NHS
Health Education
Yorkshire and the Humber

QUALITY MANAGEMENT VISIT REPORT

TRUST	HULL AND EAST YORKSHIRE NHS FOUNDATION TRUST

DAY	SITE	DATE
1	CASTLE HILL HOSPITAL	THURSDAY FEBRUARY 27
2	HULL ROYAL INFIRMARY	FRIDAY FEBRUARY 28

SPECIALTIES VISITED:

- EMERGENCY MEDICINE
- SURGERY
- MEDICINE
- OBSTETRICS AND GYNAECOLOGY

This report has been agreed with the Trust.

The Trust Visit Report will be published on Health Education Yorkshire and the Humber's Website

Conditions that are RAG rated as Amber, Red and Red* will be reported to the GMC as part of HEYH's Reporting process, the reports are published on the GMC website.

Date of First Draft	**28/02/14**
First Draft Submitted to Trust	**26/03/14**
Trust comments to be submitted by	**09/04/14**
Final Report circulated	**02/05/14**

CONDITIONS

Condition 1 (continues from Condition 1 in the report from 19/3/2013)		
GMC Domain:	1 PATIENT SAFETY	
Concern relates to:	Departmental Induction	
School:	**Trainee Level Affected:**	**Site:**
Surgery	Foundation & Higher	Castle Hill
Emergency Medicine	All	Hull Royal Infirmary

Trainees highlighted that the 2 day Trust induction was very useful. There was the occasional Trainee who missed this but there was an on-line alternative available. However, departmental induction was patchy and Trainees were developing their own protocols in some cases. One FY1 Trainee was rostered to work out of hours on Ward 60 for her first shift at Hull Royal Infirmary and was the only doctor on the out of hours rota to provide cover for the three wards. The Trainee had not undertaken a departmental induction but was simply handed the on call bleep by another FY1 Trainee at 10 pm. The Trainee then worked for 12 hours unsure of what was expected. The next day a Consultant was unhappy as certain tasks, for example clerking in of patients and organising clinical investigations had not been carried out.

In addition, on commencing in post, one Core Trainee did not have access to the Orthopaedic PACS system for around two weeks and so, to enable him to carry out his role, borrowed a password to overcome this. The Trainee was aware this was contrary to Information Governance procedures. The DME demonstrated a new surgical induction video to the panel. This looks to be a good initiative but is not yet being used. The effectiveness of this will be evaluated at the next QM Trust visit in March 2015.

Trainees in Emergency Medicine did not have a Departmental induction and found this difficult, especially in view of the structural changes taking place within the department. Trainees highlighted that log rolling needed to be explained prior to commencing in the department in view of the trauma unit status.

Action To Be Taken:

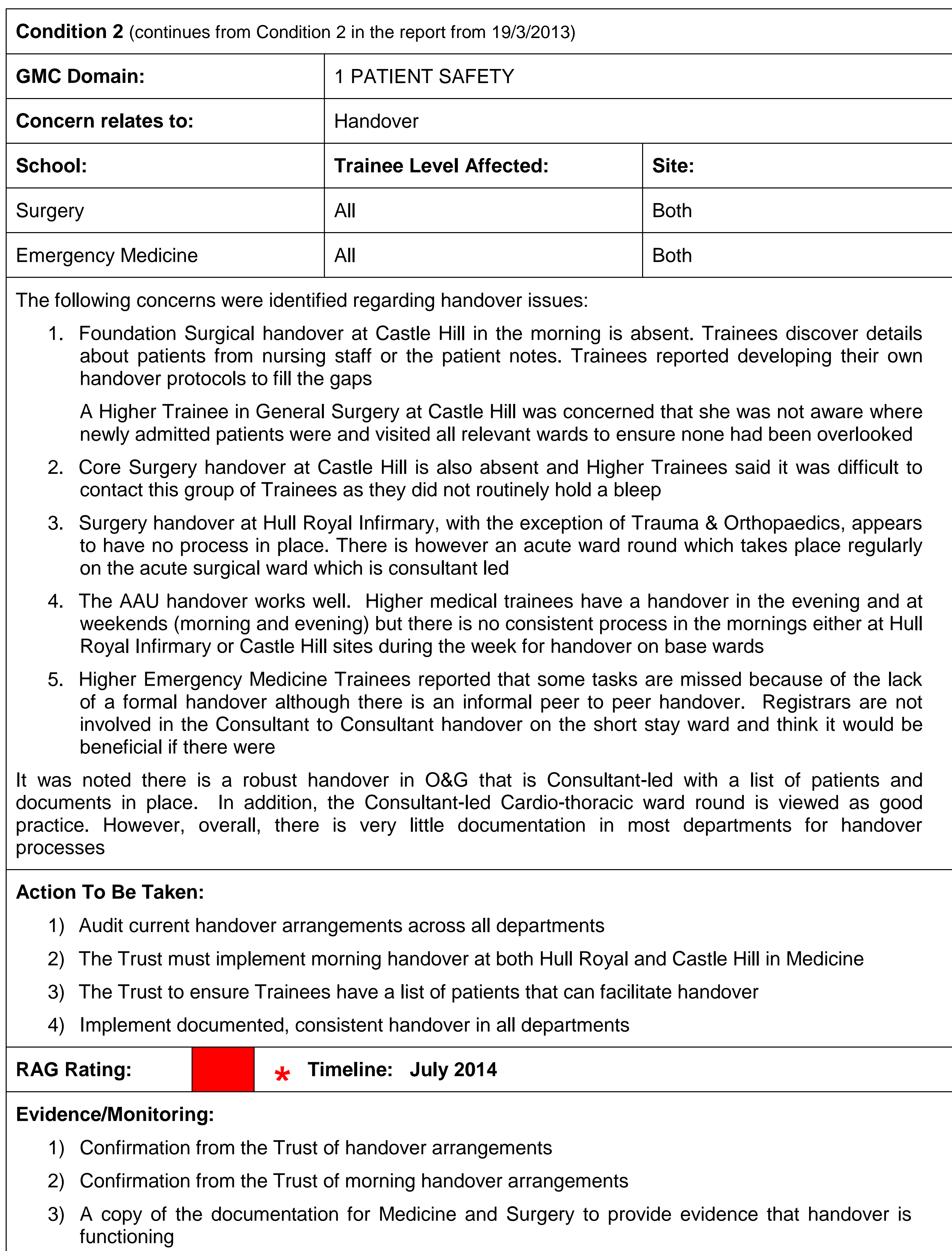
1) Review departmental induction across the Trust and take measures to introduce induction where this is not present
2) Ensure Trainees who rotate onto acute surgical wards are aware of what their role is, irrespective of when they start in post
3) Reiterate to Trainees not to share passwords and ensure they have access to the systems they need
4) Continue with the roll out of departmental video inductions that look a promising initiative

