REPORT OF THE FOUNDATION TRAINING QUALITY MANAGEMENT VISIT TO HINCHINGBROOKE HEALTH CARE NHS TRUST

03 OCTOBER 2013

VISITORS

- Professor John Saetta, Foundation School Director and Associate Postgraduate Dean, Health Education East of England
- Mr Harald Bausbacher, Foundation Training Programme Director, Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust
- Agnès Donoughue, Quality Coordinator, Health Education East of England

TRUST TEAM

- Jenny Raine, Finance Director and Deputy Chief Executive
- Dr Mark Lillicrap, Clinical Tutor
- Dr Helen Johnson, Foundation Training Programme Director
- Michaela Turner-Douglas, Medical Education Manager
- Margaret-Ann Beck, Foundation Administrator

For the feedback session they were joined by:
- Mr Hisham Abdel Rahman, Chief Executive and Medical Director

The purpose of the visit was to review and monitor the educational agreement between the Trust and Health Education East of England (‘the Deanery’), and to quality manage the provision of Foundation Training in the Trust on behalf of Health Education East of England in accordance with the standards for Foundation Training set out by the GMC in *The Trainee Doctor* (2011).

This visit was undertaken as part of our second cycle of Quality Management for Foundation Training across the East of England. The visit commenced with a welcome and introductions.

1. MEETING WITH TRUST TEAM

Professor Saetta clarified that any patient safety concerns which may arise during the course of the visit would be shared with the Trust and would require appropriate action.

2013 GMC Trainee Survey analysis

The visit started with a presentation by Professor Saetta of HEEoE’s analyses of GMC Trainee Survey results 2013 relating to Foundation training at Hinchingbrooke Hospital including the Trust’s position in relation to national standards which was in line with, or not far off, the national mean.
The visitors were asked to clarify whether the results still included comments applicable to psychiatry which had originally been listed as gynaecology by the GMC. It was thought that these had been removed from the Trust data; however, the visitors would check and report back to the Trust to ensure the accuracy of the findings. It was later confirmed that the results had been amended to remove the comments relating to psychiatry from the Trust data.

The teams reviewed the GMC outliers as below:

**Positive outliers**
- The GP F2 trainees showed a total number of six positive outliers.
- A vast improvement was noted in EM compared to 2012 corroborated by the Clinical Tutor who reported a change of ethos in the department and the development of a very good educational programme which could serve as an example of good practice.
- Access to educational resources and adequate experience were also positive outliers both in the 2012 and 2013 surveys.

**Negative outliers**
The main areas of concern in the survey related to understaffing and confidence issues. It was thought that the negative outlier for overall satisfaction in surgery must be due to T&O.

Medicine F1. Overall satisfaction and workload were also negative outliers in medicine F1, possibly due to sickness and absence amongst core trainees and the difficulty generally in recruiting locums. Positive steps have been taken by the Trust to address this. The visitors were informed that the teams in medicine had been restructured and the rotas modified. Two F1s from surgery had been moved to medicine to try and redress the issue of workload in this specialty.

Dr Johnson highlighted that, due to the small number of F2 trainees in each specialty (one or two), the Trust never received feedback on these posts. The only feedback from the GMC survey relating to F2s was in the patient safety concerns or free text comments, which did not include areas of good practice. The visitors agreed to feed this back to the GMC and would find out if the results could be aggregated for FY2s as a group and report back to the Trust.

**Patient Safety Concerns and free text comments from GMC survey**

**Update on Orthopaedics**
Dr Lillicrap informed the team that a seven point action plan had been implemented by the Trust over a 3-month period from June – August, and an internal survey of trainees carried out at the end of August with a 75% response rate. Consultants were reported as approachable; a good teaching programme is in place; on call is satisfactory.

- **Middle grade cover.** However, the T&O department is currently in a period of flux. The main issues relate to middle grade staffing/middle grade cover and recruitment, with a shortage of middle grade doctors (there are only 3 middle grades within orthopaedics). The Trust has appointed LAS doctors at F2 level to increase the number of trainees; it is too early however to ascertain the impact of this. Dr Lillicrap confirmed that funding has been identified to appoint middle grades (three permanent full-time; two 1-year locums). Interviews for two non-training registrar posts are scheduled for 15 October and it was hoped that the number of consultants would be up to six again by January 2014.
- **Outpatient experience.** The trainees are not getting outpatient experience because of workload. Supervision has not been adequately resolved so the action plan is still to be fully implemented. The number of procedures is very limited, which has been highlighted to the department by the clinical tutor.

- **Consent issues.** It was apparent that trainees are still asked to perform procedures beyond their competence.

