Health Education England

HEE Quality Interventions Review Report

Barts Health NHS Trust (Royal London Hospital)
Neurology and stroke medicine
Urgent concern (learner and educator) review

London – North East London

Date of review: 20 September 2021

Date report issued to Trust: 17 November 2021

Version 1

Review Overview

Background to the review:	Following conversations with the Trust that highlighted possible trainee and patient safety issues relating to a lack of trainee clinical supervision whilst participating in the out of hours acute thrombolysis rota and unsustainable workload while covering stoke medicine, HEE decided to conduct an urgent concern review of the stroke and neurology departments to ascertain the extent of, and understand the Trust's plans to mitigate against, these concerns.
Subject of the review (e.g. programme, specialty, level of training, healthcare learner group)	Neurology and stroke medicine
Who we met with:	Director of Medical Education Two Medical Education Managers Guardian of Safe Working Hours Clinical Director Clinical Lead for Stroke Education Lead for Stroke Joint Clinical Lead for Neurology Education Lead for Neurology College Tutor General Manager Neurosciences, Stroke and Trauma Associate Director Medical & Dental Trust Dean Head of Foundation and Undergraduate Medical Director Deputy Chief Medical Officer Divisional Director Seven foundation trainees, internal medicine training trainees and clinical fellows Six higher trainees and ITF trainees Six clinical and educational supervisors in stroke and neurology
Evidence utilised:	Summary of Guardian of Safe Working Hours Board report Rota including fill rate Evidence of organisation-wide and departmental induction feedback Evidence of teaching sessions and attendance lists Summary of relevant complaints related to learners Most recent staff Friends and Family Test (FTT)

Review Panel

Role	Name / Job Title / Role
Quality Review Lead	Louise Schofield Deputy Postgraduate Dean Health Education England (North East London)
Specialty Expert	Catherine Bryant Deputy Head of the London Specialty School of Medicine
Specialty Expert	Keren Davies Foundation School Director (North Central and East London)
Lay Representative	Saira Tamboo
HEE Quality Representative(s)	Chloe Snowdon Learning Environment Quality Coordinator Health Education England (North East London) Ed Praeger Deputy Quality, Patient Safety and Commissioning Manager Health Education England (North East London) Andrea Dewhurst Quality, Patient Safety and Commissioning Manager Health Education England (London)

Executive summary

Conversations with the Trust highlighted possible trainee and patient safety issues relating to a lack of trainee clinical supervision whilst participating in the out of hours acute thrombolysis rota and unsustainable workload while covering stoke medicine. Health Education England (HEE) decided to conduct an urgent concern learner and educator review of the stroke and neurology departments to ascertain the extent of, and understand the Trust's plans to mitigate against, these concerns.

The review team met with foundation, internal medicine training (IMT) trainees and clinical fellows working on the on call stroke rota, higher trainees in neurology, clinical and educational supervisors in stroke and neurology, and representatives from the department and hospital management team. Additional information from trainees was received via email and in person in the days following the review and where possible, this has been included in the report.

The review team heard that junior doctor staffing levels on the ward frequently fell below the requirements identified by the service. In addition, the review panel heard that there was only one junior doctor in the hospital on call and, out of hours, this doctor had to manage the stroke ward as well. The review team heard from foundation trainees, IMT trainees and clinical fellows that this was insufficient to safely manage the number of unwell patients. Higher trainees told the review team that the workload their colleagues on the stroke rota were expected to manage was too high and they had witnessed their colleagues in distress because of this. The review team heard from foundation trainees, IMT trainees and clinical fellows that their workload was unmanageable and that their

placements were impacting on their wellbeing. The foundation trainees, IMT trainees and clinical fellows said that attempts to raise concerns with consultants in the department had been dismissed and that no improvements had been made. Additionally, the review team heard that there was a culture of not exception reporting in stroke and neurology, despite trainees saying everyone worked hours over their rostered times. Trainees reported that when doctors had tried to exception report, this had not been well received by consultants.

Two immediate mandatory requirements were issued at the review relating to the management of stroke mimic patients in the hospital and improvements to the stroke rota. The review team informed the Trust that HEE would be issuing a letter to the Trust stating that the Intensive Support Framework (ISF) rating for stroke medicine would be set at three (major concerns), meaning the Royal London Hospital, as a placement provider, had fallen, or was at risk of falling, well below the standards expected by HEE. The Trust was informed that an ISF three rating meant that training would be suspended if rapid and sustained improvements were not made by the time of the next quality intervention. The Trust were also informed that HEE would be enacting the emerging concerns protocol to notify other arm's length body organisations of the concerns.

Review findings

The findings detailed in the sections below should be referenced to the quality domains and standards set-out towards the end of this template. Specifically, mandatory requirements should be explicitly linked to quality standards. Not all of HEE's domains and standards have been included, only those that have a direct operational impact on the quality of the clinical learning environment, which a quality review will be most likely to identify (although this does not preclude other standards outlined in the Quality Framework being subject to review, comment and requirements where relevant).

