Health Education England

Bart's Health NHS Trust (Newham University Hospital)

Medicine

Risk-based Review (on-site visit)

Quality Review report

05 November 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Training programme / learner group reviewed	Medicine
Number of learners and educators from each training programme	The review team met with four foundation, GP, core and higher medical trainees, working across acute medicine and medical specialities (including respiratory, endocrinology, geriatrics and gastroenterology). The review team also met with clinical/ educational supervisors from the department of medicine and the following Trust representatives: • Chief Medical Officer • Director of Medical Education • Associate Director of Quality for Medical and Dental Education • Foundation Training Programme Director (FY1) • Foundation Training Programme Director (FY2) • Deputy Director of Medical Education • Deputy Director Education and Quality (Medical & Dental) Education Academy • RCP Tutor and local Core Medical Training/Improving Medical Training Lead

Background to review	This risk-based review was organised to explore a number of ongoing concerns that had impacted on the quality of education and training in the acute internal medicine and medical specialities at Newham University Hospital (NUH). Health Education England had concerns around the significant deterioration of the 2019 General Medical Council (GMC) National Training Survey (NTS) results.
Supporting evidence provided by the Trust	In advance of the quality review on 05 November 2019, Bart's Health NHS Trust submitted the following evidence to the Health Education England Quality, Reviews and Intelligence team. This evidence was reviewed by the quality review team as part of the pre-review processes. • Cardiology Dashboard for (September 2019) • Consultant Training Record • Friends and family test • General Medicine on-call Rota (August 2019) • Learning from excellence report • Local Faculty Group minutes (25 September 2019) • Medical Division Minutes • Medicine Decision Board Action Log (2019) • Medicine Division Incidents • Medicine Division PALS • Newham Medical Division Educational and Governance Day (EGAD) Minutes (29 August 2019) • NMEC Minutes • Older Person Services and Stroke Dashboard (September 2019)

	• PA Allocation • Quality and Safety Report • Respiratory Dashboard (September 2019) • Teaching and Simulation feedback • Updated Trust action plan

Summary of findings	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. The review team was pleased to note the following areas that were working well: 1. The review team was delighted to hear a universal acknowledgement of the great respect that all trainees had for their consultants, the pastoral care, the high-quality teaching and the approachability that they offered. This was a critical ingredient in balancing the many challenges that the Trust site faced. 2. The review team was pleased to hear that the Local Faculty Groups (LFGs) in medicine had been recently reinstated, and that consultants attended with great enthusiasm. Trainees recognised a willingness from consultants to listen to their concerns and make amends. 3. The review team heard that the Simulation team provided excellent in-situ training specifically in managing patients with tracheostomies in a multi-professional setting. 4. The review team noted that the consultants encouraged trainees to undertake quality improvement (QI) work that they were focused on making a true difference to the department pathways. 5. The review team was pleased to hear that the gastroenterology department had a daily multidisciplinary teams (MDT) for discussing and managing their patients. 6. The review team was delighted to hear that the Palliative Care team provided an exceptionally responsive and timely service. 7. The review team was encouraged to hear that nearly all departments were providing one to three hours of consultant led, curriculum relevant teaching to all trainees on a weekly basis. 8. The review team heard that there was a universal willingness to accommodate trainees' requests for study leave. The review team identified the following areas of serious concern: 1 The review team heard that a number of trainees arriving at the Trust were allocated to be on call on the day and night of the main induction date. The trainees reported that this resulted in them missing this induction date, not having access to SMART cards or logins to the electronic records systems for their first shifts and having to work with borrowed logins from nurses. The IT induction systems were not able to deliver to the requirements of the trainees and several trainees reported waiting up to three weeks to receive their logins. This was a serious governance concern and exposes the Trust and trainees to potential risks. 2 The Trust had recently introduced new electronic forms for do not attempt cardiopulmonary resuscitation (DNAR-CPR) orders and treatment escalation plans (TEPs) which were linked to the electronic patient records (EPRs). The trainees considered this to be unsafe as there had been incidents where the forms were not visible, forms had expired because they were not validated by a consultant within 24 hours, and printed forms were difficult to locate in the paper notes. Trainees also reported that the complex acute medical on call consultant rota meant it was not always

clear which consultants these forms should be referred to. It was reported that several patients had received CPR despite the presence of a DNA-CPR order because of these issues.

3 The weekend cover for critical care unit-acute care unit (CCU-ACU) (which included up to 25 patients requiring enhanced monitoring and management) was reported to have been provided by the geriatric core training-grade doctor. It was reported that this individual was not part of the team managing the patients during weekdays and there were concerns that there was not a sufficiently robust handover process or a clear plan for senior supervision or oversight for these shifts. The review team felt that this was unsafe and exposed relatively inexperienced trainees and a cohort of more acute patients to potentially suboptimal care. The trainees also described feeling unsafe and unsupported under this arrangement.

However, the review team also noted several other areas for improvement:

1 The review team heard that NUH did not have a designated Medical Assessment Unit (MAU), which was noted to be unusual and contributed to significant challenges around the acute medical on call pathway. The review team did not consider the current system of flexible use of an 'Observation Ward' attached to the emergency department (ED) to be an efficient, safe or sustainable solution.