The visitors were informed that the Trust is going towards zonal care (acute/non acute), with patients being physically moved into another zoned area and the cross cover provided by doctors in the zone. It is hoped that this 6 month-plan will take pressure off T&O and that concerns will be phased out. The junior team has been restructured and the single orthogeriatrician is developing the care pathway.

**Hospital at night** covers obstetrics, gynaecology and orthopaedics. The on call medical team comprises the majority of the Hospital at Night component. There is an out of hours gynaecology registrar. At night, there is no registrar for orthopaedics on site.

It was reported that the issue of **bullying and harassment** relating to one particular individual has been addressed.

**General Surgery**
The comments have been taken up within the clinical unit and the clinical tutor is confident that these are being addressed proactively; the department is very keen on dignity at work.

2. **DISCUSSION WITH EDUCATIONAL SUPERVISORS**

The visitors met nine Educational Supervisors and the Senior Resident.

There is a large number of Educational Supervisors for the size of hospital. Supervisors on the whole felt that the calibre of trainees at Hinchingbrooke is very good. However there are problems with supervision due to cross-Trust rotations. Experiential teaching was seen as a valuable tool.

The following areas were covered:

- **E-portfolios.** Keeping up with developments in the e-portfolio was a challenge; not felt to be a straightforward user-friendly form, [with the trainees tending to leave things to the last minute, or reluctant to enter assessments]. Prof Saetta clarified that the e-portfolio is trainee-owned and used as a tool for transfer of information. It can also be used to identify trainees in difficulty. Any concerns or clinical conditions about a trainee relating to patient safety should be entered in the e-portfolio. It needs to be signed off by the trainee to allow transfer to another Trust.

- **New ARCP form and form R (declaration of trainee that there are no issues).**

- **Educational supervision in job plans should be 0.125 PA per trainee although time constraints and staff shortages made it sometimes difficult to deliver educational supervision. Educational and clinical supervisors are often one and the same person at Hinchingbrooke.**

- **Career advice is provided by Dr Helen Johnson.**
- Mechanisms are in place in the Trust to provide support to trainees in difficulty including tutorials/dedicated training sessions for supervisors by the Clinical Tutor.

- The Trust is continuing to provide a faculty development programme. Educational and clinical supervision should be provided at Trust level through the E&E programme. Prof Saetta recalled that £2m were available for the region this year for PDP and faculty development.

- ITU would like to have more trainees.

- The group were reminded that The Deanery runs a swap shop for F2 trainees only should they wish to swap posts. Details on the website. It was clarified that F1 exposure should be acute and F2 community.

3. MEETING WITH FY1 TRAINEES

The visitors were pleased to meet 14 F1 trainees from a range of specialties including Medicine (general and acute), Surgery, ITU, Respiratory, who clearly valued their foundation training at Hinchingbrooke Hospital.

Clinical supervision and support. The trainees felt well supported by medical staff, and were well supervised. The surgical consultants and registrars were described as very approachable. There were no issues with supervision in Acute/General Medicine despite the busyness of the night shifts, with the registrar covering acute admissions. The thorough review of patients sometimes taking up to an hour was felt to be a valuable learning experience. The trainees in ICU could call on the SHO-equivalent at night if they had any queries.

Handover. The trainees reported a lack of handover of acute patients on Juniper Ward. The F1s on this ward cover medical and surgical patients with the ‘SHO/CT1 or GPVTS trainee covering all patients. The F1 to F1 handover does not happen routinely and there is no team handover. There is no formal clinical handover in Medicine from the night team to the day team (although there is a handover from the day to the night team). One trainee reported handing over patients to a nurse as no consultant was available. One of the F1s reported as a concern the fact that a patient had not been seen for two days and was only seen by the ortho-geriatrician after a chance meeting with the trainee in a corridor.

In AAU/AMU, handover is team-based and there is an evening handover from day F1 to evening F1. There is an acute physician on call (available via bleep or telephone) and the medical registrar is the key contact for medicine during the day. Most consultants are available on wards if needed.

In Surgery, a full team handover happens in the morning as well as at night (evening to night).

The trainees reported that there is a patient management system; however there are no facilities to enter free text comments but handover sheets can be printed out.

The trainees didn’t seem to know about Hospital at Night.

Concerns about patient safety. When asked if they had any patient safety concerns, the trainees reported a patient not getting medication and a patient not having been observed for 12 hours. No harm came to either of them.
**Short Stay Unit (SSU).** Concerns were raised about the Short Stay Unit which should cover 35 patients but sometimes covered up to 59 patients. The trainees had raised concerns with the Senior Resident about workload, nursing cover, patient care, and sometimes being pressured by nurses at weekends to write discharge summaries for patients they didn’t know very well. The trainees felt uncomfortable doing this.

