Review of Mid Yorkshire Hospitals NHS Trust *(Postgraduate Medical)*

## Quality Assurance of Local Education and Training Providers

## Guidance

From 1 April 2015 Health Education England, working across Yorkshire and the Humber (HEE YH) introduced a new quality function and team structure. The quality function is responsible for leading and overseeing the processes for the quality assurance and quality management of all aspects of medical and non-medical training and education. Our aim is to promote an ethos of multi-professional integrated working and believe that improving quality in education and training is at the heart of delivering outstanding patient care.

HEE YH invests £500 million every year on commissioning a wide range of education on behalf of local and national health systems. It has a duty to ensure that the Education Providers delivering this education provide a high standard of professional education and training.

## Standards are built around 5 core themes:

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| **Theme 1** | Supporting Educators |
| **Theme 2** | Supporting Learners |
| **Theme 3** | Learning Environment and Culture |
| **Theme 4** | Governance and Leadership  |
| **Theme 5** | Curricula and Assessment |

In developing our new framework we have developed a set of standards for education providers built around five themes. The five themes have been chosen to reflect the multi-professional aspects of training and care and to ensure all Healthcare Regulator standards can be aligned.

All standards have been mapped against the following regulatory documents:

* NMC Quality Assurance Framework Part Three: Assuring the safety and effectiveness of practice learning
* Future pharmacists: Standards for the initial education and training of pharmacists (May 2011)
* HCPC Standards of education and training: Your duties as an education provider
* GMC Promoting Excellence: Standards for medical education and training

## Details of the Review

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| **Visit Date(s)** | 13 May 2016 |

This visit was conducted in conjunction partnership with …

* School of Surgery
* School of ACCS (ACCS / Emergency Medicine)
* School of Obstetrics and Gynaecology
* School of Medicine ( Core Medical Training and Neurology)
* Factors considered include:
* NTS
* HEE YH Survey data
* CQC reports
* LEP Provider Assessment report

**Visit Panel / team**

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| --- | --- |
| **Name** | **Role** |
| Peter Taylor | Deputy Dean |
| David Ita | Lay Representative |
| Paul Renwick | Head of School, Surgery |
| Helen Cattermole | Training Programme Director, Core Surgery |
| Gavin Anderson | Associate Postgraduate Dean |
| Jackie Tay | Head of School, Obstetrics and Gynaecology |
| Padma Munjuluri | Training Programme Director, Obstetrics and Gynaecology |
| Maya Naravi | Joint Head of School, Emergency Medicine |
| Sarah Kaufmann | Associate Postgraduate Dean |
| Trevor Rogers | Deputy Head of School, Medicine |
| Teresa Dorman | Associate Postgraduate Dean |
| Anita Relins | Programme Support Officer |
| Hannah Staniland | Programme Support Administrator |
| Alison Poxton | Quality Administrator |
| Sarah Rowson | Quality Co-ordinator |
| Jane Burnett | Quality Manager |

## Information about this Local Education Provider

Mid Yorkshire Hospitals NHS Trust provides acute and community health services to two local populations; Wakefield which has a population of 350,000 people and North Kirklees with a population of 185,000. The Trust operates acute services from three main hospitals – Pinderfields Hospital, Dewsbury and District Hospital and Pontefract Hospital. In total the Trust has approximately 1,116 beds.

The CQC undertook a comprehensive inspection of the Mid Yorkshire Hospitals NHS Trust in July 2014 and carried out a follow up inspection of the Trust between 23-25 June 2015. After this inspection, the CQC received a number of concerns and an unannounced, focussed inspection took place on 25 August 2015 on Wards 20, 41, 42 and 43 at Pinderfields Hospital. The focus of that inspection was to look at staffing levels, missed patient care and poor experiences of care. The inspection revealed serious concerns regarding the staffing levels on Wards 20, 41, 42 and 43 which had impacted on the care patients received. The CQC also had concerns regarding the management and escalation of risk and where actions had been implemented these had not always been monitored or sustained.

The overall rating for this Trust is Requires Improvement. In relation to “Are services at this Trust safe?” the overall rating was Inadequate.

The Trust’s library and knowledge service is 80% compliant with national standards and has therefore been rated as an amber service.

