NHS
Health Education England

Barking, Havering and Redbridge University Hospitals NHS Trust

Neurology

Risk-based Review (focus group)

Quality Review report

06 August 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	This risk-based review was planned following the release of the General Medical Council National Training Survey (GMC NTS) 2018 and 2019 results and subsequent discussion with the Clinical Lead for Neurology. The focus group was also an opportunity for the review team to revisit the agreed actions from the last quality review and to assess whether these changes had been implemented and sustained by the Trust. The three main issues found at the last quality review were: • Neurology registrars were taking calls from different wards with no designated consultant to get advice from. Additionally, as there were no foundation or core medical trainees, the higher specialty trainees were having to "step down" to cover rota gaps. • Trainees were not being given access to specialty clinics due to workload pressures and service commitments. • There was found to be no engagement, pastoral care or specialty support from majority of the consultants to the trainees.
Training programme / learner group reviewed	The review team met with three Neurology trainees from the London Neurology training programme and the East of England Neurology training programme.
Quality review summary	Health Education England (HEE) thanked the Trust for the work done to prepare for this review and for ensuring that the trainees were released from their duties to attend. HEE also thanked the trainees for their attendance and participation in the review.

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty Deputy Postgraduate Dean Health Education England (London)	**London School of Medicine Representative**	Dr Catherine Bryant Deputy Head of School of Medicine Health Education England (London)
East of England School of Medicine Representative	Dr Fraz Mir Head of School of Medicine Health Education England (East of England)	**HEE Representative**	Andrea Dewhurst Quality, Patient Safety and Commissioning Manager Health Education England (London)
East of England Training Programme Director	Dr Rhys Roberts Health Education England (East of England)	**HEE Representative**	Paul Smollen Deputy Head of Quality, Patient Safety and Commissioning
Observer	James Oakley	**Lay Representative**	Robert Hawker

	Quality, Patient Safety and Commissioning Officer Health Education England (London)		

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive learning experience for service users.

1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.

1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence based practice (EBP) and research and innovation (R&I).

1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.

1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.

1.6 The learning environment promotes inter-professional learning opportunities.

Ref	Findings	Action required? Requirement Reference Number
S1.1	**Patient safety** The review team heard that there had been a couple of occasions when specialty trainees had been unable to reach a consultant via telephone for an acutely unwell patient and that this had posed a risk to patient safety. The trainees confirmed that these instances had been raised as a serious incident although no individual feedback had been received. The trainees confirmed that they felt secure that consultants would review the patients when requested. However, it was also commented that the consultant body did not appear to be proactive in reviewing patients face to face. The review team heard that there was no routine consultant-led daily ward round of all inpatients.	Yes, please see S1.1a Yes, please see S1.2a Yes, please see S1.1b
S1.2	**Appropriate level of clinical supervision** The trainees reported that consultant supervision and feedback had improved since August 2018 with the majority of consultants calling in at least once a day to discuss patients with the trainee; previously it was one hour per week to review 35 to 40 patients. However, the review team heard that consultant supervision for trainees had been variable particularly in relation to patient referrals and commented that there had been instances when the consultant was inaccessible and they had faced difficulty in obtaining	Yes, please see S1.2a