2 The medical rota included three sections; Acute, Geriatrics and ward cover. This was combined with a traditional system of individual firms being on call and taking responsibility for all medical admissions for a 24-hour period. The on-call team did not clerk these patients or review them on ward rounds until the day after admission.

3 The system for managing outlier patients was described as inefficient and potentially unsafe. Outlier patient numbers were not restricted and there was no system for grouping outlier patients to ensure that nursing teams could track which medical team was responsible for their care, creating delays to escalation of unwell patients and to patient discharges.

4 All patients over the age of 75 years were allocated to the Geriatrics team irrespective of their frailty needs. The review team advised that it would be more appropriate to move to a needs-based system to allow the Geriatric medicine team to provide a dedicated acute frailty service. The current practice of multiple outliers will need to change to a more robust and stable ward-based management.

5 The 09:00 Geriatrics team handover was attended by the consultant in charge of the post-take where all geriatric inpatients were discussed. The Acute Geriatrics team did not routinely attend handover but reviewed patients on other wards. None of the clerking doctors were able to present the patients except for the night team and only for over 75years between 08:00 till 09:00.

6 The review team heard that ward cover was provided by a middle grade doctor and a foundation year one (FY1) trainee, who were responsible for covering six wards accommodating over 150 patients in total. The review team heard of no established system of handover of deteriorating patients or jobs at 17:00. It was reported that the Geriatric team doctor on call in the evening (usually the FY1 doctor) received a high volume of bleeps from various wards with multiple requests. This shift was described as unsafe and unmanageable. The Acute Medical on call junior doctor appeared to be the only person who could provide senior support to the FY1 doctor.

7 The review team heard that the weekend acute medical handover at 16:00 on a Friday required a robust electronic system for safe transfer of information and an audit trail. The weekend management of deteriorating

	patients was the responsibility of a middle grade doctor and a FY1, but there was a need for senior oversight and support. The review team heard that the Critical Care Outreach team provided much needed support and expertise to colleagues caring for deteriorating patients on the wards but required additional resources (such as physician associates and nursing associates) to ensure sufficient capacity and skill mix. 8 The review team noted that the Radiology department appeared to be unable to accommodate the requests for Ultrasound Scan (US), Computer Tomography (CT) and Magnetic Resonance Imaging (MRI) scans based on clinical need and that trainees frequently experienced delays in receiving written reports. Trainees described delayed management and significant alteration to the 'verbal reports' leading to risks in timely management and discharge. 9 The review team was informed that the nursing teams required training in the use of National Early Warning Scores (NEWS), escalation of unwell patients and use of standard handover tools when making referrals. There were concerns that the lack of training or consistent process around this created a patient safety risk as well as leading to inappropriate referrals and tension between the nursing and medical teams. 10 Due to a reduction in capacity at consultant level in the Geriatric medicine team, there was an interim cover arrangement in place for the Fothergill ward and intermediate care beds. The trainees advised that this arrangement reduced their access to the specialist wards, offered few learning opportunities and depleted the junior doctor cover on other inpatient wards. 11 The Trust must ensure that FY1 doctors on the new rota must be expected to clerk and present patients on ward rounds. 12 The review team was disappointed to hear that the Internal Medical Trainees (IMT), Core Medical Trainees (CMT) and higher trainees were not able to attend the requisite number of clinics to meet their curricular requirements. 13 The Trust was urged to ensure that private spaces were available in ward areas for supervision conversations and for completing work-based assessments.

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty Deputy Postgraduate Dean Health Education England	**Foundation School Representative**	Dr Keren Davis Foundation School Director
Head of School Representative	Dr Catherine Bryant Deputy Head of School of Medicine	**General Practice Representative**	Dr Lakhvinder Larh Programme Director, Newham Scheme
Newham General Practice Representative	David Price Associate Programme Director (Newham)	**Training Programme Director**	Dr Cianan O'Sullivan Consultant Geriatrician/Physician Homerton University Hospital
Lay Member	Robert Hawker Lay Representative	**Shadow Lay Member**	Rosealine Thornton Lay Representative

HEE Representative	Tolu Oni Learning Environment Quality Coordinator Health Education England

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

The review team met with the former Divisional Director (DD), Director of Medical Education (DME), Deputy Director of Medical Education (DME), Clinical Director (CD), College Tutor, Foundation Training Programme Directors (FY1 & FY2), Associate Director of Quality and Medical Education Manager (MEM) and discussed the General Medical Council National Training Survey 2019 (GMC NTS) and the department's response to the current pressures on the current acute pathway system. In terms of 2019 GMC NTS survey, the College Tutor (CT) advised that the number of red and pink outliers had been unexpected.

