School of Postgraduate Medicine Visit to Southend University Hospital Foundation Trust

Visit Report
17th March 2015

HEEoE representatives:

Ian Barton, Head of School of Medicine, HEEoE
Ian Cooper, Quality Lead School of Medicine, HEEoE
Catherine Bryant, Deputy Head of School of Medicine, London (JRCPTB external visitor)
Helen Richardson, GMC Enhanced Monitoring Associate
Jennifer Barron, Education QA Programme Manager, GMC

Trust representatives:

Neil Rothnie, Medical Director
Jon Findlay, Chief Operating Officer
Sarietha Kumar, College Tutor
John Kinnear, Director of Medical Education
Katie Palmer, Medical Education Manager
John Day, Clinical Lead for Medicine
Consultant representatives from a range of medical specialties relevant specialities

Number of trainees & grades who were met:

11 Foundation Trainees (7 F1s, 4 F2s)
7 CMT1s, 2 CMT2s, 3 GPSTs
11 ST3+s (renal medicine (2), rheumatology (2), respiratory medicine (2), geriatrics, diabetes and endocrinology, gastroenterology, neurology, clinical oncology)

Purpose of visit:

This was a targeted visit confined to assessing the Trust’s progress with addressing the concerns reported following the School of Medicine’s visit on December 16th 2014 and, specifically, the following requirements:

- The Trust must ensure that there is Departmental induction for all trainees joining a department
- The Trust must ensure that CMTs are able to attend 12 outpatient clinics per year
- The Trust must ensure that CMTs and higher specialty trainees in medicine are able to attend at least 60% of their formal (internal and external) teaching
- The Trust must ensure that safe and effective morning and evening handover is re-instituted; ideally this should be consultant-led
- An effective process of patient tracking must be put in place to ensure that patients are not “lost”
- Middle grade and junior trainees must not undertake unsupervised clinics without a clearly identifiable
supervising consultant being available

- F2s should not hold the acute referrals bleep during the first two months of their first placement in medicine; after this they should be allowed to hold the bleep, but only if they feel confident to do so and they are adequately supervised.
- The Trust must ensure that the staffing levels on the joint gastroenterology/respiratory medicine ward are adequate; if the two specialties are to continue working together on this ward, each specialty should have its own dedicated team of at least three foundation and/or core trainees.
- The Trust must revise the acute admissions pathway to ensure that it is safe and provides appropriate training opportunities for Foundations trainees, CMTs, GPSTS and ST3+s in medicine. In particular, Foundation trainees and CMTs should have the opportunity of seeing patients “de novo” so that they can make their own assessments and management plans. There should be extensive involvement of the consultant physicians and trainees in this revision.
- Undermining in all areas must be investigated and effectively addressed. The named consultant physician should not hold any educational roles until effective remediation has been demonstrated.
- The Trust should review the CMT on-call rota (with input from the CMTs themselves) to explore the possibility of allowing more rest time or spreading out the on-calls during the period when most daytime, night time and weekend on-calls occur; this would make an ideal Quality Improvement Project for a CMT

and the following recommendations:

- The Trust should consider reconfiguring wards so that:
  - the two AMU wards are closer together
  - the two respiratory medicine wards are closer together
  - the current joint gastroenterology/respiratory ward becomes a single specialty (e.g. geriatrics) ward
- The Trust should investigate the quality and appropriateness of referrals from the A&E Department
- The Trust should consider appointing a Consultant lead to support Quality Improvement projects for CMTs
- Junior doctors requesting investigations from the imaging department must ensure that they have adequate information before approaching a consultant to make the request

HEEoE had received an action plan from the Trust on 9th January 2015, outlining the Trust’s proposed actions, which was felt to be satisfactory in principle.
**Strengths:**

- The report of the last School of Postgraduate Medicine visit had been widely shared with the trainees.
- The Trust had instituted a “Transformation Plan” with a greater emphasis on medical education.
- A new education lead has been appointed in the AMU, since when:
  - A teaching programme for Foundation doctors has been introduced.
  - There is an opportunity to complete WPBAs on interesting patients on Mondays.
  - There is an opportunity to provide anonymised feedback of concerns.
- Attendance at CMT formal teaching has improved and it is reported to be “bleep-free.”
- The higher specialty trainees felt that their training in their base specialties was of a high standard.