There have been significant changes within the Trust over the last few months. The current Chief Executive is on secondment and Martin Barklay has been appointed as the next Chief Executive on a fixed term contract. A reconfiguration of services across all three sites is ongoing.

## Summary of findings

Trust, trainee and trainer engagement in relation to the visit was excellent and it was well organised. Findings from the specialties visited are detailed below however there were some general themes that became apparent during the visit. The Trust is struggling to recruit and as a result there are significant gaps in some rotations. This has led to trainees feeling pressured and increased the work intensity. There is a feeling amongst trainees that gaps are known about yet there is a widely held perception that only limited attempts are made to fill them with locums. As a consequence they then feel pressured to take on extra shifts or find when they start their on call that they are covering additional wards or that there is no one to hand over to. Trainees also commented on a lack of clinical leadership and that no one within Trust management seems to want to take responsibility for the situation.

The Trust is in the process of reconfiguring services across the 2 mains sites of Dewsbury and Pinderfields. A lot of groups are involved with the reconfiguration and the Trust keeps trainees informed at all times. The changes will mean that surgery trainees will be able to spend much more time in theatre and the wards will be staffed by non-training grades. Since March, the hospital reconfiguration has become more clinically led. Trust management feel that concentrating all the trainees on one site should improve access to education.

A new rotation for MAU at Pinderfields has been implemented recently but it has not been in place for long enough to enable feedback to be sought. The new rota is based on patient flow. More staff have been appointed to MAU to address the leadership and work pressure issues. Despite this the department is still very busy.

One aspiration for the Trust is to appoint Physician Associates (PA’s) when the current cohort complete their training in 2017.

**Specialty findings**

**General Surgery (including Trauma and Orthopaedics)**

The reconfiguration of surgery across the Dewsbury and Pinderfields sites will result in a split between the General Surgery and Urology on call rota from September. The on call rota will need to be monitored to ensure compliance. The current proposal is to have two on call rotas at Pinderfields. Dewsbury is a smaller hospital therefore easier to cover however there are problems with gaps in the rota at Core Surgery and above.

As a result of rota gaps, there have been nights when there was no StR on call and the F2 can be the most senior resident person. Consultants will come in if called but they do not stay.

The rota co-ordination for Core Surgery is considered to be suboptimal. Trainees only find out about rota gaps on the day and are sometimes only told that they are on call on the day. Trainees have been called on their day off or asked to come in early after nights off. Some trainees have felt pressured into doing more than they want to. If someone is off sick there do not appear to be any contingency plans and they are not told that there will be no cover. If they are on call they have no idea who will be taking over from them.

Core Surgery and Foundation trainees commented that they found the Emergency Medicine Department could be ‘pushy’. Trainees are asked to see patients identified by triage and referred by GPs that they know nothing about. They are on their own covering three separate Emergency Medicine Departments. On call has been covered by trainees who are not qualified to do this. Core Surgery trainees are regularly expected to discharge patients from A&E and feel pressurised into doing this. Patients are often sent home without a review by a senior colleague and there is a 2 weeks wait for an appointment at facture clinic.

Trauma and Orthopaedics trainees felt that they were asked to do things for which they believed they did not have the required competencies. They felt that they were on their own with no teaching beforehand. Trainees commented on a lack of leadership and communication. They also noted poor patient care and that the Trust seems to be caught in a vicious cycle with no one willing to take control of the situation. A lack of clinical leadership and structure was also mentioned in General Surgery.

**Urology**

The trainees were very complimentary about the training and support they receive and it was highlighted as an area of excellent practice.

**Obstetrics and Gynaecology**

Overall the trainees felt that the midwives and consultants provided a supportive environment. There is a consultant on the labour ward until 1pm and 7pm at weekends. This is slightly different at Dewsbury as it is a smaller site, trainees there feel that the range of cases is more limited and creates issues with completing WPBAs as they don’t get exposure to certain type of cases. This is likely to improve following the reconfiguration. Trainees have also been consulted about the rota following service reconfiguration.

Rotations can change and when this happens trainees often find themselves driving from one site to another during their breaks. Rota issues are as frustrating for the trainers as the trainees. Clinic access is no longer the responsibility of the rota co-ordinator and often these do not get cancelled.

