NHS
Health Education England

University College London Hospitals NHS Foundation Trust

Foundation Medicine

Risk-based review (on-site visit)

Quality Review report

19 March 2019

Final report

Developing people for health and healthcare

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Quality Review details

Background to review	The review was planned in response to the General Medical Council National Training Survey (GMC NTS) 2018 results. The Trust returned red outlier results for foundation year two (F2) medical training for the following indicators: overall satisfaction, teamwork, supportive environment, induction, adequate experience and curriculum coverage. The Trust returned no pink or red outliers for F1 medicine.
Training programme / learner group reviewed	Foundation Medicine
Number of learners and educators from each training programme	The review team met with eight F1 and six F2 trainees. The review team also met with educational and clinical supervisors from medical specialties including clinical pharmacology, acute medical unit, medical oncology and rheumatology. The review was attended by the following Trust representatives: • Chief Executive • Director of Postgraduate Medical Education • Medical Education Manager • Training Programme Directors for F1 and F2 • Deputy Director of Education • Guardian of Safe Working Hours.
Review summary and outcomes	The review team thanked the Trust representatives for their work in preparing for the review. Several areas of good practice were identified, including the quality of teaching, the availability of mentoring and career guidance and good support for supervisors from the Trust (please see Good Practice section). One area of serious concern was identified and brought to the attention of the Trust management: • The morning triage meeting, where patients admitted over the past 24 hours were handed over to the relevant medical team, was described as rushed, chaotic and providing insufficient information about patients for teams to prioritise reviews appropriately. This meeting was attended by the F1 trainee from each team and there was concern that this was not appropriate. The review team heard that patients had been missed or had their reviews delayed due to incomplete handover being given. Health Education England (HEE) will continue to monitor this issue closely and has written to the Trust outlining the action to be taken in more detail. There were some other areas for improvement identified during the review: • In the weekday evenings, one F2 or core medical trainee (CMT) was on ward cover duty responsible for all medical inpatients. Trainees found these shifts difficult to manage safely, were unaware of how to escalate to an on-call consultant and were concerned that more middle-grade or senior level support was required to ensure patient safety • There were plenty of opportunities for departmental teaching but trainees were often required to answer bleeps and return to the wards during these sessions • Trainees described being asked to undertake out of hours on-calls without receiving a comprehensive, formal departmental induction in several medical specialty departments. Where there was a departmental induction this was sometimes not appropriate to trainees' needs and often did not orientate trainees to the locations of critical areas

	• The trainees were not aware of the purpose of the local faculty groups (LFGs) or how to raise issues through LFG meetings • The current pool of educational supervisors provided a high quality input to trainees but their job plans were not able to accommodate the time commitment needed. There seemed to be delay in opening up the educational supervision accreditation opportunities to a wider or newer group of consultants • The Trust acknowledged that the workload was high in certain areas such as gastroenterology and clinical pharmacology where trainee feedback was proportionately negative. With the intervention of the Guardian of Safe Working Hours, some areas, such as gastroenterology, had diversified the workforce to include physician associates and advanced nurse practitioners, which had a positive impact on trainees' workloads.

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty Deputy Postgraduate Dean North Central and East London	**Foundation School Representative**	Dr Keren Davies North East Thames Foundation School Director
School of Medicine Representative	Dr Andrew Deaner Head of the London School of Medicine	**Lay Representative**	Robert Hawker Lay Representative
HEE Representative	Louise Brooker Learning Environment Quality Co-ordinator Quality, Patient Safety & Commissioning Team Health Education England (London)	**Observer**	Louise Lawson Apprentice Quality, Patient Safety & Commissioning Team Health Education England (London)
Observer	Chiraag Dave Quality, Patient Safety and Commissioning Officer Quality, Patient Safety & Commissioning Team Health Education England (London)		

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

The Trust had 18 foundation year one (F1) posts and 11 foundation year two (F2) posts across eight medical specialties; acute internal medicine, clinical pharmacology, gastroenterology, geriatric medicine, infectious diseases, medical oncology, respiratory medicine and rheumatology. The medical oncology F2 posts were new for the 2018-19 academic year and had replaced two core medical training (CMT) posts. Foundation training was discussed at both of the relevant Medical Education Committees, which met quarterly and reviewed the end of rotation and end of year feedback from trainees.

