Health Education England

The Hillingdon Hospitals NHS Foundation Trust

Medicine

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	Medical specialties including acute medicine, gastroenterology and geriatric medicine
Number of learners and educators from each training programme	The review team met with nine higher medicine trainees at specialty training levels three to seven (ST3 to ST7). The review team also met with educational and clinical supervisors, training programme directors and educational leads from medical specialties including gastroenterology, geriatric medicine, cardiology, respiratory medicine, anaesthetics and endocrinology. The following Trust representatives attended the review: • Medical Director • Director of People and Operational Development • Director of Medical Education • Medical Education Manager • Deputy Medical Education Manager • Divisional Director for Medicine, Emergency Medicine and Rehabilitation • 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. Two immediate mandatory requirements were issued: • An increase was required in the number of staff to cover the acute medical take, including reintroduction of the 'twilight' middle-grade junior doctor shift and consultant presence until 21:00 seven days per week • The Trust is to ensure appropriate clinical and educational supervision by an acute medicine consultant for the higher trainee in acute internal medicine. The review team identified the following areas for improvement: • Trainees had commenced working on the acute medicine on-call rota without receiving an induction • There was a lack of clarity around whether the on-call team were responsible for attending cardiac arrest calls in the intensive care unit and emergency department.

Quality Review Team			
HEE Review Lead	Orla Lacey Deputy Postgraduate Dean for North West London	**Head of Specialty School**	Andrew Deaner Head of London School of Medicine and Medical Specialities
External Clinician	Nidhi Vaid Acute Medicine Consultant, London North West University Healthcare NHS Trust Training Programme Director, Acute Internal Medicine, North West Thames	**External Clinician**	Kevin Monahan Gastroenterology Consultant, Chelsea and Westminster Hospital NHS Foundation Trust Specialty Lead for Gastroenterology Higher Training, North West London
HEE Representative	Louise Brooker, Learning Environment Quality Coordinator	**Lay Member**	Kate Rivett, Lay Representative

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 for 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.

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 awaited approval. The plans were developed based on feedback from junior doctors, consultants, senior nurses and clinical site practitioners. At the time of the review, approval had gone through for additional technician and administrative support out of hours. 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. There was an additional proposal under the HAN plans to introduce another higher trainee and another foundation, GP or core trainee (or non-training grade equivalents) to the on-call rota. There were discussions around introducing

additional physician assistant (PA) roles on certain wards at night, but no specific plan had been developed at the time of the review. 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
M1.1	**Patient safety** The trainees advised that due to the number of patients admitted to outlier wards, there had been cases of patients being 'lost' to the specialty team in charge of their care. The Trust had altered the arrangements for outlier wards to prevent this from happening, for example by assigning responsibility for one outlier ward to the geriatric medicine team. This had increased the number of patients on the geriatric medicine list (including outlier patients from other specialties) but had improved tracking of inpatients. The review team heard that the quality of nursing care was variable. The trainees reported that there had been cases where the medical teams were not notified of sick patients or where National Early Warning Score (NEWS) calls were not put out at appropriate times. It was suggested that this was linked to the number of nursing vacancies and consequent high rates of bank and agency staff use. The potential impact of rota gaps on patient safety was discussed. The review team heard that the Trust mitigated this impact by hiring locums and paying them agency rates when needed. It was acknowledged that this was not a sustainable solution due to the high costs involved, but it was anticipated that the introduction of additional nursing and support staff under the hospital at night (HAN) plan would help to increase capacity and keep the service safe.	