There are no major patient safety issues but gynaecology patients do seem to be scattered across the hospital and it was felt that there was the potential to lose a patient. Continuity of care could be at risk because of this.

Trainee who started in April received a one day induction delivered by the College Tutor. This focused on examinations, common gynaecology and obstetrics presentations and Trust paperwork. The rota was also explained as it is quite complicated. A trainee who started in August noted that the same induction was given to everyone from F2 to ST6. Even the examinations section was the same and it was questioned if this was relevant for the senior trainees to be shown how to do basic things. The August induction took place in Dewsbury so the trainees had a tour of that site but not of Pinderfields which would have been nice at some point over the two day induction. There is a possibility that this will be addressed via the AHR

**ACCS Anaesthetics/Emergency Medicine**

The rota for Anaesthetics and ICM is satisfactory but at the Dewsbury site there are concerns about the senior cover available at night as this is done by an Obstetrics and Gynaecologist Anaesthetist middle grade. They are based in a separate building and also carry the crash bleep. There is no rapid access to the middle grade Anaesthetist who is separate from Obstetrics and Gynaecology. Consultants are available off site but can be reluctant to come in, specifically when in ICM. When on call at Dewsbury the trainees are primarily used for ICM and have very little exposure to Anaesthesia which impacts on their ability to achieve WPBAs.

The rota for Emergency Medicine trainees is very busy and the worst that the trainees had experienced. They work 7 shifts of 8pm to 4am, 12 hours of rest another shift of 4pm to midnight, 15 hours rest and then a 3am to noon shift. They work 10 weekends out of 16 and never have a week of day shifts where there is a weekend free on either side. The trainees felt that as a result they had no work life balance. The trainees are only allowed to take annual leave when on an 8am to 5pm shift and as a result they end up swapping a lot of shifts and have to work intensively either side of this. Rotations may change with the implementation of new contracts,

The Emergency Department is so busy and full that ambulances are being diverted to Dewsbury.

There are no issues with the quality of the handover and the complaints related to it not being part of the shift and trainees have to stay behind.

Trainees commented that sometimes there can be a standoff with the surgeons and they make undermining remarks. One in particular is known to give trainees a hard time but no specific complaint has been raised. Another mentioned a registrar who had been undermining and on one occasion had refused to provide training, citing that they didn’t have time for teaching.

**CMT/Neurology**

The team is quite widespread so it can make it difficult to supervise the juniors. The outliers ward round includes all the patients who are not in specialty care and have remained under the care of the acute team. They cover 8 wards which is a heavy workload and creates some backlogs in A&E. Junior staffing levels is a big issue and trainees are often left on wards clearing jobs whilst the consultants try to discharge patients. Acute Medicine consultants look after neurology and other “specialty- undifferentiated” patients when they are placed on outlying wards creating considerable strain on this team, a problem shared also with geriatrics. The Trust has 4 acute medicine consultants and has 4 locums at any one time. The Trust has been trying to recruit substantive acute medicine consultants for some time without success.

Access to clinics for CMTs in geriatrics was raised in the discussion with trainees. Trainees also commented on the approval of study leave by the rota co-ordinator and that this does not take into account adequate levels of cover.

There is an out of hours issue in that patients can be spread over a large area and a number of wards. Junior doctors have reported that they avoid going into the mess as there are surgeons and Trauma and Orthopaedics doctors using it to sleep in and they do not want to wake them up. The Trust moves wards around a lot and doctors do not always know where their patients are. When additional wards are opened up this is rarely communicated to doctors and they start their shift unaware that they are required to cover extra wards. The consultants often only find out about extra patients allocated to them when they receive a phone call asking then to see the patient. Trainees will just be bleeped in the middle of the night and asked to attend an additional ward. There seems to be no process whereby the Trust determines who will staff the additional wards.

Outliers are missed and in the week of the visit a patient had not been seen by a consultant for 4 days. This is a regular occurrence and any case that does not fall into a particular specialty is allocated to GIM. Outliers are a continual issue and over Christmas 1 consultant and 1 trainee were covering 120 outliers.