The discharge summaries are saved on the v:drive which was felt not to be secure and it was ‘easy to make mistakes’. Paper copies of the discharge letters are sent out by post rather than electronically.

The orthopaedic patients are not handed over formally; in one instance a patient had not been seen for four days. The trainee had raised his concern with the consultant.

The trainees were not aware of the Trust’s intentions to ‘zone’ wards.

**Community Transition Unit (CTU).** Trainees reported that patients ready to be discharged are transferred to this Unit. There is a weekly review of patients by consultants once a week. If a patient develops an acute problem, they are incorporated into the daily round and transferred to a ward. Whilst on CTU, an incident involving a patient with AML who developed acute sepsis, and who was discovered by pure accident, was reported by a trainee. If a patient gets moved out of hours to CTU, there is a risk that the team may think they have been discharged.

The trainees do not consent patients for a procedure they do not feel able to do.

They are not allowed to prescribe cytotoxics.

They receive sufficient acute experience. They usually do one General Medicine rotation, one General Surgery and one Acute Medicine.

Most of the trainees met had started their e-portfolios.

All the trainees had had meetings with their Clinical/Educational Supervisors and had been given time to attend generic teaching. Departmental teaching had not happened in Surgery yet although they reported receiving a lot of exposure and attending business rounds rather than teaching, thus getting exposure to elements of training.

The formal teaching programme is not always bleep free. The generic teaching programme is joint F1/F2, with elements of the programme allowing for the separation of the two groups if the topic is relevant to one and not the other.

The trainees felt well supported by the Education Centre staff, particularly Margaret-Ann and Michaela, ‘the highlight of Hinchingbrooke’.

They reported no undermining or bullying.

All had had departmental induction, and in the case of Medicine, they had received a booklet of useful information (ITU, Medicine, day of shadowing previous F1). All had done shadowing.

They all knew that Dr Johnson was the Career Advisor operating an open door policy.

Although the F1s are not entitled to study leave, they were informed by the visitors that they could apply to do tasters (a week in the desired specialty), if planned in advance.
One trainee had done ALS, with most of the others booked to do it. The trainees however complained that they have to do the ALS locally and only at weekends. This had led to some trainees not having a break for three weeks (one weekend on-call followed by the next weekend doing ALS). The visitors wondered whether one ALS could be offered during the week utilising two days study leave.

Four trainees had been involved in audit.

They reported having no internet in the accommodation block. Wi-Fi in the Mess was reported to be intermittent, due to poor reception.

4. MEETING WITH F2 TRAINEES

The visitors met 7 F2 trainees.

Clinical supervision. All the trainees present were satisfied with clinical supervision. There were no problems in T&O or with any other specialty. The trainees in T&O reported being busy ‘but not too much’.

Handover. Handover occurred from day to night in Acute Medicine but there was no set handover from night to day. The trainees reported problems with delays in getting results as a potential patient safety concern. They clarified that a lot of patients on T&O get covered by the medical F1. Handover happens at 8.00am during the day but there is a problem handing back to the night team resulting in significant delays.

Emergency Medicine handover happens with trainees reporting always having somebody senior to ask. There are no patient safety concerns in this Department.

The GP F2 trainees present were very happy; they reported going through all the patients every day with a GP doctor.

They all had had, or were about to have, an initial meeting with their Educational/Clinical Supervisor.

Departmental induction. All had attended departmental induction, with GP F2s having a one-week induction and T&O having a whole day course. A&E consisted of a day induction. The Trust provides online induction in mandatory topics described as the ‘most awful system’, impossible to navigate, crashing all the time. There were reports of induction not being recorded by the system after trainees had completed it.

The trainees had not been asked to consent for procedures they did not feel confident to perform.

They were not allowed to prescribe cytotoxics.

Sufficient experience. In T&O, they reported difficulty in attending clinics.

It was felt by one trainee that the fact that the educational and clinical supervisor is the same person may not always be a good thing. Prof Saetta clarified that the Trust can change the educational supervisor if need be.

There were no difficulties completing assessments.
Generic teaching can be either joint F1 and F2 or split, where topics specific to one group and not the other exist.

Departmental teaching. Formal teaching is very good - one hour and a half on Thursday with the registrar. However, teaching in ED is not protected, and F2s are pulled out of teaching if the service demands require it.

Trainees reported the discontinuation of the grand round in Orthopaedics with only one grand round this year.

The trainees in the Emergency Department are not able to attend taster week because of the tightness of the rota.

All had done ALS. APLS has to be done on their day off.

All the trainees appreciated the support received from the PGME Centre staff.