The Director of Postgraduate Medical Education (DPGME) held meetings with each trainee group in December, March and June each year and the trainees had regular meetings with their Training Programme Directors (TPDs). In addition, there were junior doctor forum meetings every two months. The TPDs advised that trainee

feedback for the geriatric medicine, infectious diseases and rheumatology rotations was usually very good and that acute internal medicine was usually well-rated for teaching and providing a supportive environment. Feedback from the clinical pharmacology and gastroenterology rotations was described as more variable. The DPGME suggested that the Trust response to trainee feedback was improving and that feedback was analysed and acted upon more quickly. The DPGME and Guardian of Safe Working Hours (GoSWH) presented at Board meetings and the Chief Executive reported that educational issues had become more prominent on the Board agenda. The review team heard that during consultant recruitment, the Trust sought candidates with either research or training skills.

The DPGME estimated that there had been three or four serious incidents (SIs) involving a foundation trainee in the past four years. When a trainee was involved in an SI, the DPGME advised that the Trust worked to support the trainee and had received good feedback on this process. This included providing the trainee with copies of communications with Health Education England (HEE).

The 2018 General Medical Council National Training Survey (GMC NTS) results were discussed and the review team heard that there was no apparent single reason for the increase in red outlier results at F2 since 2017. It was suggested that there was some dissatisfaction around the complexity of foundation training in general and particularly for trainees in London who were subject to high living and transportation costs, as well as a lack of continuity of placement Trust from F1 to F2 level in the north central London rotation programme. The Trust had made changes following the survey, including holding in-person interim reviews with trainees, extending the F1 mentoring scheme to include F2 trainees, increasing the provision of career guidance and working to map teaching more closely to the curriculum. The review team heard that the Trust was changing the F2 training model to include full-day sessions rather than shorter, weekly sessions in order to encourage more case discussions and peer support. The Trust had also started to monitor teaching attendance rates more closely and work with the local educational leads to improve teaching quality. Induction was identified as an area for improvement and a memorandum of understanding had been issued to all departments with foundation training posts, stipulating that all trainees should receive departmental inductions. The Trust had produced a chart showing the available sources of support for trainees for human resources, training and pastoral matters and distributed this to the trainees.

The GoSWH noted that the exception reports submitted by foundation trainees in the six months prior to the review had all related to working additional hours rather than missed educational opportunities. Some teams, such as those in gastroenterology, were known to have higher workloads and previous cohorts of trainees had submitted exception reports due to this, but the current cohort had much lower rates of reporting. The GoSWH held meetings with trainees at the end of each rotation where trainees were encouraged to exception report. Trainee feedback around workloads had been used to inform business cases for recruiting physician associates in gastroenterology. The gastroenterology team had also been asked to establish minimum safe staffing levels and ensure locums were brought in to cover gaps when possible. Feedback around the acute medical unit had led to rota changes and increased funding for advanced clinical practitioner posts.

The DPGME reported that all educational supervisors (ESs) had three year accreditation periods and educator appraisals, the majority of which were done by the DPGME. The Associate Director for Medical and Dental Education (ADMDE) advised that the Trust was working to improve the way education tariff funding was tracked at a departmental level and ensuring more detailed reports were available regarding the funding for educational opportunities. The Trust had implemented an electronic job planning system which allowed more detailed planning and monitoring of allocated supervision time.

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
FM1.1	**Patient safety** The review team heard that foundation year one (F1) trainees attended the triage handover meeting each weekday morning, where all medical patients admitted in the past 24 hours via the acute medical unit (AMU) were allocated to the appropriate medical team. The trainees described the meeting as brief, chaotic, often rushed and with minimal information given about each patient, sometimes presented by doctors not directly involved in the patients' care. The trainees advised that they were not always given sufficient detail about sick patients, so there had been cases where medical teams were not aware of the clinical condition of patients until they were contacted by ward nurses seeking urgent medical reviews. Both the supervisors and trainees were confident that the nurses assessed patients appropriately and alert the medical teams with any concerns, but if it was not clear which team the patient was triaged to, the nurses had to contact the general medical doctor on-call. The F2 trainees were concerned that it was difficult, particularly for new F1 trainees to note the relevant information and determine which patients were high priority in this environment. The supervisors noted that there was an electronic handover list in place but this was not used to its full potential. A new electronic records system was due to be implemented and it was hoped that this would improve the handover process and make it easier to access full patient details. The supervisors described a different system in the medical oncology team, where the incoming team received a full patient list and multidisciplinary team handover each morning and evening. The review team heard that the out of hours on-calls in medical oncology were covered by core medical trainees (CMTs) and a higher trainee or equivalent grade locally employed doctor.	Yes, please see action FM1.1
FM1.2	**Responsibilities for patient care appropriate for stage of education and training** On weekday evenings, the on-call F2 or core medical trainee (CMT) took over ward cover duty, making them responsible for all medical inpatients in the Tower Block. There was also a higher trainee on-call but the review team was informed that this individual was typically required to remain in the emergency department (ED) to take admissions. The day shift teams handed over lists of sick patients and urgent tasks to be done to the F2 or CMT on-call, but trainees did not think this handover was robust enough. F2 trainees found these shifts difficult to manage safely, were unaware of how to escalate to an on-call consultant and were concerned that more middle-grade or senior level support was required to ensure patient safety. There was a critical care outreach team which the trainee could call to escalate concerns or to manage medical emergencies. There was an effective hospital at night (H@N) handover system supported by an electronic list for requesting reviews but unfortunately there was no similar system to	Yes, please see action FM1.2a