**The following requirements have been fully met:**

- The Trust must ensure that CMTs and higher specialty trainees in medicine are able to attend at least 60% of their formal (internal and external) teaching:
  - All trainee groups reported that they were able to attend over 60% of their internal and, where relevant, external teaching.
- Middle grade and junior trainees must not undertake unsupervised clinics without a clearly identifiable supervising consultant being available:
  - All trainees reported that they were adequately supervised in clinics.
- The Trust must ensure that the staffing levels on the joint gastroenterology/respiratory medicine ward are adequate; if the two specialties are to continue working together on this ward, each specialty should have its own dedicated team of at least three foundation and/or core trainees:
  - The respiratory team’s beds on the former joint gastroenterology/respiratory medicine ward have been relocated to a ward adjacent to the other respiratory ward.
  - The gastroenterologists now share the former joint gastroenterology/respiratory medicine ward with the diabetes & endocrinology and infectious disease teams, who have their own separate team of trainees.
  - All the trainee groups reported that all the affected clinical areas are now adequately staffed and that the move had enhanced their training and patient safety.
Areas for Development:

- There is poor awareness amongst the Foundation Trainees of “Dr Toolbox”

The following requirements have been partly met:

- **The Trust must ensure that there is Departmental induction for all trainees joining a department:**
  - The Medical Director had emailed the trainers to stress the importance of departmental induction
  - When the CMTs moved placements in February, most trainees were inducted. However, the CMTs joining the gastroenterology team received only a brief introduction to their ward from a senior nurse
  - There is a half day departmental induction in the oncology unit, which could be used as an exemplar for induction in other specialties
  - The Foundation trainees have not moved placements since the last visit
  - Trainees working shifts in the AMU do not receive adequate induction and have a very poor understanding of their roles. This lack of understanding is exacerbated by a lack of consistency in the way different consultants work, resulting in what is expected of trainees being dependant on which consultant is supervising them.
  - The AMU trainees were working on a paper based induction leaflet, while the AMU consultants were working on a web-based resource; it was not clear whether the two groups were working together

- **The Trust must ensure that CMTs are able to attend 12 outpatient clinics per year**
  - The model developed in the geriatrics unit of trainees attending clinics during the afternoon of late shifts has been rolled out to other specialties
  - The CMTs have a list of clinics which they can attend – this includes clinics in specialties other than their own; e.g. neurology
  - Access to clinics in some specialties is limited by a lack of outpatient rooms
  - Early experience is encouraging but the success of this initiative cannot be fully tested until it is confirmed that the trainees have met their curriculum requirements for clinic attendances in the next round of ARCPs

The following recommendations have been partly followed:

- **The Trust should consider reconfiguring wards so that the two AMU wards are closer together, the two respiratory medicine wards are closer together and the current joint gastroenterology/respiratory ward becomes a single specialty (e.g. geriatrics) ward**
  - There are plans to relocate the two AMU wards early in the summer
  - The two respiratory wards are now closer together
  - The former joint gastroenterology/respiratory ward has now become a joint gastroenterology/diabetes & endocrinology/infectious disease ward (see above under strengths)

- **The Trust should consider appointing a Consultant lead to support Quality Improvement projects for CMTs**
  - This is being explored and two potential candidates for the role have been identified

- **Junior doctors requesting investigations from the imaging department must ensure that they have adequate information before approaching a consultant to make the request**
  - Feedback from the radiologists suggests some improvement

Significant concerns:
The visiting team were concerned that the lack of attendance of the Trust’s Board Members at the meetings might reflect a lack of commitment of the Trust Board to medical education.