Mandatory requirements

Mandatory requirements and Immediate Mandatory Requirements (IMRs) should be identified as set out below. IMRs are likely to require action prior to the draft Quality Review Report being created and forwarded to the placement provider. The report should identify how the IMR has been implemented in the short term and any longer termed plans. Any failure to meet these immediate requirements and the subsequent escalation of actions to be taken should also be recorded if there is a need to.

All mandatory requirements should be detailed in this section. The requirement reference should work chronologically throughout the report and link with the right-hand column in the 'Review Findings' section. Requirements identified should be succinct, SMART and not include the full narrative from the detailed report. Any Requirements should clearly relate to improved achievement of HEE Domain & Standards by the placement provider.

Immediate Mandatory Requirements Completion of immediate requirements will be recorded below. Subsequent action to embed and sustain any changes may be required and should also be entered below with relevant timescales.		
Requirement Reference number	Review Findings	Required Action, timeline, evidence
NSM2.1a	The review panel heard the ongoing management of stroke mimic patients was significantly adding to junior doctor workload and that junior doctors were frequently handling more than two sick patients in the emergency department (ED) on their own.	Immediately review pathways in ED in conjunction with acute medicine and other relevant services to ensure stroke mimic patients can be handed over rapidly and safely from the care of the stroke team.
NSM2.1b	The review panel heard that frequently junior doctor staffing levels on the ward fell below the requirements identified by the service. In addition, the review panel heard that one junior doctor in the hospital on call was insufficient to safely manage the number of sick patients and stroke calls that they were required to. The review panel also heard that the high workload was impacting on junior doctor training and wellbeing.	Immediately establish a task and finish group to review rota management including locum requests to ensure sufficient staff on the wards from 09:00 to 17:00 and designated middle grade support (from whichever team) for the junior doctor holding the stroke bleep out of hours. The group needs to establish an action plan for how these issues will be addressed within 5 working days.
Requirement Reference number	Progress on immediate actions	Required Action, timeline, evidence
NSM2.1a	The Trust submitted a letter and detailed action plan relating to this action. A summary of the Trust's response is included below. An immediate review has been undertaken of the pathways in ED in conjunction with acute medicine and other relevant services to ensure stroke mimic patients can be handed over rapidly and safely from the care of the stroke team. Further discussions are planned to monitor the revised mimic pathway and update as required. This will be aided by having a senior presence in ED until midnight, who will be able to support further development of the mimic pathway. As part of our response to the IMRs we have set up a Task and Finish Group comprising of senior service and educational leads. This will meet weekly and we will submit a weekly response to HEE summarising progress to date on the issues identified in the IMRs.	Thank you for providing this detailed response. We are content that it meets the requirements for the IMR but would like to continue to monitor the outcome of your interventions through the QMP to ensure that it addresses the issues raised. Please provide the revised pathways and evidence of an audit or review of how these are working, as well as LFG minutes showing confirmation from trainees that workload pressures are improving. To be provided by 01 March 2022.
NSM2.1b	The Trust submitted a letter and detailed action plan relating to this action. A summary of the Trust's response is included below. In order to support the trainees out of hours, the stroke consultants will be resident between 09:00-24:00 commencing on 04 October 2021 for	Thank you for completing this and sending through this information We are content that it meets the requirement for the IMR, however, would like to continue to monitor the response through the evidence that you detail in order to ensure

	a period of two months pending evaluation of cost-effectiveness. This will ensure senior support is available to the juniors on site throughout the busiest hours of the day, evening and night. After midnight the on-site support for medical queries will be provided by the resident acute medical SPR on call and the stroke consultant will continue to be on call from home. The stroke SHO will take part in the hospital at night meeting with Acute medicine at 9pm with immediate effect. This will provide support to the SHO in making them part of the team and addressing the feedback around isolation raised during the HEE visit. As part of our response to the IMRs we have set up a Task and Finish Group comprising of senior service and educational leads. This will meet weekly and we will submit a weekly response to HEE summarising progress to date on the issues identified in the IMRs.	that your action plan resolves the issues raised. Please provide evidence from the task and finish group that the department is continuing to monitor staffing levels. Please also provide the rotas for middle grade doctors in stroke and LFG minutes to evidence that trainees feel their clinical supervision is more robust and that they feel more supported in the department. To be provided by 01 March 2022.

Mandatory Requirements

The Quality Review Panel will consider which individual or collective findings from the intervention will be added to the Quality Reporting Register, determining the relevant risk sIMT, ISF rating and reflecting the accepted QRR narrative conventions.