In terms of 2019 GMC NTS survey, the CT advised that the number of red and pink outliers had been unexpected. The review team was encouraged to hear that the department now had regular monthly local faculty group (LFG) meetings with attendance from a named trainee representative and representation from respective Training Programme Director (TPD) Leads. At the LFG, the DME reported that the NTS results were discussed, and that the trainees' feedback highlighted some areas of concern specific to handover, educational governance and rotas (specifically relating to study leave and workload). The review team heard that the department had reinstated a new middle-grade led handover arrangement. In terms of the GMC NTS report for Gastroenterology, the DME indicated that the reports constituted mainly of feedback from core and higher trainees. The CT also asserted that the Gastroenterology higher trainees enjoyed a rich spectrum of learning opportunities which included access to endoscopy training commensurate with their curricular requirements. The DME also reported that the department had introduced educational and governance days (EaGD) which enabled increased engagement with trainees. It was understood that that learning from serious incidents had significantly improved since the implementation of EGAD days. The review team heard that General Practice (GP) trainees had highlighted concerns around workloads and difficulty in attending General Practice Vocational Training Scheme (GPVTS) study days. The DME described examples across the Trust where a number of specialities had successfully integrated study leave days into their rotas but suggested that the complex structure of the acute medical rota had impacted on the GP trainees' access to study leave. The CT informed the review team that the Trust planned to introduce a new out of hours rota in February 2020, to create a level of parity across all middle grade doctors in terms of workload.

The review team was informed of recent events which had put significant pressure on the consultant staff. The first was the untimely death of a Geriatric medicine consultant during a ward round. This and staff sickness significantly reduced the numbers of consultants available and resulted in diminished oversight cover on a vast amount of work particularly on Fothergill Ward within the Community. The DME also stated that, prior to the time of visit, a change in management across the hospital had occurred and that there had been new appointments into the roles of Medical Director, Nursing Lead and Managing Director as a result. The review team noted that the process of change management heralded an opportunity for change in culture.

The Trust representatives provided the review team with an outline of the current status of the acute medical pathway and the work which was underway to improve services and training. The DME conveyed that the Newham University Hospital (NUH) site was a popular choice for trainees due to its reputation for teaching. The department had previously had a 12-hour Observation Ward comprised of the Clinical Decisions Unit (CDU) and the Medical Assessment Unit (MAU), which had 25 beds and enabled rapid assessment of patients and referral to individual specialty wards. The DME acknowledged that the department had come under increasing pressure during the past four years due to a significant rise in patient numbers, increased acuity and a lack of adequate infrastructures to cope with these changes. At the time of the review the department did not have a dedicated Medical Assessment Unit (MAU) and the Observation Ward had been reduced from 25 to 21 beds. The DME advised that patients seen by the MAU consultants were often left in the Emergency Department (ED) for prolonged periods or admitted to the Observation Ward for up to four days with oversight from different consultants. The delays in patient transfers and discharges and the disjointed nature of care for these patients

was a concern for the Trust in terms of quality of care, the impact on junior doctor's experience and the department's ability to achieve its 95% targets.

There was work underway to improve services and training in a number of areas, including the physical space, team building and workforce strategy. In terms of physical space, the DD reported that teams were being integrated to ensure best use of space and that refurbishment work was underway to create an additional ward in the department. It was understood that upon completion, the department would be divided into two, with the assessment and discharge wards based on one floor and the inpatient and admissions unit based on the floor above. The DD also indicated to the review team that the Trust aimed to build separate units for the main Geriatrics and acute frailty wards.

The DME reported that the acute medical service at NUH site experienced a disproportionately high level of demand compared to other sites across the Trust. The Trust representatives acknowledged that the current acute medical pathway lacked the robustness to deliver up to its intended capacity. In addition, the DD highlighted to the review team that the recent shift in complexity and acuity of patients, increased ED attendances, changes in local access points to nursing homes compounded by poor relationships with local health authorities had heavily impacted on the acute medicine service, particularly at consultant level. However, the review team was encouraged to learn that the department had taken steps to create positive changes in service. The department had held a focus group with junior doctors in October 2019 to discuss different service models., The DD reported that trainees fed back that they wanted more awareness, ownership and responsibility for patients. The DD described a Trust-wide recognition of the challenges around consultant workload and junior doctors' involvement within the MAU team but reassured the review team of the ongoing piece of work aimed toward tackling these challenges. Of note was the recent expansion of the hot wing model from a five-day to a seven-day service so that junior doctors worked consistently with the same cohorts of patients in ED before being moved into the wards. The DD also reported that another piece of work was underway to strengthen and standardise the training practice for the consultant workforce level across the Trust.

The review team also heard that the department had taken steps and was working in close partnership with the Human Resources team to ensure that the induction being delivered to trainees complied with the new local and Trust induction policy.