The following requirements, all of which are significant risks to patient and trainee safety, have not been met:

- **The Trust must ensure that safe and effective morning and evening handover is re-instituted; ideally this should be consultant-led**
  - Although there is a short “Safety Check List” meeting every morning and some patients are handed over during the morning PTWR in a way that is of educational value, there is no formal, safe, effective handover of all patients admitted during the previous shift or those who are unwell on the wards.
  - Trainees completing night shifts often have to stay beyond their contracted hours to present and hand over patients on the morning PTWR.
  - Evening handover is of a better standard, but there is generally no consultant presence; a new larger location for handover with appropriate IT facilities etc has been identified and it is anticipated that, once this is available for use (which the Trust anticipates will be within six weeks of the visit), the quality of evening handover will improve and there will be a consultant present.
  - Friday afternoon handover to the weekend team was of a good standard when it was first instituted as a trainee-led QI project. However, unless one of the trainee leads is present, it is “shambolic” with little structure and little input from consultants or higher specialty trainees.
  - The list of patients requiring review or actions over weekends is not always kept up to date and often contains details of patients and tasks from previous weekends.
  - This list is maintained in an Access Database and it was reported that if one individual is entering data, no other individual can view it.

- **An effective process of patient tracking must be put in place to ensure that patients are not “lost”**
  - Patients are still sometimes moved at weekends to outlying surgical or other wards without the responsible team being informed; this leads to patients being “lost”.
  - Patients are sometimes admitted without the responsible team being informed; an example (which had been reported as an SI) was cited of a patient with pneumonia, wrongly diagnosed as having a rheumatological condition, being admitted in to a rheumatology bed on a Friday without the rheumatology team being informed, resulting in the patient not being reviewed over the weekend.
  - There is no safe and effective process which ensures that patients’ details are entered on to the admitting teams’ expected patient list at the time of referral from GPs and the A&E Department. This leads to the admitting team not being aware of the affected patients’ existence so that there are delays in them being reviewed.
  - The site manager circulates details of outlying patients’ locations to relevant clinicians every morning, but there are sometimes errors in allocating the correct responsible consultant, which limits the value of this process.
  - Information on the Electronic Patient Record is not always updated in a timely way when patients are moved, especially out of hours when there are no ward clerks on duty. There is a programme of training for ward nursing staff to teach them how to enter this data.

- **The Trust must revise the acute admissions pathway to ensure that it is safe and provides appropriate training opportunities for Foundations trainees, CMTs, GPSTS and ST3+s in medicine. In particular, Foundation trainees and CMTs should have the opportunity of seeing patients “de novo” so that they can make their own assessments and management plans. There should be extensive involvement of the consultant physicians and trainees in this revision**
  - There has been some trainee involvement in the revision of the acute admissions pathway but this appears to have been limited and there has been no widespread consultation of trainees. Similarly,
there is little evidence of widespread consultation with the general physicians
- The core trainees report that they are now able to see patients “de novo”
- Some Foundation Trainees report that they still not able to clerk patients independently
- A fundamental problem is that there is no consistent agreement among the acute physicians and the general physicians on how the “Assess to Admit” form should be used; this leads to confusion among the trainees; they are admonished by some consultants for using it and admonished by others for not doing so
- The senior assessment is generally done either by a consultant or an StR, but not both. This means that:
  - StRs get only limited feedback on the patients they have admitted
  - If the decision to admit a patient is made by an StR, the patient may not be seen by a consultant within 14 hours of admission
- The environment in the AMU was described as “toxic” by the higher specialty trainees
- The term “tribal” was used on a number of occasions by senior managers and educators to describe the behaviour of some consultant groups. It was unclear whether this reflected the relationships between different groups of physicians or between the A&E team and the physicians

- Undermining in all areas must be investigated and effectively addressed. The named consultant physician should not hold any educational roles until effective remediation has been demonstrated
  - Undermining by one of the named consultants in the Imaging Department has ceased in response to feedback following the last visit
  - Undermining by the other named consultant in the Imaging Department has persisted despite the Trust initiating a disciplinary process
  - Undermining by the named consultant physician has persisted and there were reports of this being directed at Foundation Trainees, Higher Specialty Trainees and other consultants
  - Six of the eleven Higher Specialty Trainees who met with the visiting team reported that they dreaded being on call when they knew that they would be working with the named consultant physician
  - When the trainees were asked to complete an internal survey, the response was poor with some trainees saying that they did not feel comfortable to do so as they were worried that they might be identified and others saying that, as the survey was immediately before the visit, they would prefer to defer their comments until the visit

