QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Epsom and St. Helier University Hospitals NHS Trust

Geriatric Medicine and Acute Medicine

Risk-based Review (On-site visit)

Quality Review report

21/11/17

Final Report

Developing people
for health and
healthcare

www.hee.nhs.uk

THE NHS
CONSTITUTION
the NHS belongs to us all

Quality Review details

Background to review	The risk-based review (on-site visit) of geriatric medicine and acute medicine at Epsom and St Helier was proposed in response to the results received by the Trust in the 2017 General Medical Council National Training Survey (GMC NTS). The survey produced multiple red outliers in geriatric medicine for the fourth year in a row. By programme group, geriatric medicine (Trust wide) returned three red outliers (clinical supervision, clinical supervision out of hours and study leave) and seven pink outliers (overall satisfaction, teamwork, supportive environment, induction, curriculum coverage, educational governance and educational supervision). By post specialty, geriatric medicine (Trust wide) returned three red outliers (clinical supervision, handover and study leave) and two pink outliers (clinical supervision out of hours and educational supervision). These results have led to a triple + red outlier by post specialty for handover in geriatric medicine at St Helier Hospital. The concerns in geriatric medicine had been repetitive and as such were considered serious.
Training programme / learner group reviewed	Geriatric medicine and acute medicine.
Review summary and outcomes	Three serious concerns were highlighted, and an immediate mandatory requirement (IMR) was issued for each of them. These were: • A lack of a present acute medicine consultant in Ambulatory care at St. Helier, leaving the core level trainee to run it alone. • Between 5pm and 9pm, ward medical cover at St. Helier is provided solely by FY1 trainees without senior oversight. Consultants may be there until 7pm, but there have been issues in contacting them when they are needed. • A lack of named consultant cover for the stroke unit at St. Helier, leading to serious patient safety concerns, and trainees dealing with problems above their competency level. Three areas were also highlighted as having been working well: • It was reported that Orthogeriatrics training at St. Helier was very good, with good consultant supervision and support. • Foundation doctors receive weekly protected teaching time, which the trainees reported to be of a high quality. • There are good specialty training opportunities for higher specialty trainees in cardiology and respiratory medicine. Two areas were also highlighted as requiring improvement: • For the geriatric medicine wards, there needs to be a named consultant for the patients and there needs to be named consultant cover that is urgently accessible, and that this cover is made clear to all trainees on these wards. • ST3 trainees in medicine should not routinely be doing outpatient clinics without their consultant being physically present in clinic as well.

Quality Review Team			
HEE Review Lead	Dr Catherine Bryant Deputy Head of the London School of Medicine and Medical Specialties	**Deputy Postgraduate Dean**	Dr Anand Mehta Deputy Postgraduate Dean, Health Education England South London
Foundation Representative	Dr Mark Cottee Associate Director of the South Thames Foundation School	**Lay Representative**	Caroline Turnbull Lay Representative
Scribe	John Forster HEE Quality Support Officer		

Educational overview and progress since last visit – summary of Trust presentation

The Trust reported that three new consultants in geriatric medicine had started since the previous visit in June 2016. One of these was undertaking a large amount of educational and clinical supervision, ward work and clinics; one was working to set up a frailty unit, and working with the Sutton community to construct a community service.

The Trust also reported that weekly meetings had been set up with the juniors and trainees, in order to get closer to the trainees, understand any issues they were having and attempt to troubleshoot them. The Trust gave an example of an incident where registrars were not receiving permission to go to mandatory training. After discussion, it was agreed that they did not require permission, they could just attend.

The review team heard that a review of the trust-wide teaching had been carried out, and that three hours of dedicated teaching was available each week to improve confidence and competence. It was reported that there was no question of specialty registrars not attending training days, and attendance was actively encouraged by the department.

Following the rota issues prevalent during the summer, staffing issues were being managed with locum agency support for the on-call service. There had been a review of the on-call rota frequency, and it was reported that there was a more intense on-call rota at St. Helier, going from a 1-in-16 system to 1-in-12.

The trust reported that they were actively trying to recruit more staff, and that middle grade locums were currently filling in the gaps in service. The review team heard that the Trust was also seeking international fellows in order to fill this gap.

The Trust reported plans to take two new trainees, one each at Epsom and St Helier, who would spend six months in medical care and six months in the intensive therapy unit (ITU).

It was reported that there were similar rota issues at the Epsom site, as they had lost four out of nine registrars, though they had managed to come to an agreement with the registrars to get the gaps covered.