	feedback and guidance on the patient cases. The review team also heard that some consultants would meet the trainee one to two times per week face to face. The review team heard that the consultant of the week responsible for referrals was not always on-site and that the majority of referrals were therefore not reviewed by a consultant in person. The trainees further advised that the consultant would be available by phone but that often the consultants would be based at another site for two or three days of the week. The trainees reported that patients under neurology were seen once a week by a consultant but sometimes it had been less and this had increased the responsibility for the trainee who had assumed ward registrar responsibilities. The review team heard that formally there were eight inpatient beds but that including outlier patients the average workload was between 12 and 15. The trainees further advised that the ward registrar was responsible for the planned day case unit. In terms of support, the trainees discussed patient cases but that as they were all at a similar level with no trainee above specialty training 4 (ST4) they would tend to seek advice formally from the consultant. However, it was noted by the review team that moral support and advice during difficult times came from the trainee peer group. The review team heard that none of the trainees would recommend their post.	Yes, please see S1.2b
S1.3	**Rotas** The review team heard that the rotation had been difficult due to rota gaps but it was felt that even with a full complement of trainees that it would be difficult to obtain adequate training and access to clinics. The trainees reported that the current rota for the service had made it difficult for them to achieve their clinic requirements given the need to manage the referrals phone on the ward. It was heard that majority of referrals were not specialty specific and not of educational value for trainees; the trainees reported that as part of the referral review process was spent undertaking non-neurology-based tasks and resolving issues, that there were limited learning opportunities. The review team heard that the trainees were only required to undertake stroke on-call for one evening per week and 1 in 8 weekends. There was no requirement to undertake neurology on-calls. The trainees advised that although the stroke on-call could be challenging there was support from the stroke consultants and there had not been an issue in accessing the on-call consultant who would normally be on-site.	Yes, please see S2.2a
S1.4	**Induction** N/A	
S1.5	**Protected time for learning and organised educational sessions** The trainees reported variability with regards to the quality of educational opportunities. There was a Monday neuroscience meeting but the review team heard that this was often taken over by audit and governance issues which the trainees felt was not always educational. The review team further heard that the trainees were supposed to have weekly consultant teaching but that in reality teaching happened about two thirds of the time; it did not take place every week routinely.	Yes, please see S1.5

2. Educational governance and leadership		
HEE Quality Standards **2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.** **2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.** **2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.** **2.4 Education and training opportunities are based on principles of equality and diversity.** **2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.**		
S2.1	**Effective, transparent and clearly understood educational governance systems and processes** The trainees confirmed that Local Faculty Group meetings took place with the Clinical Lead.	
S2.2	**Impact of service design on learners** In terms of the structure of the ward, the trainees reported that there was no junior support at foundation and core medical training level and in addition, the trainees felt that there was limited consultant support, with ST3 trainees responsible for all neurology inpatients. Recently a CMT doctor had been allocated to the ward for a proportion of the time. The review team heard that the key issue for trainees was the inability to attend clinics; trainees reported that they spent the majority of their time on referrals or being ward registrar due to the frequent rota gaps. It was hoped that following the appointment of a core medical doctor that the pressures on the trainees would be reduced and that they would then be able to attend clinics. The trainees advised that it was not possible to be the ward registrar and attend clinics; trainees either went to clinics or reviewed referrals. The trainees reported that they had only attended three clinics within the last month and the trainees felt that this had affected their curriculum aims for the placement. With regards to the acute clinic, the review team heard that this was registrar-led. However, there was no on-site consultant supervision, despite the consultant on-call being responsible for the clinic. With regards to the general neurology clinic, the review team heard that whilst the trainees would review some patients, they did not have their own patients on the list. The trainees also felt that the clinics did not always provide educational opportunities for learning with one in four clinics focussed on acute neurology without any Consultant supervision. It was also noted that the trainees had attended obstetric clinics as the sole neurology representative; there was no neurology consultant involvement.	Yes, please see 2.2a Yes, please see S2.2b Yes, please see S2.2a Yes, please see S2.2
S2.3	**Systems and processes to make sure learners have appropriate supervision** The review team heard that the Clinical Lead had been working with the consultant body to improve the clinical learning environment for trainees. The trainees reported that they found the Clinical Lead to be accessible and approachable at all times.	

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 to achieve the learning outcomes required.

3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.

3.3 Learners feel they are valued members of the healthcare team within which they are placed.

3.4 Learners receive an appropriate and timely induction into the learning environment.

3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.

S3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The review team heard that there had been instances where the trainees had observed behaviours that could be considered unprofessional and undermining. The trainees were also uncertain as to whether they would be happy for their friends and family to be treated within the neurology department. The trainees felt that whilst the neurology consultants had the will to change the learning environment, there was not the time within the consultant job plan to make the required changes.	