- The Trust should review the CMT on-call rota (with input from the CMTs themselves) to explore the possibility of allowing more rest time or spreading out the on-calls during the period when most daytime, night time and weekend on-calls occur; this would make an ideal Quality Improvement Project for a CMT:
  - There have been some discussions with CMTs about possible options but no changes have so far been implemented
  - The CMTs reported a number of examples when a trainee had completed an acute block at the end of one placement followed by an acute block at the beginning of the next placement; this had resulted in at least one trainee having been on call for three consecutive weekends. This carries the risk of excessive tiredness which is a risk to both trainee and patient safety

The following recommendation is now a cause for serious concern:

- The Trust should investigate the quality and appropriateness of referrals from the A&E Department
  - It is very frustrating for both the trainers and the trainees that there is no opportunity to negotiate with the A&E staff about the appropriateness of referrals even when they are clearly inappropriate, e.g. a patient being referred as having acute kidney injury having had no blood tests to make the
diagnosis, a patient with a condition that clearly needed referral to a specialist surgical unit in another hospital being handed over to the medical team do that they had to make the referral

- Patients can be handed over without “emergency” treatments (e.g. the sepsis care bundle) being started and without the admitting team being aware of this so that treatment can be significantly delayed

The following requirement could not be assessed

- F2s should not hold the acute referrals bleep during the first two months of their first placement in medicine; after this they should be allowed to hold the bleep, but only if they feel confident to do so and they are adequately supervised.
  - No F2s have started their first rotation in medicine since the last visit so this could not be tested
  - The visiting team do not feel that it is appropriate for F2s to hold the acute referrals bleep at any stage during their placements in medicine

Requirements:

- The Trust must ensure that morning, evening and Friday afternoon handover are all comprehensive, safe, effective and of educational value; ideally, there should be a consultant present at a minimum of one handover meeting every day. The individual responsible for leading all handover meetings should be clearly defined. The introduction of a Hospital @ Night team might facilitate handover. As this is a significant patient safety issue, it is strongly recommended that a consultant is identified to lead on handover with ring-fenced time in his/her job plan for this task. **Target date for completion: April 30th 2015**
- An effective process of patient tracking must be put in place to ensure that patients are not “lost”. As this is a significant patient safety issue, it is strongly recommended that a consultant is identified to lead on patient tracking with ring-fenced time in his/her job plan for this task. **Target date for completion: April 30th 2015**
- F2s must not hold the acute referrals bleep. **Target date: immediate**
- Further work must be done on the acute admissions pathway to ensure that it is safe and provides a suitable training environment and appropriate training opportunities for Foundations trainees, CMTs, GPSTS and ST3+s in medicine. There should be extensive involvement of the consultant general physicians and trainees in this work. Once an operational model has been agreed it must be consistently followed by all those involved. As this is a significant patient safety issue, it is strongly recommended that a consultant is identified to lead on patient tracking with ring-fenced time in his/her job plan for this task. **Target date for significant progress: April 30th 2015** with continued work thereafter to refine the processes
- Undermining in the AMU and Imaging Department must be re-investigated and more effectively addressed. There should be an internal process (e.g. monitoring every six weeks) to ensure that undermining has ceased. **Target date: immediate**
- The Trust must revise the CMT on-call rota to ensure that there are no prolonged periods of long days/ nights which might lead to trainees becoming exhausted (including when trainees move placements). As this is a significant patient safety issue, it is strongly recommended that a consultant is identified to lead on the trainee rota with ring-fenced time in his/her job plan for this task. **Target date for completion of the design and production of the revised rota: August 2015** (the reason for recommending the delay is to give trainees sufficient notice of the changes to the rota as many will have booked leave based on the current rota, although the trainees should be consulted on this)
- The Trust should ensure that patients are only referred to the medical team if this is appropriate in a way that ensures that there are no delays to the initiation of treatment; senior physicians (Consultants and higher specialty trainees) must be able to challenge inappropriate referrals from A&E and to ask the A&E Department to perform additional investigations and/or to initiate treatments when this is in the best
interests of patients. As this is a significant patient safety issue, it is strongly recommended that a consultant is identified to lead on handover between A&E and the medical teams with ring-fenced time in his/her job plan for this task. **Target date for completion: April 30th 2015**