Requirement Reference number	Review Findings	Required Action, timeline, evidence
NSM1.2	The review team heard that despite junior doctors often working over their hours, there was a culture of not exception reporting and heard about instances where this had been actively discouraged within the department.	The department is to work with the Guardian of Safe Working Hours to ensure that junior doctors know how to exception report and are encouraged to do so when they work over their contracted hours. To be completed by 01 March 2022.
NSM2.1c	The review team were told that there were problems with staffing levels in the wider multi-disciplinary team (MDT), and that this impacted on the workload of doctors in training and their ability to attend training.	The review team asked the Trust to work with the workforce transformation team at Health Education England to review the MDT workforce, and in particular, explore how wider medical roles or advanced clinical practitioners could support the delivery of a safe and effective service and enable junior doctors to receive adequate training. To be completed by 01 March 2022.
NSM2.2a	The review team heard that junior doctors were frequently working beyond there rostered times and were not receiving compensation for this in the form of time of in lieu or extra pay.	The department is to work with the Guardian of Safe Working Hours to ensure that all junior doctors are fairly compensated for any work outside of their rostered hours. To be completed by 01 March 2022.
NSM2.2b	The review team heard that following a meeting where trainees working in	Ensure that a local faculty group specifically relating to training and learning in stroke

	stroke raised concerns, another meeting had not been scheduled.	medicine meets at least quarterly. The group is to include trainee representation as well as education leads and service managers. Please provide minutes from these meetings which evidence that concerns are being listened to and actioned. To be completed by 01 March 2022.
NSM3.1	The review team heard that trainees' wellbeing was being impacted due to their placements.	Ensure that junior doctors have regular opportunities outside of the department to discuss their concerns regarding their own wellbeing (for example, a member of the postgraduate medical education team or a psychologist) and are able to receive the necessary support that might be identified as a result. To be completed by 01 March 2022.
NSM3.4a	The review team heard that not all trainees had received a comprehensive induction at the start of their shift, and in particular before being asked to work a stroke on call shift.	Review the stroke medicine induction so that trainees are required to receive a full induction at the start of their rotation. The induction should include simulation training covering responding to a stroke call, and management of patients receiving thrombolysis. Trainees should be signed off as competent on this training before holding the on call bleep. Current trainees should be given the opportunity to complete this training. To be completed by 01 March 2022.
NSM3.4b	The review team heard that trainees were rostered to work on call shifts before receiving a local induction.	Evidence that rotas ensure that trainees are never rostered to be on call until they have received a full induction and are competent to manage a stroke call. To be completed by 01 March 2022.
NSM4.3a	The review team heard that the department was not up to date on educational supervisor (ES) appraisals.	Evidence that all educational supervisors receive an educational appraisal as part of their yearly whole practice appraisal. To be completed by 01 March 2022.
NSM4.3b	The review team heard that the department was not up to date on educational supervisor (ES) appraisals.	Ensure that all clinical and educational supervisors participate in the Trust faculty development programmes for education. To be completed by 01 March 2022.
NSM4.4a	The review team heard that some ESs did not have time in their job plans for educational supervision.	Ensure that all educational supervisors have 0.25 Planned Activities time in their job plans for each trainee that they supervise. This should include time for the substantial numbers of Trust appointed junior doctors in the department. To be completed by 01 March 2022.
NSM4.4b	The review team heard that some of the ESs had problems meeting with trainees for educational supervision as the trainees were so busy.	Evidence that the department allows time for the doctors in training to meet their supervisors, as a minimum at the beginning, midpoint, and end of their placements. To be completed by 01 March 2022.
NSM5.1a	The review team heard that some of the IMT trainees had not had a clinic since they started their placements.	Evidence that IMT trainees are rostered to attend clinics as part of their normal duties, to meet the minimum requirements for the IMT

		curriculum. To be completed by 01 March 2022.
NSM5.1b	The review heard that stroke teaching took place from 12:00 to 13:00 on Tuesdays but the stroke team had lost its teaching room and the new teaching room was on another floor.	Evidence that there is regular timetabled teaching in stroke medicine which trainees are released to attend. To be completed by 01 March 2022.
NSM5.1d	The higher neurology trainees told the review team that they did not have any teaching built into their work schedule.	Evidence that the neurology higher trainees receive a regular timetabled teaching programme which is delivered within working hours and is supported by consultants. To be completed by 01 March 2022.
NSM5.1e	The review team heard that higher neurology trainees' clinic lists were booked to consultant timings which meant they had to stay late to get tasks done.	Evidence that neurology trainees have sufficient time in their clinic lists to consult with their supervising consultant regarding patient queries, receive on the job training and have the opportunity to complete workplace-based assessments. To be completed by 01 March 2022.

Recommendations

Recommendations are not mandatory but intended to be helpful, and they would not be expected to be included within any requirements for the placement provider in terms of action plans or timeframe. It may however be useful to raise them at any future reviews or conversations with the placement provider in terms of evaluating whether they have resulted in any beneficial outcome.

Recommendation	
Related Domain(s) & Standard(s)	**Recommendation**
NSM5.1c	The review team recommends the Trust reviews whether a teaching space closer to the stroke department can be allocated.

Good practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that, in the view of the Quality Review Team, enable the standards within the Quality Framework to be more effectively delivered or help make a difference or improvement to the learning environment being reviewed. Examples of good practice may be worthy of wider dissemination

Learning environment / Prof. group / Dept. / Team	Good practice	Related Domain(s) & Standard(s)
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HEE Quality Standards and Domains for Quality Reviews

Domain 1 - Learning environment and culture
1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive 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 interprofessional learning opportunities.