There are currently 8 neurology consultants with 5 trainees however 5 consultants have resigned and as of 30 June, there will be 3 consultants. As yet, this has not impacted on training as the leaving dates have been staggered. The trainees have voiced their concerns that as they spend most of their time dealing with discharges, they feel that the role is predominantly service orientated. The trainees currently feel well supported when dealing with complex cases however there was some apprehension about what will happen in July when the consultant numbers will drop.

The proposal is that the current specialty trainee establishment will fall to two trainees and this would be sustainable within the supervisor resources remaining.

AAU can be very busy and chaotic with trainees feeling that they are clerking and not receiving many training opportunities. Often they can be called at 4.30pm to see a patient who has been missed. Although they are not working over their hours, intensity of work is the key issue.

There is a reasonable handover system on the wards but this is not effective on AAU as it is not updated regularly enough as patients are moved around so much.

Although trainees feel that they can feedback any concerns they have and are being listened to, the perception is that the Trust is struggling to act on them. They have access to an email system called ‘Tell Sarah’ where they can log their concerns.

## Good Practice and Achievements

In terms of achievements, MESH (Medical Education Simulation Hub) is a great success. The Trust has recently appointed a Postgraduate Simulation lead to further develop postgraduate simulation, with a particular focus on patient safety training. A number of simulation courses now include nursing students as faculty.

## Conditions

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| **GMC Theme** | **LEARNING ENVIRONMENT AND CULTURE** |
| **Requirement****(S1.1 Patient Safety)** | The learning environment is safe for patients and supportive for learners. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families. |
| **HEYH Condition Number** | 1 |
| **LEP Site** | Pinderfields Hospital and Dewsbury District Hospital |
| **Specialty (Specialties)** | General Surgery (including Trauma and Orthopaedics) |
| **Trainee Level** | Foundation |
| **Concern 1** | Foundation trainees are not provided with on-site support from a senior colleague when providing on call for surgery |
| **Concern 2** | Trainees are expected to carry out duties which are not appropriate for their stage of training when covering surgical on call |
| **Evidence for Concern** | As a result of rota gaps, there have been nights when there was no StR on call and the F2 can be the most senior resident person. Consultants will come in if called but they do not stay. **THIS ARRANGEMENT IS UNACCEPTABLE. Foundation doctors MUST have more senior cover out of hours.** It was also noted that on occasion, on call has been covered by trainees who do not feel they are qualified to undertake some of the tasks.  |
| **Action 1** | The Trust must provide senior cover for Foundation trainees at all times. The opinions of the clinical staff and their suggestions for possible solutions should be considered when drawing up the action plan. | **1 months** |
| **Action 2** | The Trust must evaluate the effect of any changes introduced to ensure that the problems have been resolved. | **6 months** |
| **Evidence for Action 1** | Copy of the action plan. | **3 months** |
| **Evidence for Action 2** | Copy of the evaluation report. | **6 months** |
| **Evidence for Action 2** | Description of monitoring process. Copy of monitoring reports. | **12 months** |
| **RAG Rating** |  |
| **LEP Requirements** | * Copies of documents must be uploaded to the QM Database
* Item must be reviewed and changes confirmed with link APD
 |
| **Further Review** |  |
| **Resources** | <http://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf><http://www.yorksandhumberdeanery.nhs.uk/media/501652/201404v2Trainer%20Accreditation%20Policy.pdf><http://www.gmc-uk.org/Final_Appendix_4___Guidance_for_Ongoing_Clinical_Supervision.pdf_53817963.pdf> |
| **Question Reference** | Trainer 8Trainee 8, 9 |