**Recommendations:**

- The Trust should continue with its plan to move the two AMU wards so that they are closer together
- The Trust should continue with its plan to appoint a Consultant lead to support Quality Improvement projects for CMTs
- The Trust should ensure that there is effective and appropriate departmental induction for all trainees joining all departments; this should be in place by the time of the next changeover; i.e. when the foundation trainees rotate at the beginning of April 2015;
- A session on how to make referrals to the imaging department and other support services in an appropriate way should be included in the Preparation for Professional Practice Week for Foundation Trainees

**Decision of the Visiting Team**

- There has been some progress with meeting the requirements and following the recommendations of the last visit but this is limited
- There are ongoing significant concerns related to the delivery of education, the educational environment, patient safety, trainee safety and undermining
- The School of Medicine is therefore only able to recommend conditional approval of all CMT and ST3+ posts for a limited period of six months provided the requirements listed above are met by the time of the next visit
- It was felt that insufficient time had elapsed since the School of Medicine’s last visit in December 2015 to initiate HEEoE’s processes for the withdrawal of trainees in medical specialties from the Trust at this time
- However, failure to have made significant progress with implementing the requirements of the December and the March visit reports s by the end of June 2015 will lead to a recommendation to the Postgraduate Dean to seriously consider initiating HEEoE’s processes for the withdrawal of trainees in medical specialties from the Trust at that time
- The findings of the visit were shared with the Dean on the day following the visit and it has been agreed that a period of enhanced monitoring should continue
- This visit report will be shared with the GMC, the JRCPTB, the two relevant Foundation School Directors, the Head of School of Emergency Medicine, the GP Dean, the Regional Director of Education and Quality and the Essex Quality Surveillance Group

**Action Plan to Health Education East of England by:**

- An action plan should be provided by 31st March 2015
- The Trust should provide HEEoE with monthly updates of progress against the action plan

**Revisit:** July 2015; there will be externality from the GMC and JRCPTB, lay and trainee representation
# RELATED EVIDENCE

## Previous visit (date and summary)

**December 16th 2014:** There were serious concerns about handover, patient tracking (with patients being lost), trainees performing clinics unsupervised, F2s early in their posts carrying the acute referrals bleep, workload on the gastroenterology/respiratory medicine ward (Eleanor Hobbs Ward), the process of early senior review adversely affecting patient safety and the training of foundation and core trainees and undermining.

The visiting team were only able to recommend conditional approval of all CMT and ST3+ posts for a limited period of six months. The serious concerns about patient safety, training and undermining were escalated in line with HEEoE policy.

## 2013 Trainee survey outliers

See previous visit report

## 2013 GMC Survey: Patient safety concerns for medical specialities

See previous visit report

## 2013 GMC Survey: Free text comments for medical specialities

See previous visit report

## 2014 Trainee survey outliers

CMT: **Red outlier** for handover

Geriatrics: **Green outlier** for overall satisfaction, clinical supervision, induction, workload and adequate experience

## 2014 GMC Survey: Patient safety concerns and undermining comments for medical specialities

**Patient safety concerns** (3): related to workload on the gastroenterology/respiratory medicine ward, quality of referrals from A&E and backlog of uncompleted discharge summaries

**Undermining** (2): related to named consultants in the AMU and radiology department

## 2014 QM1

**Good practice:** includes training in the geriatrics department and appointment of a dedicated MRCP Tutor

**Concerns:** include handover and workload on the gastroenterology/respiratory medicine ward

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**Visit Lead:** Ian Barton  
**Date:** 24th March 2015