It was reported that there were trainee meetings being held weekly at St Helier, and fortnightly at Epsom, as well cross-site local faculty group (LFG) meetings. The Trust reported that a junior doctors' forum was being held every two months, driven by the juniors, facilitated by the faculty, and supported at a very high level at both sites. It was heard that this was well attended, that feedback was given to the trainees, and that the Trust felt it was effective in sorting trainees' problems. The Trust gave an example of ITU handover issues that had been resolved through face to face discussion with the director of the ITU, which probably would not have happened if it wasn't facilitated by the faculty.

The Trust reported that they had been looking into other ways of delivering the required care. It was heard that they had recently hired three new physician's assistants (PAs), and would be hiring four more in the future. This would help with junior level staffing, but it was reported that they were still struggling with higher-level staffing issues. The Trust reported that although they had not yet found a solution, they had begun looking abroad, and looking at potentially restructuring at the consultant level.

With regards to outpatient templates for trainees, the trust reported that they had taken on the previous recommendations; geriatrics trainees were receiving lists of 4-5 patients, and the clinic would be automatically cancelled if there was no consultant present.

It was reported that on the renal unit, occasionally one consultant would cover two clinics, to prevent them from being cancelled. New trainees did not receive a list, so there would be no clinic unless an in-clinic consultant was present to supervise.

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
G1.1	**Patient safety** The trainees reported that in the event of a serious crisis on the St Helier stroke ward, it was not always possible to get hold of a senior doctor to help. In one instance, an F2 was left alone to deal with a very unwell patient with no registrar present, no named registrar to escalate to, and in fact no geriatric registrar across the entire team. The trainee stressed that patient safety had been compromised in this way. The review team heard that between 5pm and 9pm on weekdays, ward cover for medical inpatients was provided by single F1 trainees who usually worked alone without supervision. It was reported that consultant cover was supposed to be available between these times, and at weekends there were two registrars. However, the consultants were often off-site or unavailable, and the registrars were busy managing the take on AMU or the emergency department. The trainees reported that technically the clerking medical registrar could be contacted, but they were often exceptionally busy, and so would not respond. Trainees reported that they had often been required to provide service that they felt was way above their competency level. One trainee reported that they felt patient safety on the St Helier stroke ward was such an issue, that they were not happy to assist providing additional cover to the ward again in the future. The review team heard of an incident where the trainee had discovered seriously unwell patients while covering at night, who were not being seen or dealt with. The trainee reported that they felt that dealing with these patients was	Yes, see G1.1a below. Yes, see G1.1b below.

	way above their competency level, and that they were not comfortable doing so. The trainees all agreed that they would not be happy for their relatives to be treated at the St Helier stroke unit.	
G1.2	**Appropriate level of clinical supervision** Trainees in geriatric medicine reported that there was rarely one known senior consultant that could be relied on in the event of a crisis, though normally someone could be found to help. One F1 trainee in gastroenterology at St Helier reported that they were left alone on the ward on their first day, and that for a few weeks the rota often had nobody covering the ward except for an F1 and a CT2 trainee. Trainees on the stroke ward at St Helier reported that there was no permanent consultant in place, and instead they had to rely on a locum consultant, and a consultant who was covering both the Epsom and the St Helier site. This had led to concern and anxiety over patient safety, as the ward was being run by an F2 and an F1. Orthogeriatrics ST1-2 trainees reported that they felt very lucky, and that the department was well organised and well supported. Trainees in gastroenterology and cardiology reported good levels of supervision from consultants on their designated wards. However, consultant support was poor if the patients were on outlying wards, which were managed mainly by the junior doctors.	Yes, see G1.2 below. Yes, see G1.2b below.
G1.3	**Responsibilities for patient care appropriate for stage of education and training** The review team heard of multiple occasions where ST3 trainees had performed clinics without a consultant present. Despite flagging the issue up in advance, the clinic wasn't cancelled. This issue was most prevalent within gastroenterology, but the trainees confirmed it was common in many departments.	Yes, see G1.3 below.
G1.4	**Rotas** Trainees reported that they often left very late, and would exception report often.	
G1.5	**Handover** Weekend handovers were reported to be a problem, where F1s were left to complete the handover alone, which were often poorly attended. Trainees reported that when turning up at the weekend, they often knew nothing about the patients. It was also reported that handing over to the hospital at night (HaN) team at the St Helier site was a two-step process, where whoever was on ward cover would receive a verbal handover, before subsequently handing over to the HaN team. This meant that they were passing on second hand information, and so any questions that the HaN team might ask could not be answered. It was reported that morning handovers for medical patients at the St Helier site were poorly attended, and that those present would often be pulled away due to being still on call. The trainees felt that this was not a stable or robust system. Trainees at Epsom confirmed that similar issues were present at the Epsom site. Trainees in medicine reported that they felt that handovers from the surgical team were poor, and that they often handed over surgical jobs, in a manner which the trainees felt was opportunistic. Handover problems were also reported by the ST1-2 trainees, especially with regards to morning handovers, where attendance was poor, often leading to trainees searching the hospital to find someone to hand over to. This issue was compounded by severe rota issues, as the trainees were never fully aware of who was supposed to be attending the handover.	Yes, see G1.5a below. Yes, see G1.5b below.