RAG Rating:	[Red]	* **Timeline: July 2014**

Evidence/Monitoring:

Trust to provide evidence to the Trust Link APD that the following are in place:

1) A copy of each departmental induction procedure
2) A copy of Trust induction outlining important of password security



Condition 2 (continues from Condition 2 in the report from 19/3/2013)

GMC Domain:	1 PATIENT SAFETY	
Concern relates to:	Handover	
School:	**Trainee Level Affected:**	**Site:**
Surgery	All	Both
Emergency Medicine	All	Both

The following concerns were identified regarding handover issues:

1. Foundation Surgical handover at Castle Hill in the morning is absent. Trainees discover details about patients from nursing staff or the patient notes. Trainees reported developing their own handover protocols to fill the gaps

   A Higher Trainee in General Surgery at Castle Hill was concerned that she was not aware where newly admitted patients were and visited all relevant wards to ensure none had been overlooked
2. Core Surgery handover at Castle Hill is also absent and Higher Trainees said it was difficult to contact this group of Trainees as they did not routinely hold a bleep
3. Surgery handover at Hull Royal Infirmary, with the exception of Trauma & Orthopaedics, appears to have no process in place. There is however an acute ward round which takes place regularly on the acute surgical ward which is consultant led
4. The AAU handover works well. Higher medical trainees have a handover in the evening and at weekends (morning and evening) but there is no consistent process in the mornings either at Hull Royal Infirmary or Castle Hill sites during the week for handover on base wards
5. Higher Emergency Medicine Trainees reported that some tasks are missed because of the lack of a formal handover although there is an informal peer to peer handover. Registrars are not involved in the Consultant to Consultant handover on the short stay ward and think it would be beneficial if there were

It was noted there is a robust handover in O&G that is Consultant-led with a list of patients and documents in place. In addition, the Consultant-led Cardio-thoracic ward round is viewed as good practice. However, overall, there is very little documentation in most departments for handover processes

Action To Be Taken:

1) Audit current handover arrangements across all departments
2) The Trust must implement morning handover at both Hull Royal and Castle Hill in Medicine
3) The Trust to ensure Trainees have a list of patients that can facilitate handover
4) Implement documented, consistent handover in all departments

RAG Rating:		* **Timeline: July 2014**

Evidence/Monitoring:

1) Confirmation from the Trust of handover arrangements
2) Confirmation from the Trust of morning handover arrangements
3) A copy of the documentation for Medicine and Surgery to provide evidence that handover is functioning

Condition 3

GMC Domain:	1 PATIENT SAFETY	
Concern relates to:	Clinical Supervision	
School:	**Trainee Level Affected:**	**Site:**
Surgery	Foundation	Castle Hill
Surgery	Higher	Hull Royal Infirmary

FY1 Trainees in Surgery are triaging GP calls. They can be expected to provide advice to GP's and this is inappropriate. As a consequence they naturally default to arrange hospital admission. The Trainees reported they take an average of 24 calls from GPs per shift. They highlighted that they may be criticised the following day for admitting inappropriate patients. They do not take calls from A+E.

