QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Barking, Havering and Redbridge University Hospitals NHS Trust

Medicine

Risk-based Review (focus group)

Quality Review report

17 October 2017

Final Report

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Quality Review details

Background to review	The Risk-based Review (focus group) of core medicine and higher medicine trainees at Barking, Havering and Redbridge University Hospitals NHS Trust was proposed in response to the results that were received by the Trust in the 2017 General Medical Council National Training Survey (GMC NTS). Health Education England therefore felt it was necessary to meet with the trainees to explore the reasons behind the poor results received and to ensure that the learning and training environment was suitable for trainees.
Training programme / learner group reviewed	Core and higher medicine training
Quality review summary	The review team met seven core medicine trainees from gastroenterology, cardiology, oncology, endocrinology and haematology at CT1 and CT2. The review team also met with eight higher medicine trainees from infectious diseases, geriatrics, cardiology, gastroenterology and respiratory at ST3 –ST7. The quality review team was informed of two areas of serious concern, for which immediate mandatory requirements were issued: - Firstly, the review team was informed that the management of the acute medical rota was a major challenge for the Trust, especially the out of hours rota. Several instances of patient safety concerns were highlighted by trainees at all levels, due to unplanned and unexpected rota gaps, changes to which site the trainee was supposed to be based at during their on-call shift without notice and trainees being put under pressure to continue on duty after a long day shift. The issue appeared to be related to rota mismanagement and lack of clinical leadership and oversight. The inability for trainees to gain access to information required to arrange swaps to support the rota had been particularly difficult. Furthermore, the trainees reported that when they tried to contact the rota coordinator, there was poor responsiveness and often no communication. The Trust was therefore required to appoint a clinical rota lead and rota manager with oversight of both the acute and ward cover rota. The Trust was further required to deliver a plan to provide a joint rota that was visible to all trainees, which me the training hours' requirement, met training needs and that facilitated the trainees swapping shifts and taking leave. - The review team was informed by both the medicine trainees and those based in the emergency department, that when patients with type 2 respiratory failure presented to the emergency department there was often not enough cover from respiratory nurses who were trained to administer none invasive ventilation (NIV) and that the high dependency unit (HDU)/ and intensive care unit (ICU) outreach nurses had to attend the emergency department, which often resulted in a delay of the timely management of such patients, on occasion for up to two hours. The review team was also informed that there was a lack of NIV equipment in the emergency department and access to trained members of staff. The machines available in HDU/ICU were different to those available in ED and Respiratory wards which was a challenge for safe care provision. The trust was required to confirm that there was 24 hour cover every day in the emergency department, from trained staff and adequate equipment, which was sufficient for the expected patient turnover. In addition, areas for improvement regarding the training of foundation doctors within medicine were highlighted as follows:

- The review team was informed that although the core trainees received good opportunities to see and clerk patients, that due to the way the on-call was structured and as there were four consultants with partial responsibility for patients on the acute medical take, they struggled to complete their acute care assessment tool (ACAT) requirements (as they routinely did not see and clerk five patients with the same consultant). This was echoed by the higher trainees, who faced similar issues and further reported that on-call they were predominantly involved in bed management due to the busy nature of the department and did not get a chance to review or present any patients. Although the acute take appeared to be efficiently run in terms of providing patient care, it did not provide adequate training opportunities to trainees.
- The review team was informed that the trainees only received their own personal rota and therefore did not know who they would be undertaking the shift with. The trainees indicated that this prevented them from negotiating swaps with other trainees as they did not know who to contact. The trainees also stated that they did not get a response from the rota coordinator when they tried to contact them and that the rota in general was poorly coordinated. This was exacerbated by the fact that the on-call rota and specialist ward rota was not organised by the same person, which could result in the majority of the trainees based in one specialty being on-call at the same time, leaving the relevant ward extremely short staffed.
- The review team was informed that there were significant issues in the gastroenterology department, relating to staffing shortages. However, the review team heard that the Trust were aware of the issues the department was facing and were taking action via a set of internal special measures. It was agreed that an urgent communication between the Trust Senior Management team and PG Dean would be organised followed by an education lead conversation in the near future, to discuss the many challenges, workforce and patient safety issues as well as plans being formulated as per internal special measures and their respective timelines.
- All trainees reported that they had received a comprehensive Trust and induction, and most indicated that they had also received a prompt departmental induction. However, the trainees indicated that they did not receive a specific induction into the acute medicine out of hours' rota and therefore were not aware of the pathways and how the on-call shifts were run. The higher trainees indicated that there were other higher trainees who they were able to ask about the rota, but that it was not formally explained.
- Although all trainees were aware of how to exception report, many felt that they were actively discouraged to do so by the consultants and offline deals were being recommended to compensate for the extra hours worked but there was a significant reluctance to allow for this to be documented via the exception reporting process.

