NHS
Health Education England

The Hillingdon Hospitals NHS Foundation Trust

Emergency Medicine, General Practice and Foundation

Risk-based Review (on-site visit)

Quality Review report

26 September 2018

Final

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Quality Review details

Background to review	Health Education England (HEE) planned to conduct the review based on the deterioration in the General Medical Council National Training Survey (GMC NTS) results from 2017 to 2018. There was a significant amount of trainee feedback around workloads and safety concerns, particularly relating to on-call shifts on the acute medicine rota. At the time of the review the Trust had been rated Inadequate by the Care Quality Commission (CQC) and was undergoing additional monitoring by the CQC and NHS Improvement.
Training programme / learner group reviewed	Emergency medicine, foundation, general practice
Number of learners and educators from each training programme	The review team met with eight trainees including general practice (GP), core and foundation year one and two (F1 and F2) trainees. The review team also met with educational and clinical supervisors, training programme directors and educational leads. The following Trust representatives attended the review: • Medical Director • Director of Medical Education • Medical Education Manager • Deputy Medical Education Manager • Training Programme Director for Foundation Year One • Training Programme Director for Foundation Year Two • Programme Director for General Practice (GP) • Deputy Divisional Director for Emergency Care • Guardian of Safe Working Hours • Assistant Director of Operations, Women's and Children's Division.
Review summary and outcomes	The review team thanked the Trust for accommodating the review and for the efforts made in facilitating the process. Several areas of good practice were identified, particularly around supervision, supportive consultants and the quality of specialty training. The review team identified the following areas for improvement: • The national early warning score (NEWS) call arrangements required urgent review. The review team heard that there were approximately 800 NEWS calls per month. The trainee on-call was required to attend all the calls but did not receive adequate information about the case to give advice about initial management or prioritise patients • Not all trainees received a local induction prior to starting in post. Some trainees had an induction but this did not include adequate information to prepare them for the acute medical take • Foundation year two (F2) trainees on-call were responsible for taking emergency department referrals

	• The acute medical unit (AMU) did not have an educational lead for general practice (GP) training. GP trainees working in the AMU were not always released to attend local GP teaching sessions • Foundation and core trainees advised their supervisors that they feared taking responsibility for acute take on-calls as they progressed through their training programme. Some trainees considered altering their plans for training and applying for posts which did not include participation in the acute on-call rota.

Quality Review Team			
HEE Review Lead	Orla Lacey, Deputy Postgraduate Dean for North West London	**External Clinician**	Wendy Matthews, Emergency Medicine Consultant and Training Programme Director, North West London
Emergency Medicine Lead	Chris Lacy, Head of Specialty School of Emergency Medicine	**GP Lead**	Andrew Tate, Head of School for GP, North West London
Foundation Lead	Keren Davies, North Central and East London Foundation School Director	**Lay Member**	Jane Chapman, Lay Representative
HEE Representative	Louise Brooker, Learning Environment Quality Coordinator		

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

The Trust team acknowledged the worsening General Medical Council National Training Survey (GMC NTS) results from 2017 to 2018. It was suggested that much of the negative feedback related to the acute medicine on-call rota rather than to the trainees' experiences of working in specialty wards and clinics. The on-call rota was more affected by rota gaps than other areas and this, coupled with high workloads out of hours, made on-calls particularly stressful for trainees. Difficulties with covering the rotas had been compounded by delays in the Healthcare Education Team at Health Education England (HEE) sending information around trainees working less than full-time, trainees requiring reasonable adjustments for medical reasons and trainees taking out of programme (OOP) periods. There were also vacancies in consultant and non-training junior doctor posts, making the Trust heavily reliant on locums.

The review lead acknowledged these difficulties and enquired about the Trust plans for non-medical staffing solutions, given the decreasing numbers of junior doctors available to fill posts and the national plan to move more medical training posts out of London. The review lead also discussed the need to make both training and non-training medical posts more flexible and attractive to candidates, including the possibility of offering rotations within or between Trusts to non-training junior doctors. At the time of the review there were two physician associates (PAs) working in the emergency department (ED) and recruitment was underway for two further PA posts. It was noted that, although the PAs helped to relieve some workload pressures on the trainees, they were not able to prescribe medications.

