Health Education England

King's College Hospital NHS Foundation Trust
Medicine
Urgent Concern Review (senior lead conversation)

Quality Review report

05 February 2019

Final report

Developing people for health and healthcare

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Quality Review details

Training programme	Medicine
Background to review	The Urgent Concern Review (Senior Leads Conversation) was organised to discuss with the executive team the concerns raised from the Risk-based Review of Medicine on 29 January 2019 at the Princess Royal University Hospital site. The Risk-based review was conducted due to the high number of red and pink outliers from the General Medical Council (GMC) National Training Survey (NTS) in 2018.
HEE quality review team	Geeta Menon Postgraduate Dean Health Education England (South London) Anand Mehta Deputy Postgraduate Dean, Health Education England (South London) Lynda Frost Head of Quality, Patient Safety & Commissioning Team Health Education England (London) Andrew Deaner Head of School of Medicine Health Education England Jan Welch Director, South Thames Foundation School Health Education England Ed Praeger Deputy Quality, Patient Safety and Commissioning Manager Quality, Patient Safety & Commissioning Team Health Education England (London) Bindiya Dhanak Learning Environment Quality Co-ordinator Quality, Patient Safety & Commissioning Team Health Education England (London)
Trust attendees	The review team would like to thank the Trust for the excellent attendance at the meeting. The review team met with the executive team within the including: – Chief Executive Officer – Executive Medical Director – Executive Director of Workforce Development – Director of Medical Education – Guardian of Safe Working Hours

Conversation details

GMC Theme	Summary of discussions	Action to be taken? Y/N

1	**Introduction** The review team raised concerns to the executive team regarding feedback the review team heard on the Risk-based Review (on-site visit) that took place on 29 January 2019 which was conducted due to the high number of red and pink outliers from the General Medical Council (GMC) National Training Survey (NTS) in 2018. The review team had met with all levels of trainees in medicine as well as the trainers. The review team informed the executive team that they had no memory of encountering a group of doctors so distressed, disillusioned and exhausted. It was noted to the executive team that no Immediate Mandatory Requirements (IMRs) was issued on the day as the review team felt the concerns raised would not be fixed within five days.	
2	**Trust response** The Executive Medical Director (EMD) indicated to the review team that parts of the letter received by Health Education England (HEE) had been expected as the Trust was aware of the issues raised by the junior doctors and were proactively working towards addressing them. The EMD indicated to the review team that there were certain themes that they thought had progressed more than others, in particular regards to educational and clinical supervision and staffing issues in the ward environment. The EMD indicated to the review team that there are components of the letter that had changed and some components were actively improving. The review team noted that the GMC survey showed white outliers for Foundation Trainees Level 1 (F1s), Core Medical Trainees (CMTs) and geriatrics in 2017 which deteriorated to red and pink outliers in 2018. The Director of Medical Education (DME) indicated to the review team that this was due to changes in the medical staffing structure and leave arrangements not being addressed.	
3	**Rota Gaps** The Trust were informed by the review team that three CMTs had emailed the review team that had attended the visit as they felt they could not provide feedback on the day. The CMTs highlighted that they felt they had received good experience in the role but commented on the poor management of rotas. The EMD informed the review team they were aware of the issues in regard to the interaction of medical staffing and junior doctors. The review team heard that the medical staffing structure had been remodeled to facilitate the issues and that this had only been implemented within the last month. The EMD felt that changes may not have been seen in such a short period of time by the junior doctors and that the junior doctor frustrations may have been in reflection to historic interactions and not in real time. The Guardian of Safe Working Hours (GoSWH) indicated to the review team that communication between rota coordinators and junior doctors had been variable with junior doctors feeling that they heard of rota gaps and sickness late. The GoSWH recognised that better dialogue between the junior doctors and rota coordinators was needed and informed the review team that trainee representatives attended rota coordinator meetings for perception of roles and future planning of rotas. It was noted by the review team during the on-site visit that the junior doctors were having to chase medical staffing themselves to ensure appropriate support on wards would be provided on the day which took up one to two hours of their shift. The junior doctors felt they were very busy providing service which had a negative impact on educational opportunities. The EMD recognised as a Trust and across both sites that they were aware of a lack of Physician Associates (PAs) and Advances Nurse Practitioner on the wards. The EMD indicated to the review team that the Trust needed to implement a new clinical model to ensure doctors in training felt supported.	