4. Supporting and empowering educators

HEE Quality Standards

4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.

4.2 Educators are familiar with the curricula of the learners they are educating.

4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.

4.4 Formally recognised educators are appropriate supported to undertake their roles.

	N/A	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.

5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.

5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

S5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The trainees reported that they would receive feedback for a work place based assessment if requested from their consultant.	

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

Immediate Mandatory Requirements

The most common outcome from a quality intervention. The risk rating must fall within the range of 8 to 12 or have an Intensive Support Framework rating of 2.

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
	None	N/A	

Minor Concerns

Low level actions which the Trust need to be notified about and investigate, providing HEE with evidence of the investigation and outcome. Given the low level nature of this category, the risk rating must fall within the range of 3 to 6 or have an Intensive Support Framework rating of 1.

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
S1.1a	The Trust should ensure that there is learning from serious incidents and as part of this there is the requirement for the Trust to provide evidence on what is included within the audit and governance meetings.	The Trust is to provide evidence within one month of this report being issued as final that learning is given to trainees from serious incidents (through the form of discussion at Local Faculty Groups or weekly neuroscience meeting) and also confirm what areas are covered within the audit and governance meetings.	R1.3
S1.1b	The Trust is required to ensure that there is at least one daily consultant led ward round of all neurology inpatients.	The Trust is to provide evidence within one month of this report being issued as final that there is a daily consultant ward round of all patients.	

S1.2a	The Trust is required to ensure that the consultant of the day is free of duties and available on-site. The consultant of the day should also be expected to review requests for Neurology consults (referrals) from any other ward before being passed to the trainee. There should also be an end of day face-to-face meeting with the trainee, to provide support, guidance and learning from the review of Neurology referrals.	The Trust is to provide evidence within one month of this report being issued as final that the consultant of the day has responsibility for managing the referrals and that there is daily, face-to-face, communication with the trainees.	R1.8
S1.2b	There should be a review of the consultant working patterns to ensure that they are accessible and on-site for trainee support.	The Trust is to provide evidence within one month of this report being issued as final that there has been consideration and a review of the consultant work plans.	R1.8
S1.5	The teaching session must be consultant delivered with feedback.	The Trust is to provide evidence within one month of this report being issued as final that weekly consultant delivered teaching is taking place for all neurology trainees.	R1.16
S2.2a	The Trust is required to ensure that each trainee has a timetable for the week with a named consultant with three clinics per week: one general neurology clinic which is consultant supervised with their own list of nine or ten patients, one specialist trainee led clinic, and one acute neurology clinic to give the trainees a mix of referrals. All clinics must be supervised with a consultant present and next to the trainee. The Trust is required to ensure that there is adequate provision of junior staff to provide daily clinical input for ward and day unit patients. This may be in the form of a multi-skilled workforce including Physician Assistants, Nurse Practitioners, Advanced Practitioners and junior medical staff. The ward cover registrar must not be routinely required to step down and undertake routine ward cover duties not appropriate to their educational needs.	The Trust should provide evidence within one month of this report being issued as final that all trainees have access to, and attend, three clinics per week and that these are consultant supervised.	R1.12
S2.2b	The Trust is required to ensure that no clinics (e.g. Acute Neurology & Joint Obstetric clinics) are run without the presence of a designated Consultant to provide on-site supervision.	The Trust to provide evidence within one month of this report being issued as final that the trainees are no longer attending clinics without direct Consultant supervision.	R2.3

Recommendations

These are not recorded as 'open' on the Trust action plan so no evidence will be actively sought from the Trust; as a result, there is no requirement to assign a risk rating.

Rec. Ref No.	Recommendation	Recommended Actions	GMC Req. No.
	None	N/A	

Other Actions (including actions to be taken by Health Education England)

Requirement	Responsibility

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Indranil Chakravorty (Deputy Postgraduate Dean Health Education England London)
Date:	03 September 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.