The review team heard that there had been 570 exception reports from trainees in the two years prior to the review. Two reports related to missed teaching sessions. The Trust was aware that trainees underreported despite being encouraged to submit exception reports. Approximately half of the exception reports submitted came from foundation trainees. The Guardian of Safe Working Hours advised that this was due to increasing workloads and a desire to avoid overburdening the out of hours on-call team by handing over too many patients. Trainees were usually given time off in lieu rather than overtime payments when exception reports were approved. The Trust had recently introduced an electronic rostering system which had helped to identify and manage gaps in advance.

There was a discussion around the reasons for the increased trainee workloads. It was reported that activity in the ED had increased by approximately 10% per year over the past three years. In response to this, ED was to be renovated and a new ambulatory care unit was to be created. The Trust was working to build up frailty pathways and optimise the discharge process, as well as increasing links with community services to avoid unnecessary admissions. The acute medical unit (AMU) was challenged by vacant consultant posts, leading to a 3.5 whole time equivalent (WTE) consultant rota rather than 6.25 WTE. It was also noted that the physical environment in ED was very challenging and the patient flow through the department required improvement.

Despite the difficulties with staffing, it was reported that trainees gave good feedback about supervision and consultants were engaged with training. Regular local teaching sessions had been well-received and trainees were achieving competencies. GP trainees reported more issues with supervision, particularly in AMU, but a new consultant was due to start shortly after the review and was expected to become the AMU clinical lead for GP training. The Trust ran training for supervisors on managing trainees requiring additional support, assisting trainees to make career choices and delivering feedback. A clinical supervision workshop was also planned.

The review team heard plans for an increased hospital at night (HAN) service. Some elements of this had been agreed and were to be implemented in the months following the review, while others were pending approval. The plans were developed based on feedback from junior doctors, consultants, senior nurses and clinical site practitioners. The Trust was recruiting additional critical care nurses to provide a critical care outreach (CCO) service every day from 08:00 to 20:00. An electronic system for recording patient observations was being rolled out and was expected to be live by the end of 2018. It was hoped that this would make it easier for doctors to manage NEWS calls by allowing them to access patient observation charts remotely. The HAN plans included consideration of the staffing required at all levels, including consultants, junior doctors, senior nurses, PAs, administrators and technicians. The number of national early warning score (NEWS) calls was acknowledged as a challenge and the Trust was looking at ways to reduce senior nurses' workloads to allow them to filter the amber NEWS calls. The peak in activity at weekends had led to a proposal that the CCO service be expanded to provide 24 hour cover from Friday to Sunday. The HAN plans had not been discussed with the current trainees but the previous trainee cohorts had contributed feedback when the plans were initially developed. The Trust was considering the supervision needs of an increasing non-medical workforce and how to manage these.