M1.2	**Appropriate level of clinical supervision** The trainees reported that they felt able to phone the on-call consultant when needed. Some consultants were particularly proactive and would phone the trainee on-call at the start of the shift to ensure the trainees had their contact details and to discuss any anticipated issues. There was an on-call consultant rota which listed the name and phone number for the consultant on-call each night, but some trainees had started working on-call prior to receiving an induction so were not aware of this. Each morning there was a consultant assigned to the acute medical unit (AMU) who reviewed the patients admitted overnight and a post-take consultant who reviewed the patients admitted during the day and patients on outlier wards. The higher trainee on-call from the previous night had to choose which consultant to work with during the two-hour handover period. If the reviews took longer than this, the consultant would continue the reviews alone but the medical and ward teams would have to check the individual patients' notes afterwards to find out what the management plans were. The trainees did not feel that this was safe due to the possibility of delay in reading the notes and acting on the plan.	
M1.3	**Rotas** The review team heard that between 40 and 75 acute medical patients were admitted per day, with more being admitted at night. The acute medicine consultant day shift lasted from 07:00 until 19:00. The consultant shift times were different within the medical specialties, for example in geriatric medicine the consultant day shift lasted from 09:00 to 21:00. Consultant on-calls lasted 24 hours and started at 09:00. The junior doctor on-call rota started at 21:00 and included a foundation year one (F1) trainee, a higher trainee and two core, F2 or GP trainees. The doctors on this rota covered the acute medical take, inpatients and bleeps including referrals and NEWS calls. At weekends the rota included a higher trainee and a core, F2 or GP trainee to cover admissions and another higher trainee working with a core, F2 or GP trainee and two F1 trainees to cover the wards, NEWS calls and discharge reviews. The review team heard that there were around 800 NEWS calls per month, with 70% of these placed out of hours. Staff shortages at all levels in medicine presented challenges for the consultants as well as the trainees. The supervisors reported that consultants were often required to 'step down' to cover junior duties on day shifts. For example, the cardiology team had a single higher trainee so the rota at this level was only covered half of the time. Some trainees reported being moved from their planned area of work to help cover the acute medical take. However, it was acknowledged that this was fairly infrequent and had occurred more often in previous years. Trainees were encouraged to submit exception reports if they missed training opportunities due to being moved to cover the take, but several of them had not received login details for the exception reporting system. The trainees recalled four or five occasions over the past year when a consultant had stepped down to run the on-call team at night in the absence of a higher trainee.	Yes, please see Other Actions
M1.4	**Induction** All trainees reported that they had undergone a specialty induction but some had not had additional induction or information regarding how to manage the medical take. These trainees had commenced working out of hours on-call without knowing the arrangements for handover, ward rounds or the bleep system.	Yes, please see M1.4
M1.5	**Adequate time and resources to complete assessments required by the curriculum** The clinical and educational supervisors (CSs and ESs) advised that they were able to conduct workplace-based assessments with trainees and that there was good access to training opportunities at the Trust. The review team heard that it was sometimes challenging to find time to give trainees feedback as consultants often completed the	

	post-take ward rounds alone while the trainees performed other tasks such as clerking or responding to calls.	

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	**Effective, transparent and clearly understood educational governance systems and processes** The trainees were aware of the local faculty group (LFG) meetings and had a trainee representative who attended. The LFG agenda included feedback from trainees and supervisors, discussion of teaching events and learning opportunities, review of the risk register and any outstanding action plans. The trainees felt that the consultants were receptive to hearing their concerns but had a limited capacity to make changes.	
M2.2	**Impact of service design on learners** There was a discussion around the NEWS call system. The system required the nurse caring for a patient with an amber or red NEWS to put out a call. The call stated whether the score was amber or red and the name of the ward but did not include any further details. As the trainee on-call did not know the patient's name, nurse's name or bed number it could be difficult to locate the patient on arrival at the ward. The trainees reported that sometimes scores were incorrectly calculated leading to unnecessary calls. In addition, the trainees felt that the focus on the NEWS meant that some nurses were slow to call them to see patients who were sick but whose vital signs were within acceptable parameters. On occasion, a healthcare assistant (HCA) would identify a red or amber NEWS and contact the trainee on-call directly without discussing the score with the patient's nurse. It was possible to specify altered NEWS parameters for an individual patient, but this was done using a paper form so the trainee still had to attend the ward to do this. When asked how the system could be improved, trainees suggested that senior nurses or clinical site practitioners (CSPs) could be responsible for filtering the calls, that the calls could include more information and that a better system of handover, such as SBAR (situation, background, assessment, response) be used to allow trainees to prioritise calls. The review team asked the trainees to suggest changes which could improve the service and training experience. The trainees identified the interface between the emergency department (ED) and medical specialties as a problem area, as staff in ED often contacted the medical team rather than seeking support from the ED consultants. It was also reported that once a patient had been referred to the medical team, the ED team would not manage them even if the patient was still located in ED and no member of the medical team was present. The medical trainees on-call were also bleeped to attend cardiac arrests in the ED and in the intensive care unit (ICU) after 17:00. It was reported that the ICU was often full, leading to delays in admitting patients there. Until patients were physically located in the ICU, the ICU team would	Yes, please see M2.2a Yes, please see M2.2b