On occasions, Orthopaedic Higher Trainees felt that they operate beyond their level of competence on T&O Trauma List at weekends at Hull Royal Infirmary, as Consultants have other commitments in a fracture clinic. An incident was described of a Trainee operating on a patient with multiple complex fractures following trauma with no clear escalation pathway.

Action To Be Taken:

1) Remove the practice of FY1 Trainees holding the GP calls bleep. Phone triage should be conducted only by a doctor with the appropriate level of experience. A proper admissions communication process is required; the Bed Bureau in AAU may provide a model
2) A Consultant to be named on the theatre list as providing supervision for each trauma list at weekends

RAG Rating:		**Timeline: 31 May 2014**

Evidence/Monitoring:

1) Confirmation that FY1/2Trainees are no longer responsible for providing advice to GPs on emergency admissions
2) Confirmation of appropriate individuals being used to advised GPs
3) List of Consultants who provide out of hours clinical supervision for T&O trauma lists at weekends

Condition 4		
GMC Domain:	1 PATIENT SAFETY	
	7 MANAGEMENT OF EDUCATION AND TRAINING	
Concern relates to:	Work Intensity	
School:	**Trainee Level Affected:**	**Site:**
Surgery	Foundation & Core	Both
Emergency Medicine	Foundation	Both

On the Acute Surgical Ward Trainees are working four 12 hour days followed by three 12 hours nights. Although EWTR compliant, this work pattern was felt to be onerous and leading to increasing amounts of sickness/absence towards the end of the week. The Trainees regularly stay half an hour extra for handover or even longer if the FY1 Trainee for the next shift does not arrive at work. This state of affairs is a regular occurrence and they feel pressurised to stay until cover is organised. Emergency Medicine Trainees found the rotas very intensive with several long shifts without a break and the Trainees find these both mentally and physically draining. They also described that shift patterns regularly change from day to night at short notice that is causing them to have difficulty in adjusting. The Core Trainees in surgery said the rota arrangements were impacting on their ability to achieve competencies and targets for ARCP.

In terms of the family and friends test the Trainees are concerned for patient safety at weekends as clinical cover is so reduced, for example, one Foundation Trainee described covering 3 wards.

Higher Trainees in Medicine felt work intensity was impacting on their quality of life. None of the Foundation Trainees in Emergency Medicine who were interviewed would recommend their posts due to the major pressures on resources. However, when patients do get to see a clinician the care, in their opinion, is of a very high quality.

The Core Surgical Trainees are told that when they are on a 'zero hours day' they must be within 3 hours of the Hospital. This is contrary to the concept of a zero hour day which the trainees take flexibly to maintain hours compliance.

Action To Be Taken:

1) Review rota patterns across Medicine, Surgery and Emergency Medicine
2) Audit achievement of competencies in core surgical trainees by the school of surgery SMART objectives
3) Review the cover provided at weekends
4) Revise the policy of restricting Trainee's movements when on a zero hour day

RAG Rating:	(Red)	**Timeline: 31 May 2014**

Evidence/Monitoring:

1) Confirmation of improved rota patterns that do not require Trainees to switch from day/night shifts so regularly
2) Confirmation of an increase in cover at weekends
3) Zero hour days do not have restrictions attached
4) TPD has an overview of CST competencies and if there are potential problems with ARCP outcomes