	hand-back patients deteriorating overnight to the day teams. The handover of patients from the evening to the H@N team was described as well-organised and thorough, with full multidisciplinary involvement.	Yes, please see action FM 1.2b
FM1.3	**Induction** All trainees reported that they had undergone a Trust induction but departmental inductions were described as variable. Most trainees had had departmental inductions for their first rotations but not all had inductions for their second rotations. Where there was a departmental induction this was sometimes described as not meeting the trainees' needs. The trainees were often not orientated to the locations of critical areas in the hospital and described having to struggle to find their way to ED or wards during a cardiac arrest call on their first shifts. In the acute medical unit, trainees were given access to an induction video, which they found very useful.	Yes, please see FM1.3
FM1.4	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The F1 trainees advised that their access to learning opportunities often depended on their team's workload. The review team heard that workloads in the rheumatology and infectious diseases teams were more manageable and that trainees in these teams had access to more ward-based teaching, whereas trainees in other teams could find it difficult to find time to attend ward rounds or discuss patients' treatment plans with the consultants. The majority of the F2 trainees felt that they were exposed to a good case mix and were able to participate in ward rounds and present to the consultants. However, it was reported that there were few opportunities to attend clinics as an F2. The supervisors agreed that team workloads impacted on training in terms of their ability to fit in ward-based teaching and complete supervised learning events at busy times. However, the supervisors advised that trainees were encouraged to actively participate in the work of the team and were usually able to attend at least part of the ward round and to discuss cases with consultants afterwards.	
FM1.5	**Protected time for learning and organised educational sessions** The review team heard that each specialty had dedicated teaching sessions and that there were additional learning opportunities in some teams, such as the gastroenterology journal club and the acute medical unit governance meetings. There was week F2 teaching for an hour but the trainees advised that a longer monthly session would be preferable. Teaching sessions were officially bleep-free, but the trainees advised that on some rotations they were unable to hand over their bleeps to colleagues and that they had missed parts of teaching sessions when responding to bleeps. The F1 trainees felt that they would benefit from more specialty teaching and reported that general F1 teaching was not always included in their rotas, making it more difficult to attend.	Yes, please see action FM1.5

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.**		
FM2.1	**Effective, transparent and clearly understood educational governance systems and processes** The trainees were aware that there were various feedback mechanisms available to them, including the junior doctor forum which was attended by trainee representatives. Most of the trainees did not know about local faculty groups (LFGs). Some trainees had submitted feedback to the junior doctor forum but they reported that they were not always informed of the outcome. A few of the trainees had submitted exception reports and had either been given time off in lieu of the extra hours worked or been paid overtime.	Yes, please see action FM2.1
FM2.2	**Impact of service design on learners** The majority of trainees said that they would be happy for a friend or family member to be treated at the Trust, but some had reservations depending on the department and timing of treatment. The trainees advised that the training experience varied between teams in terms of workload, continuity of supervision and amount of senior support available. Geriatric medicine, rheumatology and the acute medical unit were commended for providing a good overall training experience. Some teams were known to be more challenged in terms of staffing and workloads, which was reflected in the experience of trainees. It was noted that the medical oncology F2 posts were new and that the team was working to reconfigure these as they had previously been CMT posts. Clinical pharmacology was also given as an example of a busy but small team with a high numbers of outlier patients. The trainees noted that supervision in clinical pharmacology was good but that the consultants and middle-grade doctors changed frequently so there was a lack of consistent staffing in the team.	
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.**		
	N/A	
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.**		
FM4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The review team was informed that most supervisors had time allocated in their job plans for supervision work, either as part of their SPA (supporting programmed	

	activities) time or as specific PA (programmed activities) time. The Trust was transferring job plans to an electronic system. In teams with higher workloads or teams most affected by winter pressures, some supervisors found it difficult to fit in supervision activities. The supervisors noted that it was quite complex to obtain supervisor accreditation from the Trust. It was suggested that simplifying this process might encourage more consultants to become supervisors, which would particularly benefit teams with smaller numbers of consultants. The supervisors commended the support provided by the postgraduate medical education (PGME) team. The review team heard that there were regular communications from the PGME team, all supervisors had regular appraisals and supervision training was available on a range of topics.	Yes, please see action FM4.1

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.