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

M1.1	**Patient safety** The Trust had recently introduced new electronic forms for do not attempt cardiopulmonary resuscitation (DNAR-CPR) orders and treatment escalation plans (TEPs) which were linked to the electronic patient records (EPRs). The trainees considered this to be unsafe as there had been incidents where the forms were not visible, forms had expired because they were not validated by a consultant within 24 hours, and printed forms being difficult to locate in the paper notes. Trainees also reported that the complex acute medical on call consultant rota meant it was not always clear which consultants these forms should be referred to. It was reported that several patients had received CPR despite the presence of a DNAR-CPR order because of these issues. The acute medical consultants reviewed patients during the daytime and twilight hours in two shifts. Following this the on-call consultant was responsible and would review new admissions during the take or the following day. When asked about the on-call escalation process for deteriorating patients, the review team noted that trainees often experienced difficulty in tracking 'the responsible consultant' for timely escalation of concerns during the daytime due to the nature of the shifts. The review team heard that there was a lack of clarity around overall consultant responsibility for admissions. On the day following admission day, the patients were allocated by age to two different teams. The weekend cover for critical care unit-acute care unit (CCU-ACU) (which included up to 25 patients requiring enhanced monitoring and management) was provided by a Geriatric middle-grade doctor, who was not part of the team that managed the patients during weekdays. In some instances, trainees reported seeking advice from the cardiology registrars based at St. Bartholomew's Hospital site for CCU patients. The review team heard that there were occasions where the doctor working at the weekend did not receive a full and robust handover did not have sufficient supervision and oversight. The review team was concerned that this could be unsafe for both acutely unwell patients and trainees. The trainees also described feeling unsupported under this arrangement. The review team heard that ward cover was provided by a middle grade doctor and a foundation year one (FY1) trainee, who were responsible for covering six wards accommodating over 150 patients in total. The review team heard of no established system of handover of deteriorating patients or jobs at 17:00. It was reported that the Geriatric team doctor on call in the evening (usually the FY1 doctor) received a high volume of bleeps from various wards with multiple requests. This shift was described as unsafe and unmanageable. The Acute Medical on call junior doctor appeared to be the only person who could provide senior support to the FY1 doctor. The review team was informed that the nursing teams required training in the use of National Early Warning Scores (NEWS), escalation of unwell patients and use of standard handover tools (such as Situation, Background, Assessment, Recommendation (SBAR)) when making referrals. There were concerns that the lack of training or consistent process around this created a patient safety risk as well as leading to inappropriate referrals and tension between the nursing and medical teams. The review team heard that patient journey through the Trust was carried out by a range of different medical teams and consultants, creating challenges, fragmentation and delay in clinical decision-making, safe handover of information and discharge planning.	Yes, please see M1.1a Yes, please see M1.1b Yes, please seeM1.1c Yes, please see M1.1d Yes, please see M1.1e Yes, please see M1.1b
M1.2	**Serious incidents and professional duty of candour** The review team noted that the Radiology department appeared to be unable to accommodate the requests for Ultrasound Scan (US), Computer Tomography (CT) and Magnetic Resonance Imaging (MRI) scans based on clinical need and heard that trainees frequently experienced delays in receiving written reports. Trainees described delayed management and significant alteration to the 'verbal reports' leading to risks in timely management and discharge. The review team heard that despite Datix reports being raised, trainees did not always receive feedback which was beneficial for their learning	Yes, please see M1.2

M1.3	**Appropriate level of clinical supervision** The review team was delighted to hear a universal acknowledgement of the great respect that all trainees had for their consultants, the pastoral care, the high-quality teaching and the approachability that they offered. However, the review team heard that the system for managing outlier patients was described as inefficient and potentially unsafe. Outlier patient numbers were not restricted and there was no system for grouping outlier patients to ensure that nursing teams could track which medical team was responsible for their care, creating delays to escalation of unwell patients and to patient discharges.	Yes, please see M1.3
M1.4	**Rota Design** The medical rota included three sections; Acute, Geriatrics and ward cover. This was combined with a traditional system of individual firms being on call and taking responsibility for all medical admissions for a 24-hour period. All patients over the age of 75 years were allocated to the Geriatrics team irrespective of their frailty needs. The review team advised that it would be more appropriate to move to a needs-based system to allow the Geriatric medicine team to provide a dedicated acute frailty service. In terms of the geriatrics on-call rota, the on-call team did not clerk these patients or review them on ward rounds until the day after admission. The review team heard that trainees received their rota in advance but that a number of trainees would benefit from a structured on-call arrangement with block shifts, rather than the current variable on call shift pattern. In relation to the rota arrangement in place in the Intensive Care Unit (ITU), the review team heard that trainees enjoyed a one in three long day shift arrangement. The higher medical trainees reported that they were involved with designing a new rota which was to be implemented in November 2019.	Yes, please see M1.4a Yes, please see M1.4b Yes, please see M1.4c
M1.5	**Induction** The CMTs, IMTs and ACCS trainees advised that at the start of the rotation, some trainees had been rostered to be on call on the day and night of their induction. The trainees reported that this had resulted in some trainees missing the induction, not having access to SMART cards or logins for the electronic records systems and having to use other team members' log in details. In addition, the review team heard that the induction to Trust IT systems lacked robustness and that several trainees had waited up to three weeks to receive their log ins. This presented a serious governance concern.	Yes, please see M1.5
M1.6	**Handover** The review team heard of handover arrangement occurring in the morning (09:00am) and evening (21:00). Trainees indicated that the 09:00 Geriatrics team handover was attended by the consultant in charge of the post-take where all geriatric inpatients were discussed. The Acute Geriatrics team did not routinely attend handover and reviewing patients in parallel. Trainees also reported that the opportunity to present the patients on the post-take ward round was limited to a short time before the morning handover meeting. Thus, majority of clerking doctors were not able to present the patients seen and none of the patients over 75 years were presented. This was described as creating challenges around continuity of care and clinical decision making and offered no opportunity for learning.	Yes, please M1.6a(3 &4) Yes, please see M1.6b