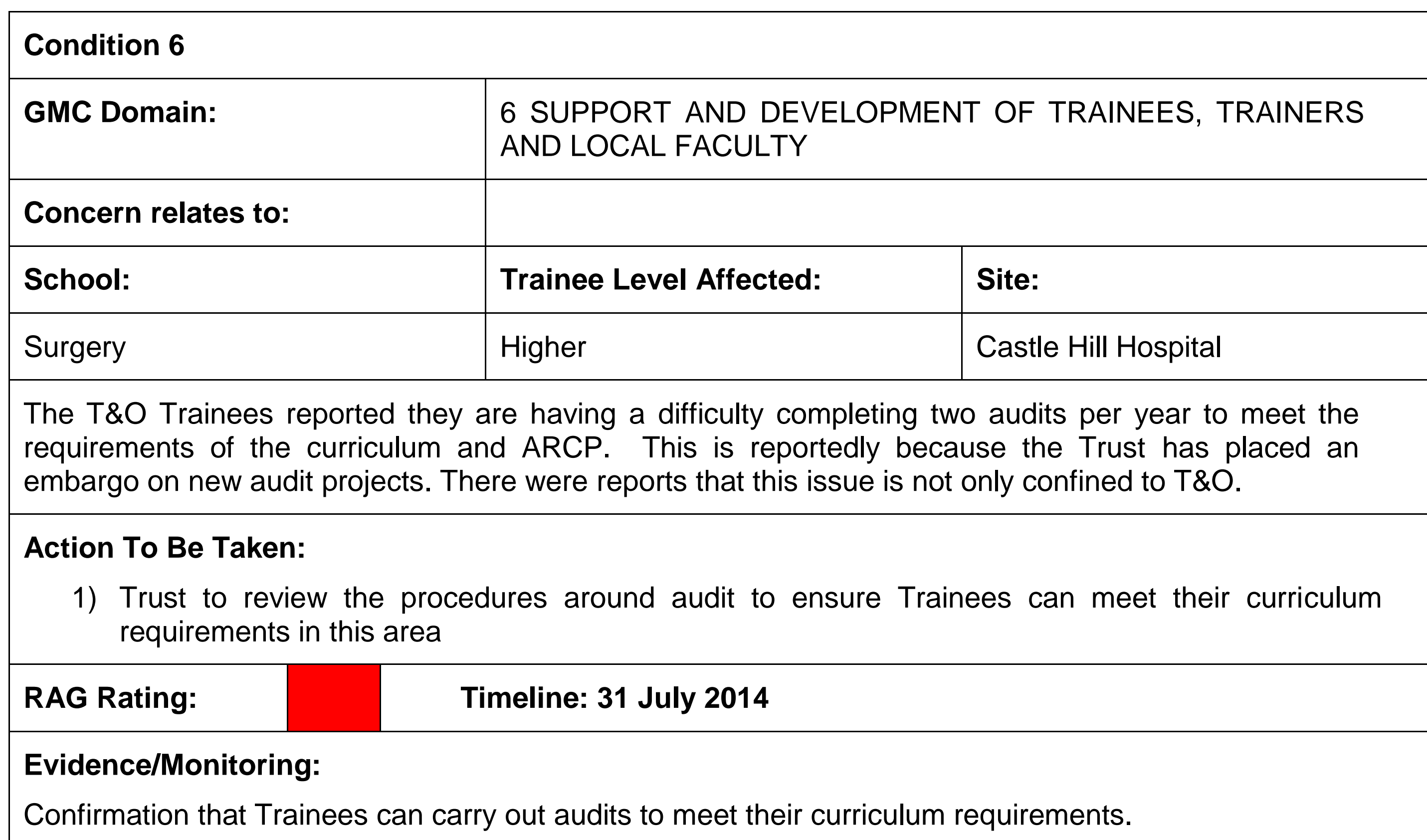
<table>
<tr><td colspan="3">Condition 5 (continues from Condition 11 in the report from 19/3/2013)</td></tr>
<tr><td>GMC Domain:</td><td colspan="2">7 MANAGEMENT OF EDUCATION AND TRAINING</td></tr>
<tr><td>Concern relates to:</td><td colspan="2">Work Intensity</td></tr>
<tr><td>School:</td><td>Trainee Level Affected:</td><td>Site:</td></tr>
<tr><td>Surgery</td><td>All</td><td>Both</td></tr>
<tr><td>Obstetrics and Gynaecology</td><td>All</td><td>Both</td></tr>
<tr><td colspan="3">Issues are still apparent in Foundation, Core O&G, Core Medicine and Higher Medicine with trainees being regularly subjected to these repetitive, non-educational tasks. Castle Hill is also a particular concern at weekends. Nurses and Health Care Assistants are reporting that they are too busy to take bloods and Phlebotomists are often unavailable. The Trust reported they are working with Clinical Support Assistants as they recognise that trainees need to be carrying out tasks such as clerking in patients rather than taking bloods.

This is the third year that this issue has been raised, with little evidence of improvement. The external Renal visit identified similar issues in 2013.

The core trainees also reported spending a long time on IDLs (electronic discharge summaries).

Hospital at Night nurse practitioners are being diverted from the Hospital at Night Team to staff wards, on a regular basis. This in turn leaves Trainees to carry out tasks that the nurse practitioners would normally perform (e.g. cannulation).

The Trust must demonstrate genuine progress in reducing the burden of repetitive non educational tasks.</td></tr>
<tr><td colspan="3">Action To Be Taken:
1) A further review of the Phlebotomy action plan that needs to be implemented to reduce the dependence on trainees in the above areas
2) The Trust should again undertake an audit of who is carrying out the phlebotomy role. The audit should include the acute admitting specialties and obstetrics and gynaecology; the information may well be available via the Laboratory reporting system that is obliged to record date, time and operator who took sample. If not, then a random audit of samples from the medical wards would suffice
3) The Trust to audit at Castle Hill and HRI how long Core Trainees are spending on IDLs
4) The Trust to audit the use of Hospital at Night nurse practitioners being used to staff wards</td></tr>
<tr><td>RAG Rating:</td><td> </td><td>* Timeline: July 2014</td></tr>
<tr><td colspan="3">Evidence/Monitoring:
1) The action plan with timelines
2) Audit reports
3) Review the Hospital at Night procedures, and to develop clear escalation policies for nurse staffing of beds with a view to ring fencing the practitioner role</td></tr>
</table>