G1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** It was reported that on some wards there was no consistent senior team, which led to poor teaching, and the trainees being forced to pick up the pieces and just complete the ward round without using it as a teaching opportunity. It was highlighted by the trainees that most problems were caused by staffing issues, particularly the AMU, which was being run by two doctors and a physician's assistant. The review team heard of one consultant performing ward rounds of thirty patients. The trainees reported that this meant that almost all the time was spent on service provision, and very little time was dedicated to learning opportunities. Trainees reported that they felt they were not learning much from their time on the geriatrics ward. Cardiology was praised for covering the curriculum well, focussing on teaching and achieving a good balance between service provision and training. Senior trainees in respiratory medicine reported that due to the frequency of on call shifts, and the zero days afterwards, they were struggling to attend their bronchoscopy lists and specialist clinics. It was heard from senior trainees that they were on call one weekend out of every three, and that as a result had only completed two lists and one clinic since October, and were spending a lot of time off of the wards.	
G1.7	**Protected time for learning and organised educational sessions** The review team heard that trainees on the AMU struggled to be available to attend teaching sessions, and that sessions had been cancelled in the past due to there not being enough doctors to staff the ward. Trainees reported that though there was 1 hour of core medical training (CMT) teaching per week, this was often cancelled, and if not, often left one person covering the ward on their own. The review team heard that trainees had been told not to attend regional teaching days if they were on the rota that day, and only to go if they had the day off. Gastroenterology trainees at Epsom reported that they were encouraged to go to conferences however.	Yes, see G1.7a below. Yes, see G1.7b below. Yes, see G1.7c below.
G1.8	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** The review team heard of a number of trainees who had very little contact with their educational and clinical supervisor, including one trainee whose supervisor was based at the Epsom site, and who the trainee had only met once at the beginning of term for five minutes. The trainee reported that they had not conducted a single educational conversation, and had never been seen during clinical practice by their supervisor. Trainees reported that in some cases educational supervisors could be based at a different site to the trainees. Therefore, organising educational meetings was logistically difficult due to the long travel time involved.	Yes, see G1.8a and G1.8b 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.

G2.1	**Impact of service design on learners** F1 Trainees on medical ward cover reported that they are required to carry the '416' bleep, despite the fact that the volume of bleeps that came through was impossible for one person to deal with. The trainees felt that this became dangerous at weekends. The review team heard of one weekend where an F1 and registrar were left with a list of 79 patients to deal with, as well as bleep requests every few minutes. This issue was compounded by the fact that trainees had no way of prioritising jobs, as the bleep was used for all types of requests, including seeing patients and taking bloods. The review team heard of an incident where a trainee had been required to carry two bleeps at once, as well as an incident where the '416' bleep was left on top of a computer, and so a crash call was missed. More recently the Trust introduced an ANP to hold the '416' bleep and filter the calls on weekdays between 5pm and 9pm. Trainees reported that the ANPs are also overwhelmed by the volume of received bleeps from the wards The trainees reported consistently finding the orthopaedics department difficult to work with. The trainees reported that the orthopaedics department felt they were not accountable for patients who developed orthopaedic problems, and had refused to help on more than one occasion. Trainees reported that there had been no improvement regarding ambulatory care, and if anything it had deteriorated. Trainees reported that there was meant to be a consultant responsible for covering ambulatory care, but often the rota in the acute medical unit (AMU) office was incorrect due to swaps and sickness. As a result of this, trainees were often unable to get help when needed and time was wasted trying to chase up the consultant on call while patients were kept waiting. The review team heard of one incident where a trainee was covering on their own, without an on-call core trainee or registrar, and spent a significant amount of time running around the hospital trying to get help. The trainees also reported that many patients were referred into ambulatory care who should not be there, including those with multiple problems, leading to patient safety concerns. The trainees reported that the department acted as a "dumping ground" for patients, and was being exploited by GPs and A&E. The report team heard that patients waiting at 9am often would not be seen until 1-2pm, and that there was no handover system to the on-call team.	Yes, see G2.1a below. Yes, see G2.1b below.