	The review team heard that the acute medical team weekend handover at 16:00 on a Friday required a robust electronic system for safe transfer of information and an audit trail. The weekend management of deteriorating patients was the responsibility of a middle grade doctor and a FY1, but it was reported that there was a need for senior oversight and support. The review team heard that the weekend acute medical rota included one FY1 trainee and one core medical training grade doctor who covered all wards, including the surgical assessment unit, and outlier patients. Trainees also indicated to the review team that the ambulatory care unit (ACU) and critical care unit (CCU) lacked consultant oversight during weekend ward rounds that they found working weekends on these units to be particularly challenging in terms of maintaining patient safety. The high level of patient acuity on the ACU was felt to have contributed significantly to this. The review team heard that the Critical Care Outreach team provided much needed support and expertise to colleagues caring for deteriorating patients on the wards but required additional resources (PA/NA) to ensure sufficient capacity and skill mix. In terms of escalation during weekend shifts, the review team heard that trainees were aware that they could escalate concerns to the on-call consultant if required. The educational and clinical supervisors that the review team met reported that recruitment plans were underway and that the Trust was working towards appointing a second middle-grade doctor for ward cover in February 2020.	Yes, please see M1.1c Yes, please see M1.6c
M1.7	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The review team noted that many of the foundation and GP trainees reported a lack of opportunity to receive structured feedback on the work done. This was perceived to be due to workload, inadequate staffing and lack of physical space in ward areas. The review team heard that the on call and post-take ward rounds offered little or no opportunity for trainees to present patients clerked or learn from their management decisions. It was also understood that there were no teaching ward rounds.	Yes, please see M1.7a Yes, please see M1.7b
M1.8	**Protected time for learning and organised educational sessions** The review team was encouraged to hear that nearly all departments were providing one to three hours of consultant led, curriculum relevant teaching to all trainees. The trainees indicated to the review team that they valued consultant-led teaching sessions were which occurred twice a week on Monday and Thursday mornings. It was reported that GP trainees often struggled to attend the mandatory weekly teaching sessions due to workload and rota gaps, although the review team heard that all trainees were encouraged to attend regional study days. The review team was pleased to hear that the gastroenterology department had a daily multidisciplinary team (MDT) meeting. There were regular morbidity and mortality (M&M) meetings. It was also noted that consultants encouraged trainees to undertake quality improvement (QI) work and that they were focused on making positive changes within the department.	Yes, please see M1.7b
M1.9	**Adequate time and resources to complete assessments required by the curriculum** The review team was disappointed to hear that the IMTs, CMTs and higher trainees were not able to access the requisite number of clinics as per the curricular requirement. The trainees described inadequate opportunities for completing work place-based assessments due to workload, unavailability of consultant time and private space in clinical areas for feedback.	Yes, please see M1.9 Yes, please see 1.7a

M.10	**Access to simulation-based training opportunities** The review team heard that the Simulation team provided excellent in-situ training, specifically in managing patients with tracheostomies in a multi-professional setting.	

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.

M2.1	**Impact of service design on learners**	
	The review team heard that NUH did not have a designated Medical Assessment Unit (MAU), which was noted to be unusual and contributed to significant challenges around the acute medical on call pathway. The review team did not consider the current system of flexible use of an 'Observation Ward' attached to the emergency department (ED) to be an efficient, safe or sustainable solution	Yes, please see M2.1a
	Trainees suggested that the design of the acute on-call pathway**,** including the consultant shift system for providing intra-take and post-take cover, plus the 'firm' structure of a single team taking all patients was inefficient, disrupted continuity of care and offered little opportunity for training.	Yes, please see M2.1b(2)
	The trainees also highlighted to the review team that the current system of having 'home wards' and a high number of outlier patients on other wards was unsafe. The trainees advised that nurses were sometimes unable to keep track of which medical team was responsible for each patient, which could delay escalation and discharge planning.	Yes, please see M1.3
	. The review team heard that there was an uneven distribution of workload and staffing amongst the medical teams working in the department, particularly between the respiratory and cardiology teams, which trainees described as a source of frustration. The review team heard that the 28- bedded respiratory unit was staffed by two junior doctors at FY1 level and one middle grade doctor, compared to the nine-bedded cardiology unit of where cover was provided by three FY1 level doctors and four middle grade doctors.	Yes, please see M2.1c
	Due to a reduction in capacity at consultant level in the Geriatric medicine team, there was an interim cover arrangement in place for the Fothergill ward and intermediate care beds. The trainees advised that this arrangement reduced their access to the specialist wards, offered few learning opportunities and depleted the junior doctor cover on other inpatient wards.	Yes, please see M2.1d
	Most trainees reported that they were not allocated a regular clinic in their job plans, including higher trainees who were not able to attend regular sub-specialty clinics required for completion of training. Trainees described difficulty in being released from other duties to attend clinics and stated that they were not always allocated lists or clinic rooms.	Yes, please see M1.9a