Condition 6		
GMC Domain:	6 SUPPORT AND DEVELOPMENT OF TRAINEES, TRAINERS AND LOCAL FACULTY	
Concern relates to:		
School:	**Trainee Level Affected:**	**Site:**
Surgery	Higher	Castle Hill Hospital
The T&O Trainees reported they are having a difficulty completing two audits per year to meet the requirements of the curriculum and ARCP. This is reportedly because the Trust has placed an embargo on new audit projects. There were reports that this issue is not only confined to T&O.		
Action To Be Taken: 1) Trust to review the procedures around audit to ensure Trainees can meet their curriculum requirements in this area		
RAG Rating: (Red)	**Timeline: 31 July 2014**	
Evidence/Monitoring: Confirmation that Trainees can carry out audits to meet their curriculum requirements.		

Condition 7		
GMC Domain:	6 SUPPORT AND DEVELOPMENT OF TRAINEES, TRAINERS AND LOCAL FACULTY	
Concern relates to:		
School:	**Trainee Level Affected:**	**Site:**
Surgery	All	Both
Emergency Medicine	All	Both
Trainees were not allocated Educational Supervisors and therefore have to find out this information for themselves. A number of trainees interviewed were yet to have their first educational meeting.		
Action To Be Taken: 1) Trust to review the procedures 2) Allocation of ES to be part of Trainees' induction		
RAG Rating: (Amber)	**Timeline: 31 July 2014**	
Evidence/Monitoring: All Trainees in Surgery and Emergency Medicine have Educational Supervisors allocated at induction.		

Condition 8		
GMC Domain:	1 PATIENT SAFETY	
Concern relates to:	Clinical Supervision	
School:	**Trainee Level Affected:**	**Site:**
Medicine	Higher	Both

Higher Trainees are expected to interpret CT Head Scans out of hours to check for cerebral haematoma in non-stroke patients as they were have difficulty in accessing a radiological opinion for obtaining a report

In addition the Trainees are consenting for ERCP and PEGs on the ward without adequate training.

Action To Be Taken:

1) Discontinue the practice of Trainees interpreting CT Head Scans
2) Discontinue the practice of Trainees taking consent for ERCP PEGs without sufficient training

RAG Rating:		**Timeline: 31 May 2014**

Evidence/Monitoring:

1) Policy outlining that Trainees should not interpret CT Head Scans
2) Policy outlining that appropriate training should be given prior to Trainees taking consent for ERCP PEGs

Condition 9		
GMC Domain:	1 PATIENT SAFETY	
Concern relates to:	Clinical Supervision	
School:	**Trainee Level Affected:**	**Site:**
Medicine	Higher	Both

There is an issue around RMO3, medical registrar based at Castle Hill, being relocated to HRI due to acute pressures. This has then meant that the most senior medical doctor on CHH site is a FY2 Trainee. This role involves managing four wards of medical patients and leading the cardiac arrest team. There is no clear escalation policy for the arrangements that should occur when there is acute pressure at HRI or if there is a Consultant readily available to go to either Castle Hill Hospital or HRI.