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| **GMC Theme** | **LEARNING ENVIRONMENT AND CULTURE** |
| **Requirement****(R1.9 Level of Competence)** | Learner’s responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner’s level of competence, confidence and experience and provide an appropriately graded level of supervision. |
| **HEYH Condition Number** | 2 |
| **LEP Site** | Pinderfields General Hospital |
| **Specialty (Specialties)** | Trauma and Orthopaedics |
| **Trainee Level** | Core |
| **Concern** | Trainees in Core Surgical Training are often expected to carry out clinical duties such as discharging patients, which are beyond the expected level of competence for their stage of training. |
| **Evidence for Concern** | Trainees feel that they are regularly being asked to work beyond their level of competency. Lack of supervision means that they are often discharging patients from the wards or ED without senior sign off.  |
| **Action 1** | Provide details of plans to ensure that discharging of patients is by sufficiently experienced staff. Either by confirming and circulating Trust policies for discharging by junior trainees  | **1 month** |
| **Action 2** | Audit discharges to confirm policy is being adhered to | **1 month** |
| **Action 3** | Confirm that alternative arrangements have been adopted. | **3 months** |
| **Evidence for Action 1** | The policy and evidence of circulation | **1 month** |
| **Evidence for Action 2** | The audit | **1 month** |
| **Evidence for Action 3** | Written confirmation that policy has been adopted. | **3 months** |
| **RAG Rating** |  |
| **LEP Requirements** | * Copies of documents must be uploaded to the QM Database
* Item must be reviewed and changes confirmed with link APD
 |
| **Further Review** |  |
| **Resources** |  |
| **Question Reference** | Trainer 10Trainee 10 |

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| **GMC Theme** | **LEARNING ENVIRONMENT AND CULTURE** |
| **Requirement****(R1.13 Induction)** | Organisations must make sure learners have an induction for each placement that clearly sets out* their duties and supervision arrangements
* their role in the team
* how to gain support from senior colleagues
* the clinical or medical guidelines and workplace policies they must follow
* how to access clinical and learning resources

As part of the process learners must meet their team and other health and social care professionals they will be working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role. |
| **HEYH Condition Number** | 3 |
| **LEP Site** | Pinderfields General Hospital |
| **Specialty (Specialties)** | Obstetrics and Gynaecology |
| **Trainee Level** | All levels |
| **Concern 1** | Trainees are not provided with a relevant/useful orientation/induction/introduction to work in (clinical areas at the Pinderfields site).  |
| **Evidence for Concern** | Trainees at all levels are given a tour of the site where the induction takes place ie Dewsbury, but receive nothing in relation to Pinderfields where they are also expected to undertake duties |
| **Action 1** | Provide all trainees with an appropriate Trust induction. | **Next intake** |
| **Action 2** | Provide all trainees with a relevant departmental, specialty or ward induction/orientation. | **Next intake** |
| **Action 3** | Evaluate the effectiveness of Trust/departmental induction. | **After next intake** |
| **Evidence for Action 1** | Copy of induction programme. | **Before next intake** |
| **Evidence for Action 2** | Copy of induction programme. | **Before next intake** |
| **Evidence for Action 3** | Copy of induction evaluation and plans for modifications (if indicated). | **After next intake** |
| **RAG Rating** |  |
| **LEP Requirements** | * Copies of documents must be uploaded to the QM Database
* Item must be reviewed and changes confirmed with link APD
 |
| **Further Review** |  |
| **Resources** | <http://careers.bmj.com/careers/advice/view-article.html?id=20000724>  |
| **Question Reference** | Trainer 11Trainee 12, 13 |