4	**Exception reporting and Incident reporting** The review team noted that although the Trust presented to the review team that the vacancy rate had gone down, the junior doctors felt that this was not noticed on the wards which resulted in junior doctors staying beyond rostered hours. The review team noted that a junior doctor indicated to the review team that they had filed an exception report for staying back late and the feedback received from their educational supervisor was they needed to manage their time better. The EMD found this very distressing and informed the review team that the GoSWH met with trainees regularly. The GoSWH informed the review team that they met with foundation trainees more so than senior trainees and went to specialty meetings and encouraged exception reporting, also informing the junior doctors that they could speak with both themselves as well as the DME if they wished to feedback informally and confidentially. The GoSWH informed the review team that the freedom to speak up guardian had been invited to the next junior doctors' forum to explain their role and how to raise concerns. The review team wanted to highlight that there was no feeling from junior doctors that they felt bullied by consultants not to exception report. The review team noted that the junior doctors felt it was difficult to arrange Time Off in Lieu (TOIL) as it would put added pressure on colleagues. It was noted by the review team that the junior doctors would file Datix reports but reported that they had not received feedback. The EMD informed the review team that there was a robust system of reviewing Datix's which were fed back through governance meetings but recognised that this was not getting fed back to the junior doctors.	
5	**Educational and Clinical Supervision** The review team explained to the Trust that the junior doctors had expressed concerns to the review team in regards to the 48 outliers on the Princess Royal University Hospital (PRUH) site being seen by one consultant and one junior doctor. The EMD noted that this was a major problem particularly on the PRUH site as opposed to the outlier model at the King College Hospital (KCH) site which was much less. The EMD indicated that this was a failure of utilising staff appropriately on the ground. The review team noted that the junior doctors gave a perception of bullying from the Emergency Department (ED) consultants when discussing the ownership of patients. The DME informed the review team that the ED consultants were remorseful of the perception they had created amongst junior doctors. The DME indicated to the review team that they were trailing consultant review-based referrals which would remove difficult conversations in regards to patients between the junior trainees and ED consultants. The Executive Director of Workforce Development (EDoWD) informed the review team that they recognised that leadership at the PRUH site needed strengthening and that a new managing director was due to start in February and indicated that ED transformation would be a key part of their role. The review team highlighted to the Trust that they felt the consultants were not aware of the depth of concern amongst the junior doctors and the lack of progression the junior doctors felt they were making in terms of training. The review team informed the Trust that the consultants had generally felt supported as Educational Supervisors (ESs) with training, appraisals and job plans. During the Risk-based Review, the review team had noted an example of a junior doctor emailing their educational supervisor detailing concerns about a locum geriatrician who gained a copy of the email and inappropriately approached the trainee in front of colleagues and patients. The EMD indicated to the review team that junior doctors were advised to speak with ESs to raise concerns they might have ,however, indicated that they would advise junior doctors to raise concerns directly to the EMD, DME and Clinical Director (CD) in the future. The review team wanted to highlight that they had received positive comments for clinical supervision within cardiology, haematology and for two geriatric wards.	

6	**Handover** During the risk-based Review it was heard by the review team that the perception of junior doctors in regards to the administration of the take was not of the standard that they had expected. This was highlighted by the use of an Excel spreadsheet to track follow ups of acute patients. The EMD indicated to the review team that there was a robust way of following up patients. The EMD noted to the review team they had implemented e-noting and Electronic Patient Records (EPR) at the PRUH site, which had been a fairly late introduction in comparison to KCH site. The review team heard that within the EPR system there was a robust patient handover system.	

Next steps

Conclusion
The review team informed the Trust that they would send out the report from the Risk-based Review (on-site visit) to the Trust for factual accuracy checking before finalising the report. The review team also informed the Trust that a follow up Risk-based Review (Work Programme Meeting) would be organised to help work through a number of the actions that had been highlighted through the on-site visit.

Requirements / Recommendations

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

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
	N/A		

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:	Geeta Menon, Postgraduate Dean for South London
Date:	3 April 2019

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.