HEE Standard	HEE Quality Domain 1 - Learning Environment & Culture	Requirement Reference Number
1.1	**Serious incidents and professional duty of candour** The foundation and IMT trainees and clinical fellows said they had to look after a very high volume of patients and thought this impacted on patient safety. The foundation and IMT trainees and clinical fellows said that when they had new patients with potential strokes coming into the Emergency Department (ED), the unwell patients on the ward could not be a priority as there was a time pressure to assess the patients in ED and commence treatment within 30 minutes where appropriate. The trainees told the review team they prioritised what was essential to keep patients alive but due to work volume, many important jobs were not done. For example, the IMT trainees told the review team that due to pressure on beds, patients were sometimes repatriated before a discharge summary had been completed. The IMT trainees highlighted that this meant patients were repatriated without important information about their care being provided to the local team. The foundation and IMT trainees and clinical fellows said they felt everyone was doing their best to provide good patient care but that they felt embarrassed to be attributed to the level of care some patients were receiving. The foundation and IMT trainees and clinical fellows told the review team it was impossible to provide the level of care they should be able to. The review team heard that a Never Event had happened in the stroke unit in recent months and the foundation and IMT trainees and clinical fellows said they thought this had happened due to workload stressors which meant basic care was being missed. The review team heard the Trust was doing an internal investigation. The foundation and IMT trainees told the review team that they felt that the operating model and staffing levels were unsafe and that a previous group of trainees had raised these patient safety issues, as well as the lack of support and training, but the situation had not improved. The review team heard that during a meeting in which foundation and IMT trainees and clinical fellows raised concerns with consultants, the consultants dismissed patient safety concerns, saying concerns could only relate to a single patient, and not to many patients receiving less care than they should.	

1.2	**Bullying and undermining** The higher neurology trainees told the review team that previously when trainees had tried to exception report this had not been well received by the consultants in the department, and some had heard comments that it would affect their future employability. The foundation and IMT trainees and clinical fellows said that other than the conversations about exception reporting, they were not aware of bullying behaviours in the department. Some of the foundation and IMT trainees and clinical fellows did say they had experienced some uncomfortable conversations with consultants questioning why they were raising concerns.	NSM1.2
1.4	**Appropriate levels of Clinical Supervision** The review team heard from the foundation and IMT trainees and clinical fellows that the consultants rarely came down to the ED, even when they were in the hospital. The foundation and IMT trainees and clinical fellows said they called the consultant of the week for advice and the consultant made decisions remotely instead. The review panel asked the foundation and IMT trainees and clinical fellows whether the consultant would come to the ED if they told them that they were overwhelmed with work and the trainees and clinical fellows said they did not think they would and would tell them to ask ED for help or to prioritise instead. The trainees and clinical fellows told the review team they felt much more comfortable when a consultant was present in ED, but it depended on the individual consultant and their workload whether they came during the day. The review team asked the foundation and IMT trainees and clinical fellows where the other consultants were during working hours and the trainees and clinical fellows said that they often did not know, but the consultant of the week was on the ward and others were in clinics. The foundation and IMT trainees and clinical fellows told the review team that the consultants did 24 hour on call shifts from home at the weekend. The review team heard from the foundation and IMT trainees and clinical fellows that out of hours they were alone in the hospital, holding the stroke bleep, with consultant support by telephone from home. The foundation and IMT trainees and clinical fellows told the review team that they were found it unusual that no higher trainee was on call for thrombolysis given that the treatments were high risk, and that the staffing for the service was unusual in comparison to services in other Trusts. The review team heard of one instance where a trainee had rung the consultant to request that they came in or that incoming referrals were stopped overnight as the workload was already unmanageable heading into the night shift and the consultant had instead prioritised patients over the phone (without reviewing them). The review team heard of another instance where a consultant had come down to the ED because of a high volume of patients and had appeared to find the situation very stressful, despite having support. The foundation and IMT trainees and clinical fellows highlighted to the review team that they were expected to deal with the same number of patients and level of stress without help overnight. The Trust representatives told the review team that the consultant was responsible for making treatment decisions on the phone, and the trainee	

	on the rota then arranged for the intervention. The Trust representatives said that the volume of calls the consultant received at night could be very high because calls came from other hospitals within the Trust and because they often came from more junior doctors who needed more direction than middle grade doctors would. The educational supervisors (ESs) and clinical supervisors (CSs) said that they got two planned activities (PA) time for out of hours work which they said was a minimum for the workload they had. The supervisors said they did not mind being called but said the workload was intense and that they got a lot more queries than they would if there were a middle grade doctor onsite. The ESs and CSs said that it would be good if they did not have to come in on a Monday morning after being on call from home for the weekend because of the volume of calls they received overnight. The review team asked the supervisors whether they had ever felt concerned about workload and felt they should go in when they spoke to junior doctors on the phone and the supervisors said they had got used to identifying what was important and prioritising on the phone. The ESs and CSs said that the question of coming in was difficult because by the time they arrived, the patients would have been managed. The supervisors said that the senior nurses were very experienced and helped the junior doctors too and that the consultants often spoke to the senior nurse on call to check in.	
1.5	**Access to Technology enhanced and simulation-based learning** The IMT trainees told the review team that having worked in other stroke units in London, they were surprised that there was no thrombolysis simulation training which they said had been extensive elsewhere.	