	not take over their care so medical trainees could be left caring for very sick, high-risk patients in other wards until an ICU bed was available. The trainees suggested that the remits of each department should be reviewed and clarified, as well as the overall patient pathway for medical admissions. The ESs and CSs were not aware that trainees were expected to attend and manage cardiac arrests in ED and ICU. It was reported that these calls used to be put out as 'managed arrest' calls, so the medical on-call team were aware of the situation but were not expected to attend. The trainees advised that they were aware that the Trust intended to increase staffing at night but did not know the details of the HAN proposals. It was reported that the Trust had introduced an additional higher trainee (or equivalent non-training grade) 'twilight' shift from 14:00 to 22:00 daily to help manage the additional workload during winter. The trainees had found that having an additional team member during this period had been extremely helpful and reported that the additional capacity had improved patient flow, as well as making workloads more manageable for trainees at all levels. In particular, it had reduced the number of patients handed over from the day shift to the on-call team. Following the removal of this additional shift, trainees reported that the on-call team frequently took on a list of 10 to 15 patients from the day team, which added to the significant workload overnight and made on-call shifts very stressful. Due to the competing demands on the on-call team, the higher and junior trainees would often go to see patients individually in order to keep up with the number of calls. When asked if this was safe, some trainees admitted that they feared being unable to manage a cardiac arrest appropriately if their colleagues had been called to other locations in the hospital. When asked about the HAN proposals, the ESs and CSs were positive about the possibility of increased staffing capacity and improvements such as the electronic NEWS records. The ESs and CSs agreed with the trainees that the additional 'twilight' doctor had helped significantly with workloads and patient care. There was some concern about the financial cost and length of time that might be required to implement the HAN plans. The CSs and ESs reported that the current arrangements in acute medicine sometimes led to unnecessary admissions as it was simpler to admit a patient than to manage them under the acute service. The trainees advised that they would all recommend their medical specialty training posts to colleagues and that they would be happy for a friend or relative to be treated within their specialty. However, the trainees reported that they would be concerned if a friend or relative presented to the acute medical service out of hours.	Yes, please see M2.2c Yes, please see M2.2d
M2.3	**Appropriate system for raising concerns about education and training within the organisation** The trainees were aware of the Datix system and knew how to submit incident reports, but often did not complete them due to the time required. The review lead emphasised the importance of submitting Datix reports in order to ensure that issues were investigated and that Trust managers were aware of incidents. The review team heard that feedback from incident investigations was sent to the staff member who had submitted the original report. Feedback from serious incidents was escalated to the clinical governance forum meeting. The ESs and CSs also participated in specialty leads and governance meetings where they could raise issues around training. Information around lessons learned from incidents was cascaded via email, bulletins and teaching sessions. There were opportunities for higher trainees to sit on serious incident investigation panels.	
M2.4	**Organisation to ensure access to a named clinical supervisor** Clinical supervision for trainees in the AMU during day shifts was provided by a group of consultants who each worked in the unit for one day per week. One of these was an acute medical consultant but the others were from different specialties. There was some concern that these consultants did not have a full grounding in the acute medicine curriculum and were not able to offer consistent clinical supervision.	Yes, please see M2.4

	There were plans to expand the acute medical unit (AMU) and to move from a five-day to a seven-day service. There was one higher acute internal medicine (AIM) trainee and a core, foundation or GP trainee was also assigned to AMU each weekday. The Trust had attempted to recruit more AIM consultants to run the AMU but had been unsuccessful. The posts were under review to make them more attractive to potential candidates.	
M2.5	**Organisation to ensure access to a named educational supervisor** All trainees had met with their named ESs and knew how to contact them.	

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 supervisors advised that there was good support available for trainees. The Trust had run training sessions for supervisors on how to manage trainees requiring additional support. If trainees raised issues which required escalation, supervisors could bring these to the department of medicine meetings.	

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.

M4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The ESs had time in their job plans for supervision, although it was reported that 0.125PAs (programmed activities) were allocated per trainee rather than the 0.25PA stipulated by the General Medical Council (GMC).	

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
There were local faculty groups in place for medical specialties which met every two months.
The higher trainees advised that one consultant (Dr De Souza) was particularly proactive during on-calls and would contact the higher trainee on-call at the start of each shift to discuss the patient list and offer support.
Specialty training was described as good across the medical specialties reviewed.

Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
M2.2d	HEE requires an immediate increase in staffing including added consultant support to improve the management of the acute take. A minimum of the reintroduction of a twilight middle-grade post and consultant presence until 21:00. This should be on a seven day per week basis.	Please provide copies of the consultant and middle-grade doctor rotas showing these changes.	R1.12
M2.4	HEE requires that immediate arrangements are made for appropriate clinical and educational supervision of the AIM higher	Please provide details of the revised arrangements for supervision of the AIM trainee, including a copy of the consultant	R2.14

	specialty trainee by a consultant in acute medicine with a full understanding of the acute medicine curriculum.	rota for the AMU and feedback from the trainee on the new arrangements.	

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
M1.4	Trainees should be given a full induction at the start of each rotation, including an induction to the acute medical take prior to commencing on-call shifts.	Please provide copies of the induction plans for the next higher medicine trainee rotations which include preparation for the acute medical take.	R1.13
M2.2a	The NEWS call system requires urgent review. The Trust should seek feedback from the trainees as to how best to improve this.	Please provide evidence that the Trust has sought trainee feedback around this issue, this could take the form of LFG minutes. Please provide a copy of the revised NEWS call policy/process document when available.	R2.3
M2.2c	The Trust should clarify the arrangements for cardiac arrest calls and communicate these to the trainees, detailing the types of calls and which teams are responsible for managing arrest calls in ITU and the ED.	Please send a copy of the communications sent to trainees regarding the management of cardiac arrest calls.	R2.3

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
M2.2b	The Trust is advised to review the current system for sending bleeps.	The Trust is advised to consider other members of the team who could filter these, such as CSPs or senior nurses.	R2.3

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
Trainees should be given login details for the exception reporting system. This action is being monitored following the review of Emergency Medicine, Foundation and GP training on 26 September 2018 and is included in the Trust master action plan under reference EFG2.1.	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.