The review team was further informed of a number of areas that were working well with regard to the education and training of core and higher medicine trainees, as outlined below:

- The majority of the trainees the review team met with confirmed that they had met with their educational supervisors, and could access them.
- The core medicine trainees reported that they felt well supported by the higher trainees within the department.
- Trainees at all level stated that they received exposure to an excellent mix of pathology and that they received good specialist training and exposure which covered the curriculum.

	- All of the core trainees indicated that they would be happy for their friends and family to be treated in the department, as did the majority of the higher trainees.

Quality Review Team			
HEE Review Lead	Dr Karen Le Ball Head of the London Specialty School of Medicine	**Trust Liaison Dean**	Dr Indranil Chakravorty Trust Liaison Dean, Health Education England North East London
Trainee Representative	James De Boisanger Trainee Representative	**Scribe**	Ed Praeger Quality Support Officer Health Education England London and the South East
Lay Member	Robert Hawker Lay Representative	**Observer**	Elizabeth Dailly Deputy Quality and Reviews Manager Health Education England London and the South East
Observer	John Forster 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

M1.1	**Patient safety** When asked by the review team regarding any patient safety issues, the core medicine trainees highlighted that although they had not been directly involved in an issue that placed a patient's safety at risk, they were aware of situations within the Trust that they felt could have a direct impact on patient safety. The core trainees informed the review team that the large number of locum and agency staff employed at the King George site lacked knowledge of the Trust, building and placement of equipment, slowing down processes and possible leading to patient safety issues. The core trainees highlighted that they felt that the two-person verification of a pregnancy policy within the Queens Hospital site were too rigid. The trainees felt that this was taking valuable resources away from other patients. The review team was informed by both the medicine trainees and those based in the emergency department, that when patients with type 2 respiratory failure presented to the emergency department there was often not enough cover from respiratory nurses who were trained to administer none invasive ventilation (NIV) and that the high dependency unit (HDU)/ and intensive care unit (ICU) outreach nurses had to attend the emergency department, which often resulted in a delay of the timely management of such patients, on occasion for up to two hours. The review team was also informed that there was a lack of NIV equipment in the emergency department and access to trained members of staff. The Trust was required to confirm that there was 24 hour cover every day in the emergency department, from trained nurses and adequate equipment, which was sufficient for the expected patient turnover. The core trainees informed the review team that a regular patient safety forum was held each week, lasting approximately for 30 minutes to one hour.	Yes, please see M1.1 below
M1.2	**Serious incidents and professional duty of candour** The higher medicine trainees informed the review team that they had submitted serious incident forms (SI's) and although they had not received feedback back from the Trust after a month, they admitted that they did not know what time scale to expect for the feedback to be given. The core trainees informed the review team that they felt that filling in Datix reporting tool took too long and that they regularly feedback concerns to a senior colleague. The trainees felt that they did not have time during their shift to raise concerns officially through the Datix system, due to the cumbersome form that needed to be completed.	
M1.3	**Appropriate level of clinical supervision** The review team was informed that although the core trainees received good opportunities to see and clerk patients, that due to the way the acute on-call rota was structured with four different consultants responsible for a limited number of on call patients each, they struggled to complete their acute care assessment tool (ACAT) requirements (as they routinely did not see and clerk five patients with the same consultant). This was echoed by the higher trainees, who faced similar issues and further reported that on-call they were predominantly involved in bed management due to the busy nature of the department and did not review or present patients. Although the acute take appeared to be efficiently run in terms of providing patient care, it did not provide adequate training opportunities to trainees.	Yes, please see M1.3 below
M1.4	**Exception Reporting** The review team heard from the core medicine trainees at the Queen's Hospital site that a number of them had not been able to submit an exception report due to not receiving an emailed link and explanation email on the process.	