Domain 2 – Educational governance and leadership
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.

HEE Standard	HEE Quality Domain 2 – Educational Governance and Leadership	Requirement Reference Number
2.1	**Impact of service design on users** <u>Structure of the service</u> The Clinical Lead for Stroke told the review panel that the stroke service received about 1000 referrals a year (although this had reduced during Covid-19). The Clinical Lead for Stroke said that about 20% of these were stroke mimics, 20% were intra-cranial haemorrhages, 30% were transient ischaemic attacks (TIAs) and the remainder were acute ischemic strokes. The review team heard that of the patients with acute	

	ischemic stroke, 20 to 30% had acute thrombolysis. The Clinical Lead for Stroke explained that the percentage of eligible patients receiving a mechanical thrombectomy at the Trust was much higher than the national average and this part of the service had grown considerably in recent years. The higher trainees told the review team that the hospital took referrals from all of North East London and also any centres for thrombectomy, including outside of London. The ESs and CSs told the review team that a TIA clinic ran five days a week and that stroke and thrombectomy clinics ran every week also. The Clinical Director told the review team that the number of patients being admitted to the service was variable but was between 20 and 25 a month. The Clinical Director said that about a third of these were out of hours. The review team asked the Trust representatives how many referrals were being received at night and the Trust representatives said that the stroke doctor on call could be required to clerk six or seven patients a night, even though only one or two of those patients would be admitted under the care of the stroke service. The Trust representatives explained that the stroke doctor on call had to clerk stroke mimic patients and then handover to the right team once the patient had been admitted. The Trust representatives said that when more than one patient came in at once, the stroke doctor on call had to prioritise and that the ED did also try to help as they knew the service was under pressure. The higher neurology trainees explained to the review team that a very high proportion of the calls the stroke doctor on call had to deal with were stroke mimics and that these patients were very unwell. The foundation and IMT trainees and clinical fellows told the review team they were expected to cover the 26-bed stroke ward as well as the thrombolysis bleep out of hours. The foundation and IMT trainees and clinical fellows told the review team that often going into a night shift, four or five patients would be handed over to the doctor on call who would then have to manage those patients plus those that came in overnight. The foundation and IMT trainees and clinical fellows said that more than one thrombolysis call can come in simultaneously and when this happened, they had only consultant help via phone. The trainees said that it was variable whether the stroke nurse would attend each call with them; this often depended on staffing levels on the ward. The review team heard that working alone in this way had been the exception previously but had recently become the rule. The foundation and IMT trainees and clinical fellows said these simultaneous calls were impossible to manage and the thought of doing an on call shift worried and overwhelmed them. The trainees said that when they had more than one patient, the consultants told them to prioritise. The foundation and internal medicine training (IMT) trainees and clinical fellows explained that the stroke service had always been busy and stressful but trainees had felt supported in the past. The trainees and clinical fellows said they thought the situation in the stroke unit had deteriorated in recent months. The foundation and IMT trainees and clinical fellows said that they had worked busy jobs before but in this job, they felt they could not leave and had to stay late to keep the service running. The foundation and IMT trainees and clinical fellows explained they regularly stayed two hours late as the workload was completely unmanageable and staying hours later than they were supposed to was normal in the department.	NSM2.1a

	The foundation and IMT trainees and clinical fellows explained they had to clerk the stroke mimic patients and were often asked by the medical team to start treatment, adding to their workload. The foundation and IMT trainees and clinical fellows told the review team that these patients could be very unwell (for example, they could have sepsis or seizures). The foundation and IMT trainees and clinical fellows said that the number of people the stroke doctor on call had to see over night was not predictable but it would be helpful if they could hand over stroke mimic patients to the ED once it was determined they would not be under the care of the stroke team. The higher trainees in neurology said that it was a common occurrence for a foundation trainee, IMT trainee or clinical fellow to be dealing with three unwell patients at one time in resus on their own. The higher neurology trainees told the review team that the work intensity was high and that the trainees in stroke medicine were often so busy they did not have time to reach out to the acute medicine higher trainee on call for help. The higher neurology trainees said it was clear their colleagues were overwhelmed by the workload and that they had all seen those trainees in distress following shifts. The higher neurology trainees explained the service sounded unsafe and they would not be happy to be working as a foundation or IMT trainee in it. The higher trainees told the review team they were aware of some trainees in the past who had raised concerns but that these concerns had not been well received by some of the consultants in the department. The CSs and ESs told the review team that the stroke on call had always been intense and that various work patterns had been used over the years (with different grades of doctor on the ground and the use of telemedicine). The supervisors told the review team the service got two to three times more stroke mimic referrals than stroke referrals and not having to clerk and start treatment for these patients would help the stroke doctor on call considerably. The supervisors told the review team that the junior doctors found it difficult to hand over patients as other teams often asked them to start treatment which they said may only add half an hour to workload, but when under a lot of pressure with many unwell patients, this added considerably. Some of the supervisors highlighted to the review team that managing stroke mimic patients was very good for training. Some ESs and CSs said that the current pathway was very efficient for dealing with stroke mimics as everyone in the hospital had a good understanding of how these patients were managed, although agreed that it added to the stroke workload. The ESs and CSs said that if the pathway changed so that stroke mimic patients were reallocated following a review by the stroke team, it needed to ensure patient safety so that the stroke doctor on call did not worry about clinical responsibility for that patient. The supervisors said that sometimes the acute medicine team were not always as responsive as they could be. The CSs and ESs said that there was currently no middle grade doctor cover. The higher trainees in neurology told the review team that they had been on the stroke rota on a trial basis from August 2020 until March 2021. The higher trainees explained that they covered stroke calls on the same days they were covering neurology calls and their role was to take calls from doctors in the hospital and discuss with the consultant where needed. The higher trainees said that they had expressed concerns prior to the rota commencing about workload but were reassured that it would	