M2.2	**Appropriate system for raising concerns about education and training within the organisation** The review team was pleased to hear that the Local Faculty Groups (LFGs) in Medicine had been recently reinstated, and that consultants attended with great enthusiasm. It was also noted that the trainees recognised a willingness from consultants to listen to their concerns and to give feedback. When asked about exception reporting, the review team heard that trainees were aware of the process for raising exception reports and that the induction process afforded the opportunity for trainees to discuss safe working practices with the Guardian of Safe Working Hours (GoSWHs). The review team also heard of several instances where trainees had raised exception reports after working past the end of their rostered shifts. The review team noted that the high workload volume, particularly within the Geriatric and Respiratory teams, was the most frequently cited reason for working additional hours, but that the department had instituted informal arrangements which allowed affected trainees to claim back time in lieu. The consultants were supportive and suggested informal and unrecorded ways to compensate for the time owed. Trainees reported that they were able to claim time in lieu, but some had experienced difficulties in obtaining payment for additional hours worked after submitting exception reports.	
M2.3	**Organisation to ensure time in trainers' job plans** The review team heard that the consultants' job plans offered time (0.5 PAs) for educational supervision but noted that almost all consultants were supervising up to five trainees with no additional time in their job plans.	Yes, please see M2.3
M2.4	**Organisation to ensure access to a named clinical supervisor** The review team heard that the trainees had adequate access to a named clinical supervisor when on duty, although the fragmented nature of consultant shifts sometimes made it difficult for trainees to determine who was supervising them during on call shifts.	
M2.5	**Organisation to ensure access to a named educational supervisor** The review team heard that trainees had access to a named educational supervisor, and all had found time to meet them as part of their induction.	
M2.6	**Systems and processes to identify, support and manage learners when there are concerns** The review team heard of the education team's processes for supporting trainees and trainers when concerns were raised. The Trust documentation clearly identified serious incidents where trainees were involved and outlined the support provided. The trainees did not highlight any concerns around being able to raise concerns or discuss issues in LFGs, and felt that their consultants were approachable, supportive and provided pastoral care as needed.	

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.**		
M3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The trainees raised significant concerns with the lack of predictability of shift patterns, including the random nature of single night shifts, the long period of consecutive working days without breaks and the intensity of the ward cover and weekend cover shifts. Trainees suggested that these factors contributed to feelings of stress and anxiety and had the potential to adversely impact health and wellbeing. The doctors in the Acute Geriatric, Respiratory, and Diabetes & Endocrinology teams indicated that they were particularly affected by workload. All trainees met with had experienced prolonged rounds when covering outlier patients due to the number of outliers and the fact that they were located across multiple wards. Weekend and ward cover shifts were described as being particularly onerous. Educational and pastoral support was readily available from consultants.	Yes, please see M1.4c
M3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The review team heard of no instances of trainees being exposed to bullying and undermining behaviours.	
M3.3	**Access to study leave** Despite reports of a willingness to accommodate trainees' study leave requests, a number of trainees indicated to the review team that they were expected to arrange shift swaps to cover their study leave. Trainees described this as challenging, particularly for on call shifts. The presence of rota gaps was felt to have contributed to this.	Yes, please see M3.3

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.**		
	No issues discussed.	

5. Delivering 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.**		
M5.1	IMT and CMT trainees were concerned that they would not be able to meet the curricular requirements for minimum number of clinics.	

6. Developing a sustainable workforce

HEE Quality Standards **6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.** **6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.** **6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs to patients and service.** **6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.**		
M6.1	**Appropriate recruitment processes** There were no plans described to induct a multi-professional or multi-skilled workforce to manage the workload of the busy internal medicine or specialty medicine services. The Trust described efforts to recruit geriatric consultants to fill vacant posts and to increase the middle-grade support with an additional middle-grade doctor on weekends.	Yes, please see M6.1

Good Practice and Requirements

Good Practice	
1	There was universal acknowledgement of the great respect that all trainees had for their consultants, the pastoral care, the high-quality teaching and the approachability that they offered.
2	The LFGs in medicine had been reinstated and consultant attendance was reported to be good. Trainees recognised a willingness from consultants to listen to their concerns and make improvements.
3	The review team heard that the simulation team provided excellent in-situ training, specifically in managing patients with tracheostomies in a multi-professional setting.
4	The review team noted that the consultants encouraged trainees to undertake quality improvement (QI) work and that they were focused on making a true difference to the department pathways.
5	The Palliative care team was described as providing an exceptionally responsive and timely service.

Immediate Mandatory Requirements

Given the severity of an Immediate Mandatory Requirement, the risk rating must fall within the range of 15 to 25 or have an Intensive Support Framework rating of 3. This risk rating will be reviewed once the Trust has provided their response to the Immediate Mandatory Requirement.

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.