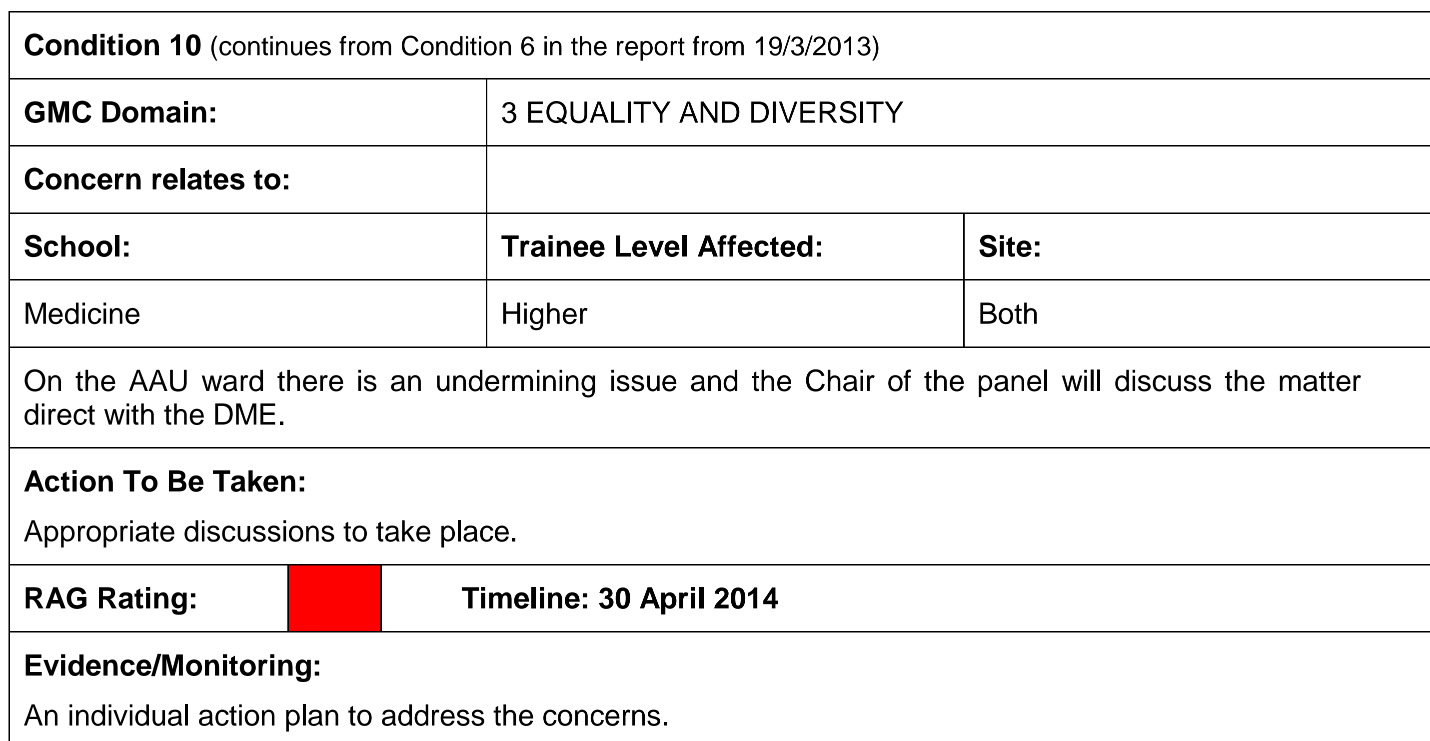
Action To Be Taken:

1) Appropriate level of out of hours cover for the Castle Hill site to be identified by the trust. This does not need to be an acute medical registrar
2) Clear escalation policy to be developed

RAG Rating:		**Timeline: 30 April 2014**

Evidence/Monitoring:

Escalation policy



Condition 10 (continues from Condition 6 in the report from 19/3/2013)		
GMC Domain:	3 EQUALITY AND DIVERSITY	
Concern relates to:		
School:	**Trainee Level Affected:**	**Site:**
Medicine	Higher	Both
On the AAU ward there is an undermining issue and the Chair of the panel will discuss the matter direct with the DME.		
Action To Be Taken: Appropriate discussions to take place.		
RAG Rating:		**Timeline: 30 April 2014**
Evidence/Monitoring: An individual action plan to address the concerns.		

Condition 11		
GMC Domain:	5 DELIVERY OF APPROVED CURRICULUM INC ASSESSMENT	
	6 SUPPORT AND DEVELOPMENT OF TRAINEES, TRAINERS AND LOCAL FACULTY	
Concern relates to:		
School:	**Trainee Level Affected:**	**Site:**
Emergency Medicine	All	Both
Morale in the department is generally low and there is a need for team building. There is also a need to foster relations with other departments, particularly acute medicine, within the Trust. There is very little emphasis on teaching in the department that has resulted in a disconnect between Trainers and Trainees. At the visit none of the Trainees interviewed would recommend a post A&E to a colleague.		
Action To Be Taken: Develop a teaching programme to improve engagement		
RAG Rating:		**Timeline: 31 May 2014**
Evidence/Monitoring: 1) Programme 2) Attendance registers		

Condition 12 (continues from Condition 8 in the report from 19/3/2013)		
GMC Domain:	5 DELIVERY OF APPROVED CURRICULUM INC ASSESSMENT 6 SUPPORT AND DEVELOPMENT OF TRAINEES, TRAINERS AND LOCAL FACULTY	
Concern relates to:		
School:	**Trainee Level Affected:**	**Site:**
Obstetrics and Gynaecology	All	Both

Core trainees:

Trainees again reported there is no local formal or informal teaching in the department. There were complaints that too much time was spent on the labour ward or in antenatal clinic and this made it difficult to achieve the required curriculum competencies, particularly in gynaecology. Core trainees rarely attended theatre and are never rostered to be in gynaecology clinic. There was however good support in achieving the clinical competencies in order to enable St2 trainees to cover labour ward at the level of a St3.

Higher trainees:

It should be noted that we were unable to speak to any pre-CCT trainees. There is recognition that greater than 50% of this rota is absent due to maternity leave/resignations. To compensate for this night time 2nd on-call duties are no longer performed by the higher trainees, leaving them available in the daytime. This means that they are used to cover the acute service i.e. labour ward almost exclusively. Post CCT fellows operate in theatre and attend clinic during the day and this takes away training opportunities from Trainees so that they may not achieve the required competencies. More senior trainees are allowed only 1 ATSM session per month.