	only be a few extra calls per night. The higher trainees said that in fact the workload was intense and that the longest they went without a call at night was 15 minutes. The higher neurology trainees explained that they then had to go into the hospital the following morning to do their clinics and other duties and they said there was no one else who could have covered those responsibilities. The higher trainees said that after they were removed from this rota, they were added to another where they were on call in the hospital until 21:00 instead; they said they covered neurology in the day and then were the resident doctor for stroke. The higher trainees said that as the higher trainee stroke post was vacant, they ended up doing stoke in hours as well. The higher trainees told the review team that they had contested this rota as they were not given due notice and they were then removed from it. The higher trainees explained that this meant they were currently not providing any stroke cover and that they had been informed that this would not happen without an appropriate notice period. The foundation and IMT trainees and clinical fellows said that having the neurology higher trainees on the stroke rota had been helpful. The ESs and CSs said having an onsite higher stroke trainee to work alongside the more junior doctor would make a big difference. The review team heard that acute neurological emergencies went through the acute medicine team out of hours and the stroke cover was mostly not involved in this. <u>Staffing levels</u> The review team heard that the thrombectomy service which used to be Monday-Friday had extended to seven days a week, and then to 24 hours a day. The review team asked how the staffing had changed with these changes in service hours and heard that there was an additional stroke consultant. The Trust representatives said that the service had planned to have more middle grade stroke doctors but this process had not been straight forward. The Trust representatives said that the service now had funding for six middle grade doctors who were due to start at various points in autumn 2021. The Trust representatives explained that six doctors were not enough to form a rota so had submitted a further business case to the hospital board for another three but said that it was hoped the six would help to alleviate stress for the more junior doctors in the service. The review team heard that one of the new middle grade doctors was familiar with NHS working, and the others would need an induction to the NHS. The Trust representatives said all of them would receive a full induction including simulation training, which was being planned with help from another London Trust. The review team heard that the service had been trying to recruit middle grade locums in the interim but that the locums currently working in stroke medicine did not work out of hours which was when most support was needed. The Trust representatives told the review team that due to various reasons, the stroke service had four junior doctor vacancies, meaning the service had eight junior doctors instead of 12. The Trust representatives explained that because of this, an interim agreement meant that junior doctors from acute medicine and neurosurgery were helping the stroke junior doctors to cover the stroke and neurology wards out of hours. The Trust representatives said that trainee feedback had been that this was helpful.	

	The foundation and IMT trainees said that previously minimum staffing levels for the stroke ward had been identified, but that it was now normal for there to be fewer doctors than recommended on duty (for example 3 doctors rather than four on a weekday) and only one doctor rostered to work at the weekend when they would be providing ward cover and holding the stroke call bleep. The foundation and IMT trainees and clinical fellows told the review team that they felt one stroke doctor on call was insufficient and placed that doctor under significant stress. The review team asked whether the workload was only high during on call shifts and the foundation and IMT trainees and clinical fellows said that that workload was unmanageable on the wards as well. The foundation and IMT trainees and clinical fellows said that the wards were also poorly staffed, with sometimes only two stroke doctors working (one of whom might be new and have no accesses set up). The foundation and IMT trainees and clinical fellows told the review team that because on call shifts were poorly staffed, during the day, the ward staff had to help. The foundation and IMT trainees and clinical fellows said that when they had locum doctors on the wards, this did improve the workload but also said that locums did not stay long working at the hospital. The higher neurology trainees told the review team that the unit did not have enough junior doctors to run the stroke service. The higher trainees told the review team that there were no higher trainees in stroke medicine at the moment and there was chronic understaffing which put a lot of pressure on the foundation trainees, IMT trainees and clinical fellows. The higher trainees said that geriatric medicine did not contribute to the stroke rota. The higher trainees said they had never worked at a London hospital where foundation and IMT trainees ran thrombolysis calls alone before and they thought it was unusual for a stroke service to not have a higher trainee alongside a more junior doctor, especially with the level of service offered at the Royal London Hospital. The higher trainees told the review team that in their experience, a thrombolysis call ran much more efficiently with a bigger and more organised the team, which usually meant at a minimum: a higher trainee, a more junior doctor, and a stroke nurse. Some of the foundation and IMT trainees and clinical fellows told the review team there had been times when no one had turned up for the night shift so they had no one to hand the bleep over to. The review team heard of another time when the bleep was due to be handed over to a medical support worker instead of a doctor. Some of the trainees and clinical fellows not based in stroke medicine explained that they had been asked to help the stroke doctor on call as part of their rota but some of them had found that when they arrived for their shift, no one was rostered to be on the stroke on call and they had had to cover. The trainees and clinical fellows told the review team that some of their colleagues would not have been able to cover this shift comfortably as they had not worked in a stroke unit before. The Trust representatives said business cases for more staffing were being produced including for 20 PAs of consultant time to allow for changes such as during the day, having one consultant to do the ward round while another took calls. The ESs and CSs explained that there was a hyper-acute stroke unit (HASU) consultant of the week and an acute stroke unit (ASU) consultant of the week but were thinking of trialling two consultants on the HASU to have one consultant on the phone and one running the ward round. The ESs and CS said that it	NSM2.1b