	A core gastroenterology trainee informed the review team that concerns had been addressed, with meetings and actions planned. The core trainees informed the review team that they felt pressure from consultants to take time back as required instead of using the more formal exception reporting system. The core trainees highlighted that they felt that their consultants were on the other end of the exception reports and did not always feel comfortable to put exception reports in, in case of any follow ups from consultants.	
M1.5	**Rotas** The quality review team was informed that the management of the acute medical rota was a major challenge for the Trust, especially the out of hours rota. Instances of patient safety concerns were highlighted by trainees at all levels, due to unplanned and unexpected rota gaps, urgent changes to which site the trainee was supposed to be based at during their on-call shift and trainees being put under pressure to continue on duty after a long day shift. The issue related to inadequate rota management and lack of clinical leadership in relation to the rota. Furthermore, the trainees reported that when they tried to contact the rota coordinator, there was poor responsiveness and communication. The review team was informed that the trainees only received their own personal rota and therefore did not know who they would be undertaking the shift with. The trainees indicated that this prevented them from negotiating swaps with other trainees as they did not know who to contact. The trainees also stated that they did not get a response from the rota coordinator when they tried to contact them and that the rota in general was poorly coordinated. This was exacerbated by the fact that the on-call rota and specialist ward rota was not organised by the same person, which could result in the majority of the trainees based in one specialty being on-call at the same time, leaving the relevant ward extremely short staffed.	Yes, please see M1.5 below
M1.6	**Induction** The core medicine trainees informed the review team that on the whole although they had had a Trust induction which had provided them with computer logins and badge access from the first day, that they had not received Rota's for their first week, limiting them to ward work. On investigation, they found that they had not been placed on an e-rostering system and that this had not been explained in the induction. The higher medicine trainees echoed the comments made by the core trainees, with a number of them finding it difficult to obtain a copy of their rota until only a week prior to starting, despite attempting to contact the Trust. All trainees reported that they had received a comprehensive Trust induction, and most indicated that they had also received a prompt departmental induction. However, the trainees indicated that they did not receive a specific induction into the acute medicine out of hours' rota and therefore were not aware of the pathways and how the on-call shifts were run. The higher trainees indicated that there were other higher trainees who they were able to ask about the rota, but that it was not formally explained. The core trainees reported that as part of their induction they had to complete all of the Trust's statutory mandatory training. However, as five of the sessions included face-to-face workshops that the trainees had to organise themselves, they found it extremely difficult to arrange due to their heavy workload on the wards and within the limitations of the rota requirements.	Yes, please see M1.6 below
M1.7	**Handover** The core medicine trainees at Queen's Hospital informed the review team that they felt that although the handover process was good within the Trust, it could be streamlined. They indicated that it felt very formal and drawn out process.	

	The core trainees at Queen's Hospital indicated to the review team that they had specific times allocated to handovers and that they felt they could raise particular issues if needed. The review team heard that the trainees at King George's Hospital found it difficult to handover due to the tardiness of consultants (usually locums) arriving, leaving little or no time for an official handover. This meant that the trainees had to either stay behind after their shift had finished or handover to a nurse.	Yes, please see M1.7 below
M1.8	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The core medicine trainees informed the review team that the learning opportunities and exposure seen at the Trust was generally felt to be high, with a number of trainees highlighting that it was better than they had received at Trusts they had worked at in the past. The core trainees did feel that any problems with trainees gaining experience was not down to the opportunities and exposure availably, but more related to their portfolio and the curriculum requirements, for example that when clerking on-call, five patients had to be seen with the same consultant. There were opportunities to undertake practical procedures in line with the curriculum requirements. The review team heard from the core trainees that a single trainee was unsure of who their clinical supervisor was, with all other core trainees having a named clinical supervisor. The review team heard from the higher trainees that they were keen to lead the ward rounds rather than the consultant, to gain further experience. The higher trainees within gastroenterology indicated that the department had the potential to provide excellent training opportunities, as there was a good mix of pathology and endoscopy lists the trainees could attend. However, due to the heavy workload it was not always possible to take advantages of the potential training opportunities.	
M1.9	**Protected time for learning and organised educational sessions** The core trainees informed the review team that due to the business of the ward it was often difficult to attend clinic sessions. However, the higher trainees confirmed that they had exposure to clinics on a weekly basis. The higher trainees in respiratory medicine confirmed that they received good exposure to bronchoscopy and pleural lists. The core trainees informed the review team that regional core medical training (CMT) teaching sessions were often in house, with a small number provided at Whipps Cross University Hospital. The trainees indicated to the review team that they often only managed to attend 70% of regional training sessions, as to attend they often had to arrange shift swaps with other members of staff. The core trainees informed the review tem that there was no private study time allotted.	
M1.10	**Adequate time and resources to complete assessments required by the curriculum** The core trainees informed the review team that with the high numbers of patients and rota structure, that completing ACATs in the required time was difficult. The higher gastroenterology trainees informed the review team that it had taken a number of weeks before they could access their e-portfolio.	

M1.11	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** The higher trainees informed the review team that although they had been allocated an educational supervisor, a number of trainees had not met them yet. However it should be noted that some of the trainees had only been in post for two weeks.	

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.