The Trainees recognised there are numerous learning opportunities from willing teachers but this this was not formalised or organised in a formal way to facilitate their attendance at some educational sessions. They felt that “there was insufficient time for informal clinical teaching”

None of the trainees, at any level, would recommend this post to a colleague

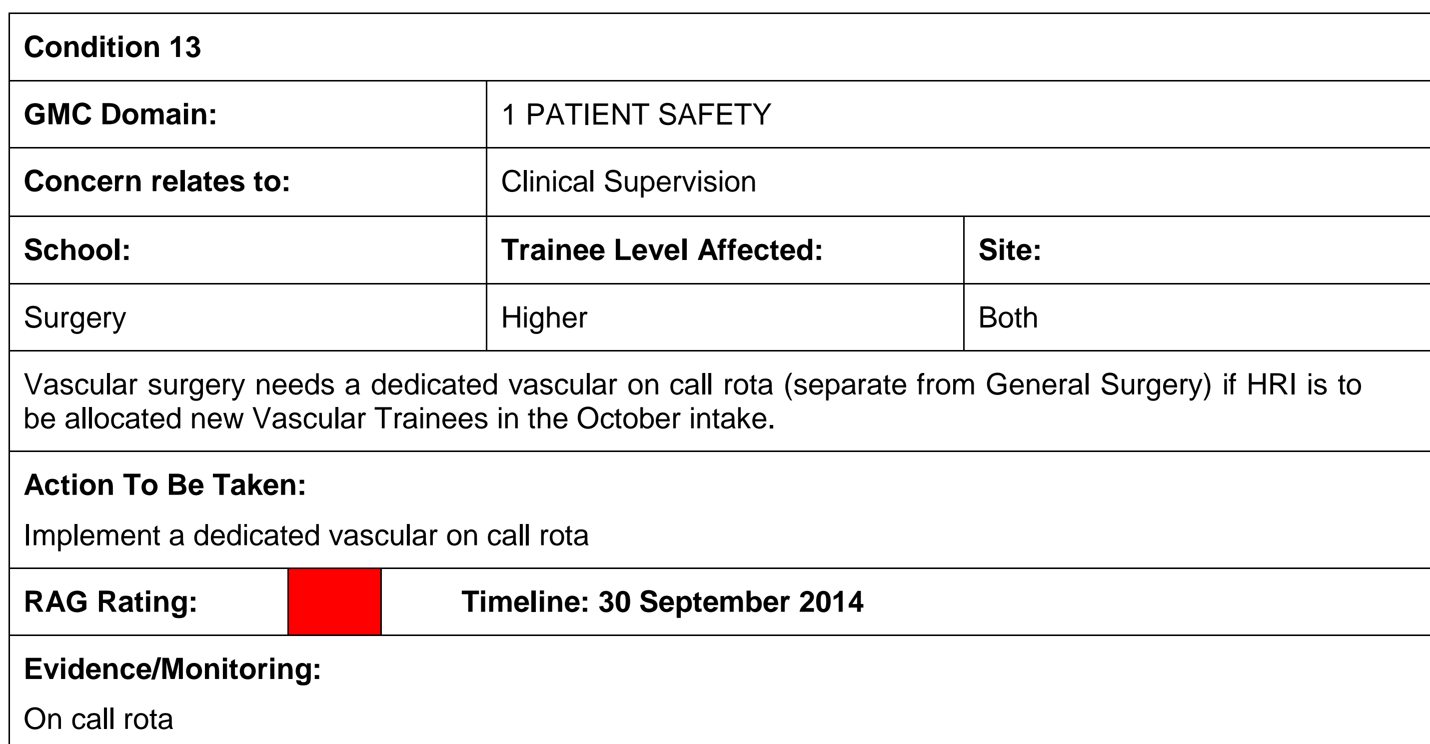
Action To Be Taken:

1) A regular dedicated departmental teaching session to be developed
2) Review the amount of time Trainees spend on Labour ward
3) Devise a balanced timetable for all trainees to facilitate educational sessions and competency signoff and progression
4) Provide a list of “special interest/educational sessions” to feed into the trainee’s timetable
5) Review the practice of post-CCT Fellows being given operating and clinic lists
6) HEYH to conduct a triggered visit in the next 6 months to assess progress

RAG Rating:	(red) *	**Timeline: 9 July 2014** (Triggered Visit to assess progress)

Evidence/Monitoring:

1) List of special interest/educational sessions – 30 April 2014
2) Departmental Teaching programme – 14 May 2014
3) Rotas/balanced timetable – 11 June 2014
4) Attendance Registers – 2 July 2014
5) Trainees have the required opportunities to meet curriculum competencies – ARCPs