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

EFG 1.1	**Patient safety** The review team heard that due to the complexity of medical admission procedures and the number of admissions to outlier wards, patients could be missed from the appropriate specialty list. This could lead to delays in patient reviews and treatment, as well as increased length of hospital stay.	
EFG 1.2	**Appropriate level of clinical supervision** Foundation trainees advised that they were well supervised in practice and that senior doctors were friendly and approachable. However, high workloads sometimes prevented senior doctors from being able to assist trainees or giving direct supervision, even when they had not worked with the trainee before and were not aware of the trainee's competency level. The foundation year two (F2), general practice (GP) or core trainee on-call was responsible for holding the emergency department (ED) referral bleep. Bleeps were not filtered by site managers or other senior clinicians. The junior trainees felt that they were more cautious than their senior colleagues and lacked the experience to identify some inappropriate referrals, leading to some unnecessary reviews and admissions. The on-call rota included a higher trainee who held the referral bleep for the urgent care centre (UCC) and GPs. At night, the higher trainee covered the wards and new admissions as well as referrals.	Yes, please see EFG1.2
EFG 1.3	**Responsibilities for patient care appropriate for stage of education and training** None of the trainees reported being assigned tasks beyond their level of competency. However, the trainees did describe difficulty with workload levels, particularly when the team was short-staffed.	
EFG 1.4	**Rotas** The trainees reported that the ED rota at foundation level was challenging and involved working seven nights in 10, but that the supervision and learning opportunities in ED were good. Foundation, core and GP trainees were rostered to work in the Acute Medical Unit (AMU) for on-calls at night and to work with the on-take consultant during the day. The AMU consultant day shift finished at 19:00, at which point the non-resident on-call consultant took over. At night there was no ward round, so the trainees on-call received bleeps regarding individual patients and added these to the list handed over from the day shift. It was reported that around 70% of NEWS calls were placed overnight and at weekends. An additional challenge at night was the high level of nursing vacancies. The trainees advised that some wards were mostly staffed by bank and agency staff. The clinical supervisors (CSs) and educational supervisors (ESs) acknowledged the problems with rotas and the number of gaps at both junior doctor and consultant levels. The Trust attempted to fill gaps with locum doctors, but the review team heard that the competency levels of these doctors varied greatly and this created further stress for the trainees on-call. The supervisors advised that trainees were reluctant to cover gaps in the on-call rota due to the high workloads and short-staffing, which further exacerbated the problem. The patient numbers had also increased in recent years. These issues existed across the medical specialties and emergency medicine.	
EFG 1.5	**Induction** The trainees had all undergone Trust and departmental inductions and were satisfied with the content of these.	

EFG 1.6	**Handover** The foundation trainees reported that there was a team handover at the start of each shift, but that this often started late and could be chaotic. Higher trainees often spent a lot of time clerking patients so were sometimes unaware of the ED referrals received by the junior trainee. Each ward had a different handover proforma and all provided printed copies. The trainees reported that the ward teams handed over sick patients first, then the teams would split so that each team member handed over to their counterpart on the next shift separately.	
EFG 1.7	**Protected time for learning and organised educational sessions** Emergency medicine trainees had a full day of training each month, although they were not always able to attend if they were working night shifts.	
EFG 1.8	**Adequate time and resources to complete assessments required by the curriculum** Trainees reported that they were mostly able to complete work-based assessments and case discussions during their shifts. Trainees tended to complete assessments outside the eight-week acute medical block and during the day rather than on-call. The review team heard that senior doctors were approachable and willing to carry out case discussions retrospectively when needed.	
EFG 1.9	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** All trainees had been assigned ESs and had met with them.	

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.

EFG 2.1	**Effective, transparent and clearly understood educational governance systems and processes** None of the trainees had been given login details for the exception reporting system when their posts started. The trainees had requested logins but the delay in receiving these details had prevented some of them from submitting exception reports.	Yes, please see EFG2.1
EFG 2.2	**Impact of service design on learners** The trainees described the difficulties created by the national four-hour waiting time target for ED. The review team heard that many UCC referrals were made	