	would be helpful to have another two stroke consultants in the service to make a one in ten weekends rota. The review team asked if the service had advanced clinical practitioners (ACPs). The Trust representatives explained that the service had band six nurses trained in thrombolysis who had a bleep and that a piece of work looking at the use of ACPs and physician associates was being discussed but the service needed to fill stroke nurse vacancies as a priority. The Trust representatives said a business case for more out of hours band five and six nursing staff was being created. The higher trainees said they had never worked in a hospital with a stroke unit which was so understaffed before. The higher trainees also told the review team that a lot of the nurses were agency and were not stroke nurses. The ESs and CSs said there was a known problem Trust-wide with nursing shortages and the stroke service did not have enough nurses. The ESs and CSs said the service had been chronically short on thrombolysis nurses for the last year (due to various reasons) which meant the nurses were being bleeped and going down to ED but then having to come straight back to the ward to manage patients there. The supervisors said recruitment of thrombolysis nurses had been difficult but was ongoing. The review team informed the Trust that based on what they had heard around clinical supervision, the lack of teaching and training, staffing levels and workload pressures, and their impact on the learning environment and trainee wellbeing, Health Education England (HEE) would be issuing a letter to the Trust stating that the Intensive Support Framework (ISF) rating for stroke medicine would be set at three (major concerns). The review team informed the Trust this meant the Royal London Hospital, as a placement provider, had fallen, or was at risk of falling, well below the standards expected by HEE. The Trust was informed that an ISF three rating meant that training would be suspended if rapid and sustained improvements were not made by the time of the next quality intervention. The Trust were also informed that HEE would be starting the emerging concerns protocol to notify other arm's length body organisations of HEE's concerns. <u>Recommending the department</u> The review team heard that the higher neurology trainees would recommend their neurology placements to colleagues but would strongly discourage anyone from working in stroke medicine at the hospital. The higher trainees said that they would much rather their friends or relatives were treated for a stroke at other hospitals in London than at the Royal London Hospital. The foundation and IMT trainees and clinical fellows said they would not recommend their placements and would not want friends or family treated by the stroke service at the Royal London Hospital.	NSM2.1c
2.2	**Appropriate systems for raising concerns about education and training** The Clinical Director said they were not aware of any exception reports in the last two years. The Guardian of Safe Working Hours told the review team that there seemed to be various reasons why trainees did not exception report in stroke medicine, including thoughts that it would not	

	make a difference and feeling like they were discouraged from doing so. The Guardian of Safe Working Hours said they had escalated this to the department lead. Some of the higher trainees in neurology explained they did not know how to exception report (although they knew it had been mentioned in induction) but said they could find out. Other higher trainees said that they had been encouraged to exception report during their local induction but because it took up more time (having already worked extra hours in the day), they would rather go home, especially as they knew that in previous incidences, trainees had not been paid or received time off in lieu. Some of the higher trainees said that they did not mind staying late and they would not exception report. The foundation and IMT trainees and clinical fellows also said that because they wanted to get home, they did not want to take the time to exception report. The foundation and IMT trainees and clinical fellows told the review team that when people had tried to exception report, this had been dismissed by the consultants and they were told they needed to prioritise better so they did not have to stay late. The foundation and IMT trainees and clinical fellows said they were told to exception report in their induction but not shown how to do this. The foundation and IMT trainees and clinical fellows told the review team that when they had spoken to consultants because they had not had anyone to handover to, the consultants had not acknowledged that they had had to stay late for this. The foundation and IMT trainees and clinical fellows told the review team that they were aware of emails which had been sent by trainees raising concerns about the level of service expected versus rota gaps, unsustainable workloads, and patient safety, and that these emails had not received a response from consultants. The foundation and IMT trainees and clinical fellows said that there had been a meeting with consultants after further concerns were raised but the meeting had been dismissive and there had not been another since.	NSM2.2a NSM2.2b