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| **GMC Theme** | **LEARNING ENVIRONMENT AND CULTURE** |
| **Requirement****(R1.12 Rotas)** | Organisations must design rotas to:* make sure learners have appropriate clinical supervision
* support doctors in training to develop the professional values, knowledge, skills and behaviours (KSB) required of doctors working in UK
* provide learning opportunities that allow doctors in training to meet the requirements of the curriculum and training programme
* give learners access to ES
* minimise the effect of fatigue and workload
 |
| **HEYH Condition Number** | 4 |
| **LEP Site** | Pinderfields General Hospital and Dewsbury District Hospital |
| **Specialty (Specialties)** | Emergency Medicine |
| **Trainee Level** | All levels |
| **Concern 1** | Trainees are provided with duty rotas (timescale), which are very difficult to modify. |
| **Concern 2** | Trainees are provided with rotas, which do not meet EWTD requirements or do not provide them with sufficient opportunities for rest and recreation. |
| **Evidence for Concern** | Shift patterns and work intensity are major issues within the specialty. It is a regular occurrence to have 80-100 patients through the Emergency Department in one day. Trainees work 7 shifts of 8pm to 4am, 12 hours of rest another sift of 4pm to midnight, 15 hours rest and then a 3am to noon shift. They work 10 weekends out of 16 and never have a week of day shifts where there is a weekend free on either side. The trainees felt that as a result they had no work life balance. The trainees are only allowed to take annual leave when on an 8am to 5pm shift and as a result they end up swapping a lot of shifts and have to work intensively either side of this.  |
| **Action 1** | Work with trainees and rota organisers to ensure that rotas are provided with sufficient notice and flexibility and fairly distribute clinical duties/responsibilities. | **3 months** |
| **Action 2** | Work with trainees and educational supervisors to develop rotas that have an appropriate balance between the needs of the patient safety and clinical service and the trainee’s legitimate expectations for teaching, training, feedback and rest and recreation. | **3 months** |
| **Action 3** | Review the impact of the introduction of new rotas/rota arrangements. | **6 months** |
| **Evidence for Action 1** | Copies of rotas. | **3 months** |
| **Evidence for Action 2** | Summary of the impact of any changes made. | **6 months** |
| **RAG Rating** |  |
| **LEP Requirements** | * Copies of documents must be uploaded to the QM Database
* Item must be reviewed and changes confirmed with link APD
 |
| **Further Review** |  |
| **Resources** | <http://bma.org.uk/practical-support-at-work/contracts/juniors-contracts/rotas-and-working-patterns>[http://careers.bmj.com/careers/advice/view-article.html?id=20001163#](http://careers.bmj.com/careers/advice/view-article.html?id=20001163) |
| **Question Reference** | Trainee 11 |

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| **GMC Theme** | **LEARNING ENVIRONMENT AND CULTURE** |
| **Requirement****(R1.12 Rotas)** | Organisations must design rotas to:* make sure learners have appropriate clinical supervision
* support doctors in training to develop the professional values, knowledge, skills and behaviours (KSB) required of doctors working in UK
* provide learning opportunities that allow doctors in training to meet the requirements of the curriculum and training programme
* give learners access to ES
* minimise the effect of fatigue and workload
 |
| **HEYH Condition Number** | 5 |
| **LEP Site** | Dewsbury District Hospital |
| **Specialty (Specialties)** | ACCS |
| **Trainee Level** | ACCS |
| **Concern 1** | Trainees are provided with duty rotas which do not allow them sufficient opportunities to meet the requirements of their curriculum (details). |
| **Evidence for Concern** | When on call at Dewsbury, trainees are primarily used for ICM and have very little exposure to Anaesthesia which impacts on their ability to achieve WPBAs and meet the curriculum requirements. |
| **Action 1** | Work with trainees and rota organisers to ensure that rotas are provided with sufficient notice and flexibility and fairly distribute clinical duties/responsibilities. | **3 months** |
| **Action 2** | Work with trainees and educational supervisors to develop rotas that have an appropriate balance between the needs of the patient safety and clinical service and the trainee’s legitimate expectations for teaching, training, feedback and rest and recreation. | **3 months** |
| **Action 3** | Review the impact of the introduction of new rotas/rota arrangements. | **6 months** |
| **Evidence for Action 1** | Copies of rotas. | **3 months** |
| **Evidence for Action 2** | Summary of the impact of any changes made. | **6 months** |
| **RAG Rating** |  |
| **LEP Requirements** | * Copies of documents must be uploaded to the QM Database
* Item must be reviewed and changes confirmed with link APD
 |
| **Further Review** |  |
| **Resources** | <http://bma.org.uk/practical-support-at-work/contracts/juniors-contracts/rotas-and-working-patterns>[http://careers.bmj.com/careers/advice/view-article.html?id=20001163#](http://careers.bmj.com/careers/advice/view-article.html?id=20001163) |
| **Question Reference** | Trainee 11 |