M2.1	**Appropriate system for raising concerns about education and training within the organisation** The core trainees situated at the Queens Hospital site informed the review team that they were aware of and had attended a local faculty group (LFG) meeting at the beginning of their academic year. The trainees also highlighted to the reviews team that although they did not currently have a trainee representative, they were hoping to have one appointed within the week. The review team were informed by a higher gastroenterology trainee that although they were aware of LFG meetings taking place, they were unsure of when these were taking place.	
M2.2	**Organisation to ensure access to a named clinical supervisor** The reviews team was informed that a number of core trainees had not been assigned a clinical supervisor, with all the higher trainees indicating that they had.	
M2.3	**Organisation to ensure access to a named educational supervisor** The review team was informed that the core trainees had all been allocated an educational supervisor and the core trainees felt that there was a good rapport between the educational supervisors and the trainees and that the core medical training educational lead was very approachable. The review team was informed that two trainees were, at the time of the review, yet to meet their educational supervisors. The reviews team was informed that a number of the higher trainees did not have educational supervisors assigned to them, with no clear consultant available to become an educational supervisor, as yet.	

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.**		
M3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The trainees informed the review team that they felt the consultants to be generally supportive and approachable, especially when requiring help over the phone. The higher trainees informed the reviews team that consultant approachability when calling out of hours was very much based on the consultant involved The core trainees informed the review team that there was a 'us and them' culture with nursing staff at the Queen's Hospital site, although the trainees felt that this was partly due to the number of bank staff in the emergency department. .	
M3.2	**Access to study leave** The core trainees informed the review team that they were unable to take access the Trust's study budget until all mandatory training had been completed. Time for this mandatory training was not rostered in to their rota.	Yes, please see TW3.2

Good Practice and Requirements

Good Practice
The majority of the trainees the review team met with confirmed that they had met with their educational supervisors, and could access them.
The core medicine trainees reported that they felt well supported by the higher trainees within the department.
Trainees at all level stated that they received exposure to a good mix of pathology and that they received good specialist training and exposure which covered the curriculum.
All of the core trainees indicated that they would be happy for their friends and family to be treated in the department, as did the majority of the higher trainees.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
M1.1	The quality review team was informed that the management of the acute medical rota was a major challenge for the Trust, especially the out of hours' rota. Instances of patient safety concerns were highlighted by trainees at all levels, due to known and unplanned and unexpected rota gaps, urgent changes to which site the trainee was supposed to be based at during their on-call shift and trainees being put under pressure to continue on duty after a long	The Trust is required to appoint clinical rota leadership, plus rota manager with oversight of both acute and ward cover rotas. The Trust must deliver a plan to provide a communal rota that is visible and accessible to all trainees, meeting the training hours' requirement and that enables the trainees to facilitate swaps and take leave.	R1.1

	day shift. The issue related to inadequate rota management and lack of clinical leadership in relation to the rota. Furthermore, the trainees reported that when they tried to contact the rota coordinator, there was poor responsiveness and communication. The Trust was therefore required to appoint a clinical rota lead and rota manager with oversight of both the acute and ward cover rota. The Trust was further required to deliver a plan to provide a communal rota that was visible to all trainees, meeting the training hours' requirement that all facilitated the trainees swapping shifts and taking leave		
M1.5	The review team was informed by both the medicine trainees and those based in the emergency department, that when patients with type 2 respiratory failure presented to the emergency department there was often not enough cover from respiratory nurses who were trained to administer none invasive ventilation (NIV) and that the high dependency unit (HDU)/ and intensive care unit (ICU) outreach nurses had to attend the emergency department, which often resulted in a delay of the timely management of such patients, on occasion for up to two hours. The review team was also informed that there was a lack of NIV equipment in the emergency department and access to trained members of staff.	The Trust is required to confirm that there is 24 hour cover every day in the emergency department, from trained nurses and adequate equipment, which is sufficient for the expected patient turnover.	R1.1

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
M1.3	The Trust is to ensure that all trainees can complete their acute care assessment tool (ACAT) requirements.	The Trust to confirm what actions have been implemented and changes made to the on-call shifts to ensure this has been adequately resolved. The Trust to monitor this through the Local Faculty Group (LFG)	R1.15
M1.6	The Trust must ensure that all trainees receive a thorough induction to the acute/GIM medicine out of hours shifts.	Trust to share timetable, agenda, register and summary of feedback from trainees. Trust to confirm, via audit of trainees, that each trainee has received an induction and that this was considered useful.	R1.13
M1.7	Trust to review handover procedures to make more workable for higher trainees handing over on both sites	The Trust to submit the handover timetable and registers of attendance at handover	R1.14

	Trust to implement set times for handover. Trust to ensure that all members of the team attend departmental handovers on time.		

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
TW3.2	The Trust to review the system in place for trainees accessing the study budget. The Trust to ensure that trainees are able to attend the face to face mandatory teaching sessions; that they have allocated time and that enough sessions are provided for them to attend.	The Trust to confirm the outcome of the review and provide trainee feedback regarding their access to the study budget.	R1.12

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 Karen Le Ball
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.