Condition 13		
GMC Domain:	1 PATIENT SAFETY	
Concern relates to:	Clinical Supervision	
School:	**Trainee Level Affected:**	**Site:**
Surgery	Higher	Both
Vascular surgery needs a dedicated vascular on call rota (separate from General Surgery) if HRI is to be allocated new Vascular Trainees in the October intake.		
Action To Be Taken: Implement a dedicated vascular on call rota		
RAG Rating:	(red)	**Timeline: 30 September 2014**
Evidence/Monitoring: On call rota		

Condition 14		
GMC Domain:	6 SUPPORT AND DEVELOPMENT OF TRAINEES, TRAINERS AND LOCAL FACULTY	
Concern relates to:	**TRAINERS**	
School:	**Trainee Level Affected:**	**Site:**
Medicine	N/A	Both
Trainers reported they require more information about the new HEYH Education package. They also said that their educational supervision is not always reflected in job plans.		
Action To Be Taken: 1) HEYH to communicate how to access the new HEYH education package 2) Trust to review allocation of PAs in job plans consistently		
RAG Rating:	(red)	**Timeline: July 2014**
Evidence/Monitoring: 1) Educational Supervisors can access the new educational package 2) Trainers report that PAs are consistently allocated to reflect their educational supervision roles		

RAG guidance can be found at Appendix 1.

FINAL COMMENTS

There was a good attendance by Trainees and Trainers and the majority of Trainees would be happy for family and friends to be treated at the hospital. A view was expressed that the cardiac-thoracic training is currently the best in the region. There was a theme from Trainees that although the posts are very busy this gives them good experience and a broad case mix. In general Trainees felt they were well supported and not asked to work beyond their level of competence.

It is noted that Trainees in Obstetrics and Gynaecology are happy with their induction.

There were several complaints from Trainers and Trainees that there was no Wi-Fi access and that mobile phone reception is poor on the CHH site, which limited trainee's ability to access guidelines on mobile devices.

There is a promising development of an induction video for AAU that is being used for local induction and the concept is being rolled out to other departments. This will be evaluated in more detail at the next routine visit and is likely it will be badged as notable practice. There is also good practice in terms of a bullying and harassment package that has been implemented successfully with O&G Trainees. In addition, there is good work being done to deliver the Trust's simulation strategy.

The conditions that were RAG rated red in previous reports and are still an issue have been badged as a red star in this report. It is important that these areas are addressed as a matter of urgency as the next step is GMC involvement and potential removal of Trainees. There will be a triggered visit to O&G on 9 July to revisit condition 5 in this report.

Approval Status

Approved pending satisfactory completion of conditions set out in this report.

Signed on behalf of HEYH

Name: **Mr J Hossain**
Title: **Deputy Postgraduate Dean**
Date: **26/03/14**

Signed on behalf of Trust

Name: **Charlotte Precious**
Position: **Medical Education Manager**
Date: **as per email of 01/05/14**

RAG Rating Guidance

The RAG rating guidance is based on the GMC RAG rating to ensure a consistent approach. The model takes into account impact and likelihood.

Impact

This takes into account:

a) patient or trainee safety

b) the risk of trainees not progressing in their training

c) educational experience – eg, the educational culture, the quality of formal/informal teaching

A concern can be rated high, medium, or low impact according to the following situations:

High impact:

- patients or trainees within the training environment are being put at risk of coming to harm
- trainees are unable to achieve required outcomes due to poor quality of the training posts/ programme

Medium impact:

- trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement
- patients within the training environment are receiving safe care, but the quality of their care is recognised as requiring improvement

Low impact:

- concerns have a minimal impact on a trainee's education and training, or the quality of provision for the patient.

Likelihood

This measures the frequency at which concerns arise eg. if a rota has a gap because of one-off last minute sickness absence, the likelihood of concerns occurring as a result would be low.

High likelihood:

- the concern occurs with enough frequency that patients or trainees could be put at risk on a regular basis. What is considered to be 'enough frequency' may vary depending on the concern eg. if rotas have consistent gaps so that there is a lack of safe cover arrangements, the likelihood of concerns arising as a result would be 'high'.

Medium likelihood:

- the concern occurs with enough frequency that if left unaddressed could result in patient safety concerns or affect the quality of education and training, eg. if the rota is normally full but there are no reliable arrangements to cover for sickness absence, the likelihood of concerns arising as a result would be 'medium'.

Low likelihood:

- the concern is unlikely to occur again eg. if a rota has a gap because of several unexpected sickness absences occurring at once, the likelihood of concerns arising as a result would be 'low'.

Risk

The risk is then determined by both the impact and likelihood, and will result in a RAG Rating, according to the below matrix:

Likelihood	**IMPACT**		
	Low	**Medium**	**High**
Low	Green	Green	Amber
Medium	Green	Amber	Red
High	Amber	Red	Red*

Please note:

* These conditions will be referred to the GMC Reponses to Concerns process and will be closely monitored

Source: GMC Guidance for Deaneries, July 2012