M1.1a	The Trust is required to institute an interim plan to have the DNAR-CPR and TEP forms clearly signed, printed and visible in the patient notes from admission as appropriate. This system should continue until the new online system is tested to be robust and reliable.	Please provide confirmation from Clinical Director for Medicine or Trust Clinical Governance lead that this risk has been mitigated and adequate training or guidance provided to all staff. Please provide required evidence by 1 March 2020.	**R1.1, R1.2 & R1.4**
M1.1c	The Trust is required to institute a senior trainee or consultant-led ward round of CCU-ACU for both days of the weekend and clearly specify pathway for escalation of these patients. The current practice of calling the Cardiology middle-grade doctor at Bart's Hospital site for advice of deteriorating patients is not adequate. This role is not suitable for the on-call medical middle-grade doctor who is responsible for the on-call and all inpatients on weekends.	Please provide a rota and confirmation from CD for Medicine that arrangements for a daily weekend ward round of all CCU and ACU patients is implemented. Please provide required evidence by 1 March 2020.	**R1.8**
M1.5	The Trust is required to ensure that no trainee is expected to be on call or deliver a service without being signed off after a full and meaningful induction. Please provide confirmation that all department rota coordinators have a common SOP which ensures that no trainee is expected to be on call on Day 1 without full induction. No trainee should be expected to work in a clinical capacity without adequate IT induction, training and log in. The SOP should also include accountability and sign off from HR and IT to provide adequate resources on or before day 1 so that all new arrivals receive training and competency in accessing and using electronic resources required for safe clinical practice.	Please provide an induction SOP and minutes of meeting with HR and IT leads confirming that accountability and adequate resource allocation. Please provide required evidence by 1 March 2020.	**R1.13**

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.
M1.1b	The Trust is required to review the current on-call system to ensure that the consultant -on-call responsibility of all patients in any on-call period must be clearly listed in the	The Trust is to provide evidence (audit) by 01 March 2020 that daily consultant led handovers with involvement from the wider multi-disciplinary medical team on the acute medical wards at shift changes.	R1.14

	appropriate areas, accessible to medical and nursing staff and switchboard.		
M1.1d	The Trust is required to ensure that there is a robust handover in the acute medical wards both in the morning, at 5pm for the ward cover team and the night team. There should be SOP, attendance sheet and a structure to the handover.	The Trust is required to submit evidence of a structured, consultant led handover arrangement on the acute medical wards. Please provide required evidence by 1 March 2020.	R1.14
M1.1e	The Trust is required to institute training and competency assessment for all staff on medical wards in the use of early warning systems, appropriate escalation and handover of deteriorating patients using a structured approach (such as Situation-Background-Assessment-Recommendation (SBAR). The Trust is required to ensure that a triage system is developed out-of-hours with adequately experienced senior nurse or nurse practitioner before the ward cover doctor is bleeped except in emergency situations	Trust to provide audit data from NEWS compliance. The Trust to ensure that an updated escalation policy document be prominently visible in clinical areas, and shared with all acute medicine trainee and staff at induction Please provide required evidence by 1 March 2020.	R3.1
M2.1c	The Trust should review the workload of out-of-hours ward cover doctors and urgently institute an additional junior doctor on the out-of-hours rota to provide safe staffing for all medical wards.	The Trust is required to provide via LFG minutes a standard item for regular monitoring of workload of out-of-hours, including evidence of action taken to improve safe staffing levels for all medical wards particularly during out of hours. Please provide required evidence by 1 March 2020.	R1.7
M2.1d	The Trust is required to urgently cease the allocation of geriatric higher trainees to off-site intermediate care wards or facilities unless accompanied by consultants as part of their training and MDT working.	The Trust should provide evidence of action(s) taken to address this. Please provide required evidence by 1 March 2020.	R1.15
M1.4b	The Trust must ensure that FY1 doctors on the new rota have the opportunity to clerk and present patients on ward rounds.	We look forward to hearing about arrangements for the facilitation of supervised acute patient clerking for FY1 doctors within their work schedules Please provide required evidence by 1 March 2020.	R1.12
M1.4c	The Trust is required to urgently set up a rota review and oversight board led by a consultant and HR manager with adequate expertise. This board must include representation from all junior doctor groups and medical specialties.	The rota board must be tasked to develop a safe and workable rota with predictable periods of on call, rest days including blocks of night/ weekend cover. Reference must be made to the British Medical Association (BMA) and HEE health wellbeing charter recommendations.	R1.12