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| **GMC Theme** | **LEARNING ENVIRONMENT AND CULTURE** |
| **Requirement****(S1.1 Patient Safety)** | The learning environment is safe for patients and supportive for learners. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families. |
| **HEYH Condition Number** | 6 |
| **LEP Site** | Pinderfields General Hospital |
| **Specialty (Specialties)** | Medicine |
| **Trainee Level** | Core Medical Training |
| **Concern 1** | Trainees and/or trainers raised concerns about the standard of care provided to patients in newly opened and outlying wards. |
| **Evidence for Concern** | Additional wards are opened and this is often not communicated to trainees. They start their shift unaware of which wards need to be covered. This has an impact on patient safety as there is the potential for patients to be lost. Outliers can easily be missed and in the week of the visit one patient had not been seen by a consultant for 4 days. The trainees felt that this was a regular occurrence. There also seems to be a marked disparity between workloads for Acute medicine and Geriatric Medicine trainees compared to those in other medical specialties. This is particularly in relation to responsibility for outliers. |
| **Action 1** | The Trust must investigate the concerns described above. The investigation should take into account the opinions of all the clinical staff who work in the clinical area. | **1 month** |
| **Action 2** | The Trust must introduce a process to ensure that there is timely, accurate dissemination of ward opening information to all relevant clinical staff. . The opinions of the clinical staff and their suggestions for possible solutions should be considered when drawing up the action plan. | **3 months** |
| **Action 3** | The Trust must evaluate the effect of any changes introduced to ensure that the problems have been resolved. | **6 months** |
| **Action 4** | The Trust must continue to monitor the (clinical area) to ensure problems with patient care do not reoccur. | **12 months** |
| **Evidence for Action 1** | Copy of the investigation report. | **1 month** |
| **Evidence for Action 2** | Copy of the action plan. | **3 months** |
| **Evidence for Action 3** | Copy of the evaluation report. | **6 months** |
| **Evidence for Action 4** | Description of monitoring process. Copy of monitoring reports. | **12 months** |
| **RAG Rating** |  |
| **LEP Requirements** | * Copies of documents must be uploaded to the QM Database
* Item must be reviewed and changes confirmed with link APD
 |
| **Further Review** |  |
| **Resources** | <http://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf><http://www.yorksandhumberdeanery.nhs.uk/media/501652/201404v2Trainer%20Accreditation%20Policy.pdf><http://www.gmc-uk.org/Final_Appendix_4___Guidance_for_Ongoing_Clinical_Supervision.pdf_53817963.pdf> |
| **Question Reference** | Trainer 8Trainee 8, 9 |

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| **GMC Theme** | **LEARNING ENVIRONMENT AND CULTURE** |
| **Requirement****(R1.14 Handover)** | Handover\*\* of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.*\*\*Handover at the start and end of periods of day or night duties, every day of the week.* |
| **HEYH Condition Number** | 7 |
| **LEP Site** | Pinderfields General Hospital |
| **Specialty (Specialties)** | Medicine |
| **Trainee Level** | Core Medical Training |
| **Concern 1** | Handover in AAU is not supported by appropriate documentation. |
| **Evidence for Concern** | Handover in AAU is not felt to be effective as patients are moved around a lot and the system is not updated regularly. There are also a significant number of outliers who may or may not have been seen by a consultant |
| **Action 1** | Introduce a reliable method of documenting the handover discussion/actions/job list/responsible individuals. If this involves IT, there must be easy access in all clinical areas. | **3 months** |
| **Action 2** | Evaluate effectiveness of handover. | **6 months** |
| **Evidence for Action 1** | 1. Production of handover policy 2. Staff training completed 3. Handover introduced 4. Introduction evaluated 5. Handover policy explained to new starters  | **- 2 months****- 3 months****- 4 months****- 6 months****- Induction** |
| **Evidence for Action 1** | Details of venue identified and time provided. | **2 months** |
| **Evidence for Action 1** | 1. Copies of handover documentation2. Description of e-handover system | **- 3 months****- 3 months** |
| **Evidence for Action 2** | Copy of the handover system evaluation. | **6 months** |
| **RAG Rating** |  |
| **LEP Requirements** | * Copies of documents must be uploaded to the QM Database
* Item must be reviewed and changes confirmed with link APD
 |
| **Further Review** |  |
| **Resources** | bma.org.uk/-/media/files/.../safe%20handover%20safe%20patients.pdf [www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-1-handover.pdf](http://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-1-handover.pdf)  |
| **Question Reference** | Trainer 15Trainee 13 |

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| --- | --- |
| **Date of first Draft** |  |
| **First draft submitted to Trust** |  |
| **Trust comments to be submitted by** |  |
| **Final report circulated** |  |
| **Report published** |  |