	approximately three hours after the patients presented, leaving insufficient time for the trainees to review, treat and discharge or transfer patients before breaching the four-hour standard. The trainees felt that there was pressure from management to rush patient cases and move patients to the Clinical Decision Unit (CDU). When making referrals from ED to the medical teams, the trainees advised that referrals were screened by senior doctors. NEWS calls were discussed and the trainees raised various issues with the system. It was suggested that the system of automatically raising a NEWS call reduced the willingness of some nurses to exercise their own clinical judgement or to make an escalation plan if the trainee on-call was unable to respond quickly. The trainees also reported that healthcare assistants (HCAs) sometimes put out NEWS calls without discussing the patient with a nurse, so when the trainee on-call phoned the ward to determine the urgency of the situation, the HCA would be unable to give an appropriate handover. The NEWS call included the ward name and stated whether the score rated red or amber but gave no further information about the patient or who had put out the call, which could make it difficult for trainees to determine which patient they had been called to see when they arrived on the ward. The trainees suggested that training the nurses to use an SBAR (situation, background, assessment, response) structured handover would allow them to prioritise calls. The trainees reported that the consultants were friendly and good at making the trainees feel part of a team. However, the trainees felt that the Trust culture encouraged acknowledgement of problems but did not necessarily tackle them in a sustained way. An example of this was the introduction of a twilight middle-grade shift during winter. The trainees had found this very helpful as it reduced delays in reviewing and discharging patients, increased the decision-making capacity within the team and meant that fewer patients were handed over to the night team. The CSs and ESs were aware of significant trainee concerns around the acute medicine on-call shifts. Some foundation and core trainees had advised their supervisors that they feared taking responsibility for acute take on-calls as they progressed through their training programme. The supervisors reported that some trainees considered altering their plans for training and applying only for posts which did not include participation in the acute on-call rota. The feedback to supervisors around specialty training was much better as trainees felt there were more learning opportunities and increased supervision on specialty wards and in clinics. The supervisors acknowledged the tension between the need for increased on-call staffing and the wish to avoid reducing time spent in specialty training areas. The supervisors were hopeful about the potential for the hospital at night (HAN) proposals and felt that the additional technical and critical care outreach (CCO) nurses would make a significant difference to trainees' experience on-call. The trainees were not aware of the HAN plans as the consultation period had occurred prior to the start of their rotations. The supervisors also discussed the possibility of altering the role of the clinical site practitioners (CSPs) to allow them to filter some of the referral calls. The need for additional senior staff who could make clinical decisions was acknowledged and the supervisors supported the proposal to add a higher trainee or equivalent non-training grade doctor to the on-call rota. The medicine division had reviewed the proposal and was considering how to meet the additional staffing demand.	Yes, please see Other Actions Yes, please see EFG2.2
EFG 2.3	**Appropriate system for raising concerns about education and training within the organisation** The trainees were not aware of any system for tracking concerns such as understaffing or excessive workload. The review team heard that these issues could be discussed with the consultant or other senior doctor on shift but the prevailing culture was to work hard and try to tackle difficulties as they arose. The trainees were not aware of the local faculty group (LFG) meetings.	Yes, please see EFG2.3
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.**		
EFG 3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The review team heard that trainees had not experienced any bullying behaviour but that all staff in ED were put under significant pressure to meet the four hour waiting time target. The trainees advised that the managers mainly contacted the nurses regarding the target and potential breaches, although all team members were aware of the management scrutiny around this.	
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.**		
EFG 4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The ESs and CSs reported that their job plans made adequate provision for their supervision responsibilities.	
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.**		
	N/A	
6. Developing a sustainable workforce		
HEE Quality Standards **6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.** **6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.**		

6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.
6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.
6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

	N/A	

Good Practice and Requirements

Good Practice
Trainees received good support from the educational and clinical supervisors.
There were local faculty groups in place for medical specialties which met every two months.
Specialty training was described as good and trainees reported access to a range of learning opportunities.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	N/A		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
EFG1.2	F2 trainees should not be responsible for taking ED referrals.	Please provide evidence that ED referrals have been diverted to a more senior team member and feedback from F2 trainees on how this impacts on their acute medicine experience.	R1.11
EFG2.1	The Trust should provide all trainees with logins for the exception reporting system.	Please add this item to the agenda for the next LFG and provide minutes confirming that trainees have login details.	R2.19
EFG2.3	The Trust should ensure that trainees are aware of the arrangements for the LFG meetings.	Please provide evidence of communication to the trainees informing them of the remit of the LFG and details of the next meeting.	R2.1

Recommendations

Rec. Ref No.	Recommendation	Recommended Actions	GMC Req. No.
EFG2.2	The Trust should seek feedback around trainees' specific concerns about certain training pathways and consider how to make these more attractive to trainees.	The Trust is advised to seek trainee feedback through forums such as the LFG.	R2.3

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
Please provide HEE with a copy of the HAN proposals submitted to the Trust Board and inform HEE of the Board's decision.	Trust
The NEWS call system requires review. This action is being monitored following the review of Medicine training on 26 September 2018 and is included in the Trust master action plan under reference M2.2a.	Trust

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Orla Lacey
Date:	14 November 2018

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.