Domain 3 – Supporting and empowering learners		
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.		
HEE Standard	**HEE Quality Domain 3 – Supporting and empowering learners**	**Requirement Reference Number**
3.1	**Learners being asked to work above their level of competence, confidence and experience** The foundation and IMT trainees and clinical fellows told the review team they had never seen a senior doctor run a stroke on call and had had to run all of their on calls alone due to staffing numbers. The trainees said	

	they had to deal with very unwell patients, did not feel safe or supported and thought they had had to make decisions beyond their competence level. Some of the foundation and IMT trainees and clinical fellows said they had been required to step up beyond their grade in other jobs but never to this level. The foundation and IMT trainees said they did not think they should be on call alone with only a consultant on the phone.	
3.1	**Access to resources to support learners' health and wellbeing and to educational and pastoral support** The foundation and IMT trainees and clinical fellows told the review team their placements were impacting on their wellbeing due to the multiple staffing shortages and other issues in the department.	NSM3.1
3.4	**Induction (organisational and placement)** The Trust representatives told the review team that the face-to-face local induction they used to run had not happened for two change overs, although the information was in the handbook. The foundation and IMT trainees and clinical fellows said that some trainees were rostered to work on calls in stroke before receiving a full induction, including being rostered on call on their first day in the service. The foundation and IMT trainees and clinical fellows explained to the review team that they had had their Trust induction one morning, were supposed to have that afternoon for admin, and then have their local induction the next day. The review team heard that the trainees received an email on the day of the Trust induction asking them to come to the ward where they were asked to start working or complete their eLearning straight away. The trainees said the department had not planned staffing for those changeover days. The trainees explained that they were taken to the ED, shown how to do a NIH Stroke Scale, and then one trainee who had eaten was given the bleep and the rest were told to get lunch and come back, whereupon they all stayed late. The review team heard that trainees were then put on call the next day and asked to work the weekend without receiving a local induction. Some of the ESs and CSs said they had concerns about the stroke induction for junior doctors saying that trainees had been sent to work weekends without a proper formal induction. The review team heard that the induction needed to be more robust and that there were problems with this because rotas were finalised last minute. The review team heard from other ESs and CSs that foundation year two trainees used to receive a two-day taster in the service before they started but this had not happened in the past two rotations due to Covid-19. The ESs and CSs informed the review team that a comprehensive induction to include simulation training and how to assess patients was being planned.	NSM3.4a NSM3.4b

Domain 4 – Supporting and empowering educators

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 appropriately supported to undertake their roles.

HEE Standard	HEE Quality Domain 4 – Supporting and empowering educators	Requirement Reference Number
4.3	**Educational appraisal and continued professional development** The Trust Dean said the department was not up to date with educational appraisals.	NSM4.3a NSM4.3b
4.4	**Appropriate allocated time in educators job plans to meet educational responsibilities** The ESs told the review team that some of them had time in their job plan, some did not, and some worked over time to make time for educational supervision. Some of the ESs said they had problems meeting the trainees for educational supervision as the trainees were so busy. The Trust Dean highlighted that the department was under extreme pressure and there needed to be a focus on the wellbeing of trainers (in addition to trainees and patients) who the Trust Dean said trainees had expressed sympathy with as they were doing their best. The higher neurology trainees said the vast majority of stroke consultants were excellent consultants and worked hard. The higher trainees told the review team that as the stroke consultants were now doing the rota they had been on previously, the consultants must be exhausted as they would be called all night long. The higher trainees said they thought this would mean the consultants would not be able to provide good support to the junior doctors running the service.	NSM4.4a NSM4.4b

Domain 5 – Delivering curricula and assessments

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.

HEE Standard	HEE Quality Domain 5 – Developing and implementing curricula and assessments	Requirement Reference Number
5.1	**Placements must enable learners to meet their required learning outcomes** Some of the IMT trainees told the review team they had not had a clinic since they started in their placements. The foundation and IMT trainees and clinical fellows said that the stroke training between 09:00 and 17:00 was okay and neurology training was good.	NSM5.1a

	The ESs and CSs informed the review team that teaching took place from 12:00 to 13:00 on Tuesdays. The ESs and CSs said the stroke team had lost its teaching room and the new teaching room was on another floor, which left the ward unmanned during teaching. The higher neurology trainees told the review team that they did not have any teaching time built into their work schedule and instead had to do this in their own time. Some of the higher trainees said they felt the consultants did not think teaching was a part of their job and instead focused on service provision. The review team heard that the neurology department was a good place to train in terms of the variety of patients trainees saw. However, the higher trainees told the review team that their clinic lists were booked to consultant timings which meant they were under pressure and had to stay late to ensure everything was done.	NSM5.1b NSM5.1c NSM5.1d NSM5.1e

Domain 6 – Developing a sustainable workforce

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 of 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.

HEE Standard	HEE Quality Domain 6 – Developing a sustainable workforce	Requirement Reference Number
	Not discussed at the review.	

Report sign off

Quaity Review Report completed by *(name(s) / role(s))*:	Chloe Snowdon Learning Environment Quality Coordinator
Review Lead name and signature:	Louise Schofield
Date signed:	05 November 2021

HEE authorised signature:	Gary Wares
Date signed:	15 November 2021

Date final report submitted to organisation:	17 November 2021

What happens next:

Any requirements generated during this review will be recorded and monitored following the usual HEE Quality Assurance processes.

As part of our intention to development a consistent approach to the management of quality across England, Quality Reports will increasingly be published and, where that is the case, these can be found on HEE's national website. Information from quality reports will usually be shared with other System Partners such as Regulators and Quality Surveillance Groups.