		Please provide required evidence by 1 March 2020.	
M1.6a	The Trust is required to review the current on-call system to implement the following changes; The post-take handover must include all patients admitted irrespective of age, be consultant led and have robust, auditable arrangements and logistics. The post-take ward rounds must have adequate time allocated for junior doctors to present their patients and receive feedback/ learning.	The effectiveness of post-take handovers should be a quality monitoring standing item in the monthly LFG and minutes should be sent to HEE for the next 2 meetings. Please provide required evidence by 1 March 2020.	
M2.1b	The Trust is required to review the current on-call system to ensure that the handover between shifts for acute medical consultants and on-call general medical consultant must be formal, time-tabled and include all junior medical and nursing staff. This should cover all patients admitted including patients admitted to acute geriatrics.	The Trust is required to demonstrate the safe and auditable handover of information from the acute medical consultants and on-call general medical consultant. The effectiveness of on-call handovers should be a quality monitoring standing item in the monthly LFG and minutes should be sent to HEE for the next 2 meetings. Please provide required evidence by 1 March 2020.	R1.14
M1.6e	The Trust is required to implement a formal, electronic, auditable handover system for out-of-hours working both on weekdays and weekends. This system should include a clinically appropriate triaging system clearly providing a timeline and seniority of staff required to complete the tasks and reviews. This list must be available to the site practitioner or nurse-in-charge on medical wards. In addition, nurses should route all non-emergency calls to ward cover doctors through a senior nurse or site practitioner for appropriate triaging.	The Trust is required to submit evidence of a structured, consultant led, documented handover meeting with auditable transfer of information between shifts with full attendance from all relevant members of staff. The effectiveness of Handovers should be a quality monitoring standing item in the monthly LFG and minutes should be sent to HEE for the next 2 meetings. Please provide required evidence by 1 March 2020.	R1.14
M1.9	The Trust must ensure that all trainees have scheduled clinic allocations (one per week for IMT and two per week for higher trainees) with allocated rooms and lists.	Trust to submit an improvement plan demonstrating when the Trust intends to fulfil the Royal College of Pathology (RCP's) recommendation. Please provide required evidence by 1 March 2020.	R1.15
M3.3	The Trust is required to provide evidence of an effective rota management system that will ensures access to study leave for all trainees.	The Trust is to provide HEE with evidence indicating trainees are able to obtain study leave Please provide required evidence by 1 March 2020.	3.12

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.**
M1.7a	The Trust is urged to ensure private space in ward areas for having supervision conversations and for completing work-based assessments.	Please provide required evidence by 1 March 2020.	R1.18
M1.7b	The Trust must ensure that teaching sessions are appropriate to training needs, consultant-led, arranged at times that most trainees can attend, and bleep free (except for emergencies).	The Trust to provide evidence that demonstrates teaching sessions are consultant-led, being attended by trainees, feedback received and are bleep-free. Please provide required evidence by 1 March 2020.	R1.16
M2.2a	The Education team is urged to provide adequate administrative support for LFG meetings.	Please submit minutes and attendance registers of local faculty group meetings for the department, together with plans for its sustainability Please provide required evidence by 1 March 2020.	R2.7
M2.3	It is highly recommended that the Trust ensures all consultants have a minimum of 0.25 SPA demonstrable in their job plans to provide educational and clinical supervision. No consultant should be expected to provide supervision to more than 4 trainees at any one time. All consultants should be expected to undergo an annual educational appraisal in line with GMC domains as part of annual appraisal cycles.	The Trust to provide evidence by 01 March 2020 that educational supervisors have a minimum of 0.25SPA time per trainee allocated within their job plan	R2.10, R4.2 & R.41
M6.1	The Trust is required to work with its HR and Medical Education Team in implementing interim mediation strategies to address the issues surrounding workload of the busy internal medicine or specialty medicine services.	Trust to submit plans of how it aims to resolve this. Please provide required evidence by 1 March 2020.	R2.20

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**	**GMC Req. No.**
M1.2	The Trust is required to review the workload and resources available in the radiology department to meet the needs of the NUH patients. It is evident from the feedback received that this is grossly inadequate. It is recommended that protocols and timelines for requesting, completing and reporting radiological investigations is agreed across the	R1.7

	site. These SOPs should be in line with NHSE/I and Royal College of Radiology (RCR) guidelines.	
M1.3	The Trust should review the current system of firm-based takes, home wards and pro ward rounds of managing outliers on multiple different wards. The department is advised to consider a stable home ward-based approach where medical teams have stability, the chance to work in supportive teams and have a predictable and manageable workload. Where outliers are required to be managed this should be based on a linked- ward system so there is clarity for nurses and doctors and a cap on the number of outliers. All patients should be reviewed by a consultant or middle grade doctor of sufficient seniority daily.	R2.3
M1.4a	The Trust should review the guidance on Acute Frailty Services from the British Geriatric Society and NHSE/I. The current system of arbitrary age-based segregation of patients should cease and move to a needs-based approach. The geriatric department should focus multi-professional resources to provide in-reach services to ED and medical wards, run complex geriatric wards, an ortho-geriatric rehabilitation service, and out-reach to intermediate care beds in the community, day units and specialty clinics.	R2.3
M1.6c	The Trust is required to review the role and remit of the critical care outreach team (CCOT). The skills and resources available to this team need to be supported so a list of 'jobs' are not left for the single junior doctor on ward cover. If there are urgent treatments or patient management required, the CCOT should be resourced to be able to complete these tasks in collaboration with the ward team.	R1.7
M2.1a	The Trust should review the NHS and Royal College of Physicians of London (RCP) guidance on the need for establishment of a MAU. This unit should include adequate space and a multi-skilled staffing for ambulatory assessment, evidence-based pathways for Deep vein thrombosis (DVT), cellulitis, pulmonary embolism, headaches etc, acute dependency patients (including diabetic keto-acidosis, respiratory failure, sepsis, asthma and so on), inpatient beds in line with an average daily take and a short stay unit. It is recommended that support can be provided by peer units from other Trust sites or via NHSE/I.	R2.3

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, North East London
Date:	22 January 2020

What happens next?

We will add any requirements or recommendations generated during this review to the Quality Management Portal. These actions will be monitored via our usual action planning process.