G2.2	**Appropriate system for raising concerns about education and training within the organisation** Trainees reported that they felt the fortnightly meeting at the Epsom site was a waste of time, and that feedback often consisted of being told nothing could be done, or that was just how the system works. They noted that they were able to speak freely, but nothing was ever done. At the St Helier site, the trainees found these forums more useful. The report team heard of an instance at St Helier where the trainees fed back about an issue with phlebotomy, and that the faculty listened and came up with a system to make a phlebotomist available every week.	

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.

G3.1	**Access to study leave** The review team heard that due to staffing issues in the geriatrics specialty, getting time off to attend regional teaching was very difficult, with help needing to be sought from other departments to cover shifts. Senior trainees reported that the study leave approval process was very slow, with one request not being approved despite being submitted six weeks before the date. The trainees reported that it was recently agreed that if they could clear the study leave with their team and get it approved on the rota they could take the time off, but they were concerned that they might have trouble getting money back if the leave was subsequently not approved.	See G1.7c

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.

G4.1	**Sufficient time in educators' job plans to meet educational responsibilities** All trainers said they had sufficient time in their job plan to supervise trainees and that the Trust ensured they had the right skills and support to supervise trainees.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The review team heard that Orthogeriatrics training at the St Helier site was good, and provided good consultant supervision and support.			
The review team heard of the weekly protected teaching time for foundation doctors which the trainees reported was of good quality.			
The review team heard that there were good specialty training opportunities for the higher specialty trainees in the cardiology and respiratory medicine departments.			

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
G1.1a	It needs to be arranged that there is consultant cover between 5pm and 9pm, for the F1s in medicine covering the wards at St Helier, and that they are always contactable and known to the switchboard.	Please provide Consultant rota for cover of ward medicine F1 and LFG minutes to demonstrate this issue has been addressed.	R1.1
G1.1b	In the stroke unit at St Helier there needs to be evidence of daily, named consultant cover, with senior review of all new and sick patients on a daily basis, as well as someone who is urgently accessible to the trainees. This needs to be addressed, or trainees may need to be removed from this clinical environment.	Please provide Consultant rota for cover of Stroke Unit and evidence to show daily ward rounds and LFG minutes to demonstrate this issue has been addressed.	R1.1
G2.1b	It needs to be arranged that a consultant is present at all times in Ambulatory care at St Helier for as long as it is open each day.	Please provide evidence of acute medicine consultant cover and job plans for cover of Ambulatory Care Unit.	R2.3

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
G1.2a	For the geriatric medicine wards, there needs to be a named consultant for the patients and there needs to be named consultant cover that is urgently accessible, and that this cover is made clear to all trainees on these wards.	Trust to provide the consultant rota for the geriatric medicine wards, as well as LFG minutes specifically addressing this issue and confirming that changes have been made.	R1.8
G1.2b	All patients under specialty on outlying wards must be regularly reviewed by responsible consultants.	Please provide evidence of daily consultant ward rounds on patients on outlying wards with appropriate level of consultant supervision and support for the junior team.	R1.8
G1.3	ST3 trainees in medicine should not routinely be undertaking outpatient clinics without their consultant being physically present as well.	When consultant is planned to be absent clinics should be cancelled if trainee scheduled to do the clinic is only a ST3 trainee. Please provide evidence that this is happening and LFG minutes.	R1.9
G1.5a	A standard operating procedure for weekend handovers at both sites to be put in place, with senior oversight and an attendance register.	The Trust to provide a copy of the operating procedure, and the registers for weekend handovers. The Trust to provide LFG and trainee forum minutes to confirm.	R1.14
G1.5b	A standard operating procedure for morning handover at St Helier to be put in place, and audits of the process to be carried out.	The Trust a copy of the operating procedure, and the results of the audits carried out.	R1.14
G1.7a	Trainees on the AMU should be able to attend teaching sessions, and sessions should not be being cancelled on a regular basis.	The Trust to provide AMU teaching programme and register.	R1.16
G1.7b	CMT teaching should not be being cancelled on a regular basis, and should not leave the ward short-staffed when it occurs.	Trust to provide CMT teaching programme and attendance register.	R1.16
G1.7c	Trainees must be released to attend regional teaching days.	The Trust to provide LFG minutes showing that this is being monitored.	R1.16

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Catherine Bryant
Date:	20/12/17

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.