FM5.1	**Opportunities for interprofessional multidisciplinary working** The trainees felt that there were good working relationships between the multidisciplinary teams and that the inclusion of additional non-medical roles in some teams had had a significant positive impact on trainee workloads. For example, the gastroenterology team included an advanced clinical practitioner (ACP) who shared the work of clerking and performing some simple procedures with the trainees. The interface between the infectious diseases and outpatient antimicrobial teams was also described positively.	Yes, please see action FM5.1

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
The trainees reported that there was excellent formal and ward-based teaching in several departments, including geriatric medicine, rheumatology and the acute medical unit.
The educational and clinical supervisors were described as being supportive and approachable.
The trainees were aware of some formal mechanisms for giving feedback to the Trust, such as the junior doctor forum.
The Trust provided F1 trainees with support to plan and develop their career pathways and offered a mentoring scheme.
The supervisors had regular appraisals, access to supervision training and felt well-informed by the postgraduate medical education team.
The trainees reported that there was excellent formal and ward-based teaching in several departments, including geriatric medicine, rheumatology and the acute medical unit.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	None		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
FM1.1	The Trust is required to (a) review urgently the structure and risks associated with the verbal transfer of information and effectiveness of the triage meeting, (b) establish an electronic handover distribution list and (c) review whether the F1 doctor (being the most junior member of the team), has the necessary training, experience and skill to receive and transfer triage information.	HEE has written to the Trust outlining these requirements and setting deadlines for follow-up by 5 April and 19 April.	R1.2
FM1.2a	The Trust is required to review the workload of the weekday evening ward cover doctor on-call (F2 or CMT). The Trust should establish a clear escalation protocol for this role, identify which middle or senior grade doctor is responsible for supervision and cascade this information to all trainees.	Please provide a copy of this escalation protocol and evidence that this has been communicated to the F2 trainees and CMTs. Please provide this by 31 May 2019.	R1.8
FM1.2b	The ward cover doctor should have a robust system of handing back patients to the day teams at the end of the shift in the morning, replicating the effective H@N system.	Please provide a copy of a protocol or process document outlining the system for handover between the H@N team and the day shift teams, as well as evidence of trainee feedback confirming that this	R1.14

		system is fit for purpose. Please provide an update on this by 31 May 2019.	
FM1.3	The Trust should ensure that trainees receive robust departmental inductions at the start of each rotation. The Trust is advised to seek feedback from the current trainees and ensure that induction includes a tour of the hospital critical areas. Trainees should not be required to work out of hours without completing this induction.	Please provide evidence that trainee feedback has been sought on this issue and that all departments are aware of the requirements for induction. Please provide an update on this by 31 May 2019.	R1.13
FM1.5	The Trust should mandate that all formal teaching sessions are bleep-free and that trainees are not prevented from attending scheduled teaching sessions due to clinical responsibilities.	Please provide trainee feedback confirming that they are able to attend formal teaching sessions and that the sessions are bleep-free. This could be in the form of LFG or junior doctor forum minutes. Please provide an update on this by 31 May 2019.	R1.16
FM2.1	The Trust should cascade information about the purpose of and arrangements for the LFG meetings, encourage trainee attendance and provide feedback as planned for the meetings between the trainees and the DPGME.	Please provide evidence that this has been communicated to the trainees by 31 May 2019.	R2.1

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
FM4.1	Trust should consider providing a more flexible access to accreditation for consultants to become educational supervisors. Some specialty teams have few accredited supervisors and the review team heard that there were consultants who were willing to become supervisors but found the accreditation process overly complex and lengthy.	The Trust is advised to review the current requirements for accreditation and consider removing any which are not essential to meet GMC guidance.	R4.1
FM5.1	The Trust should consider incorporating non-medical roles in other teams with challenging workloads, such as clinical pharmacology.	The Trust is advised to consider which teams would benefit from the addition of non-medical roles, such as physician associates and advanced clinical practitioners. The Trust is welcome to seek advice from the HEE workforce team if needed.	R5.9

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
None	

Signed

By the HEE Review Lead on behalf of the Quality Review Team:	Dr Indranil Chakravorty Deputy Postgraduate Dean
Date:	14 May 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.