pertinent for the trainees within the emergency department, as the repatriation of the higher trainees from King George Hospital to Queen's Hospital meant there were just foundation and GP trainees within the department, with locum consultants. This resulted in the trainees feeling they received more senior support and supervision when they were based at Queen's Hospital. Furthermore, as there was a consultant based in the emergency department over night at Queen's Hospital, this made a huge difference to the foundation trainees, in terms of how supported they felt. However, the Trust stated that they were recruiting new consultants in the department and making improvements, which would have a significant improvement. The Medical Director reported that the immediate solution the Trust employed, was to make it clear that the locum doctors based in the department were responsible for the trainees and had a duty to provide education and training to the trainees. The Trust anticipated that this would improve the trainees' learning and education experience. When discussing long term solutions, the Trust stated that the emergency department at King George Hospital was part of the clinical strategy the Trust was working towards. The Trust indicated that due to the sensitive nature of the issues, at the time of the review the details could not be disclosed.	
5	**Trainees in difficulty**	

	The Trust reported that they had received a disproportionately high number of trainees in difficulty at foundation and GP level, due to the Trust's positive reputation in regards to the support that such trainees were given by the medical education centre. This put the Medical Education team under increased pressure and diverted resources from many other areas of challenge within the trust.	
6	**GP School** The Trust confirmed that the communication between themselves and the GP school had improved, but that further work needed to be undertaken to ensure it was embedded. It was reported that the GP training programme directors needed to be more proactive about any trainees in difficulty, and ensure that such trainees were paired with suitable educational supervisors.	
7	**Workforce solutions** The Trust reported that they were committed to creating an organisation that was attractive to non-training grade doctors by building a system in which the doctors could progress and reenter training, either by providing the opportunities for them to undertake appropriate career orientated courses. The review team was further informed that the Trust was undertaking a scheme to recruit 10 physician assistants per year. However, they indicated that as the assistants needed to undertake exams and meet a certain curriculum, it would be beneficial to have a model of education and training to implement to ensure that they were providing the correct curriculum. The Trust also informed the review team that they were expanding the number of acute care practitioners in the Trust, especially within the emergency department,	
8	**Hospital at Night** The Trust reported that a trial run of the Hospital at Night system had been undertaken in October 2017 and that a further was due to be undertaken in November. The review team was informed that the trail run had been successful and that despite a few teething issues, everyone had been positive. The Trust indicated that they had invested in *Careflow* ® system and that the system allowed teams to escalate / communicate more effectively about results and patients.	
9	**Rota** The Trust reported that the foundation trainees had raised a lot of concerns in relation to the management of the rota, especially those based within the surgical department. The Trust acknowledged that the rota coordinators needed additional support.	
10	**Gastroenterology** The Trust indicated that a larger volume of work was being undertaken in relation to the gastroenterology department at Queen's Hospital. Due to the sensitive nature of the work (internal special measures) and discussions the Trust was undertaking, they could not disclose details of the plans they were implementing. It was agreed that a follow up conversation with PG Dean and a subsequent education lead conversation would be arranged to discuss the progress being made.	

Next steps

Conclusion
- Deputy PG Dean to address these concerns with HET team and relevant HORUS support team. - Foundation School Director and Manager to arrange regular meetings with the Foundation TPD and MEM. - HEE to work with the foundation and GP schools to ensure that the Trust is not allocated a disproportionate number of TiDs - Deputy PG Dean to arrange a visit with FPA at RCP London to assist in the implementation of a postgraduate curriculum for PAs - HEE to work with the GP school to ensure communication between them and the Trust is optimal - Trust to submit a summary of the progress made in relation to the Hospital at Night system - Rota concerns being managed through IMR - HEE to organise education lead conversation to discuss progress in gastroenterology department.

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:	Indranil Chakravorty
Date:	06 November 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.