There were no issues of undermining or bullying.

Career support is provided by Dr Johnson.

Four trainees had done audits.

Two trainees had done tasters.

Most of the F2 trainees present would recommend their Foundation programme to a friend with the exception of Medicine which was felt to be very busy with nursing shortages, ‘a struggle’.

5. FEEDBACK TO TRUST TEAM

Prof Saetta thanked the Trust team for the excellent organisation of the visit. The visiting team were very appreciative of this. The main findings of the visit were shared as below:

There were issues with CTU. The visitors were informed by the Chief Executive that, until recently, the operational framework considered patients going to CTU to no longer be the responsibility of the Acute Trust and a contractual handover of care was made to the Community organisation. However, recent changes involving the introduction of CCGs and budgetary restraints meant that the Community organisation was now split into two areas, with the loss of responsibility for the continuity of care for patients “discharged” from the Acute Trust in CTU. Whereas patients used to spend a day or so in CTU before transfer to the community, they are now in there for several weeks. The case of the septic AML patient was a case in point, where continuity of care fell between two stools, with potential ill effect on patient safety. This point was taken up positively by the Chief Executive.

The Foundation doctors met were happy and the F2s said they would recommend their post to a friend although in Medicine issues relating to staff shortages coloured their judgement.

The trainees reported getting excellent support from the PGMEC particularly from Michaela and Margaret-Ann.

No concerns were reported in T&O.
6. REQUIREMENTS

6.1 There were problems with handover in Medicine across F1 and F2 from the night to the day time shift with no official handover on Juniper Ward (acute medicine).

Patient safety concerns relating to high workload, nursing cover, concerns over clerical work (discharge summaries) taking precedence over clinical, require remedial attention.

**ACTION 1:** The Trust is asked to address the issue of team clinical handover in Medicine urgently. It should also address the fact that trainees are pressured to do discharge summaries to the detriment of clinical work (see below as well).

6.2 High workload on SSU with up to 59 patients and F1s doing the discharge summaries to the detriment of clinical work (potential patient safety issue).

**ACTION 2:** The Trust has in place plans to reduce the number of patients on the SSU to an upper limit of 35 at any one time. It is imperative that this is implemented in order to minimise any potential patient safety concerns or mishaps accruing from poor staffing ratios.

6.3 Community Transition Unit. The recent near-miss patient-safety incident is an area of concern. Negotiations should be held with the Community Trust and CCG is in order to ensure that continuity of care is paramount. There is presently only one weekly ward round.

**ACTION 3:** The Trust is required to address the above concern and measures to introduce more effective monitoring of lodged patients on CTU should be put in place urgently while agreements are sought between the Acute Trust and Community in regard to patients considered as “discharged” by the Acute Trust.

6.4 Trainees in Orthopaedics had informed the visitors that non-performer consent is common.

**Action 4:** The Trust is required to investigate the process for consenting T&O patients and ensure that Foundation trainees do not consent patients for procedures unless they have received adequate training to do so. Consenting for a procedure or operation should be undertaken by the surgeon who is to perform the procedure or operation. While deputising is considered appropriate, it must be by a clinician who has sufficient knowledge of what the operation and its complications entail.

7. RECOMMENDATIONS

7.1 The Trust should consider introducing internet in the Trainees’ accommodation and repair the temperamental access to internet in the Mess. The Trust team clarified that internet was available for Cambridge medical students through SIFT funding and that there are plans for the whole hospital to be Wi-Fi-enabled next year.

**ACTION 5:** The Trust should implement this as soon as is practically possible.
7.2 F2s reported problems accessing tasters and general induction. The trainees reported navigation problems relating to the online general induction in mandatory topics with the system crashing regularly. Consideration ought to be given to accessing the regional content (made available by Health Education East of England) that provides generic mandatory topics which also act as a passport for training in these topics.

**ACTION 6:** The Trust should address the issues relating to online induction as a matter of priority.

7.3 Departmental teaching in ED should be protected.

**ACTION 7:** The Trust should ensure that foundation trainees in ED can attend departmental teaching without being pulled out of protected learning.

7.4 Issues related to the timing of ALS courses, as described above, should be reviewed to address trainees concerns about the use of weekends for training.

**ACTION 8:** The timing of ALS courses should be reviewed as recommended above.

**8.0** The Trust is required to respond to the above requirements/recommendations within 6 weeks of receiving this report (by cop 6th December 2013).

The visit was concluded with many thanks to the organising team for releasing the trainees from work to present their views, to the Education Supervisors for committing to trainees, for the preparation and organisation of the visit, including their hospitality, as well as the recognition of the very good work undertaken in the development and ongoing delivery of Foundation training at the Trust.

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