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Pan-London Quality and Regulation Unit

University College Hospitals NHS Foundation Trust

Obstetrics and Gynaecology

Quality Visit Report

Date of visit: 2 June 2015

Final

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Health Education
North Central and East London

SPECIALTY FOCUSED VISIT REPORT

Visit Details	
LEP	University College London Hospitals NHS Foundation Trust
Specialty	Obstetrics and Gynaecology
Date of visit	2 June 2015
Background to visit	The Head of the Specialty School of Obstetrics and Gynaecology requested this visit, as the specialty had not been formally visited in the previous five years. The specialty had not generated concerns in the General Medical Council National Training Survey 2014. The lead provider, University College London Partners (UCLP) was keen to align with the visit to investigate the quality of training and education at the Trust.
Visit summary and outcomes	There was good attendance at the visit by both trainees and consultants. The visit team also met with the recently appointed clinical director and with the long-standing college tutor. The visit team found that the department offered excellent tertiary level and sub-specialty training. The trainees appreciated the friendly environment, felt well supported and commended their approachable consultants. The visit team found that the department provided good training opportunities in some aspects of obstetrics for the core trainees. The trainees also received excellent training in caesarean sections. Academic opportunities were also reported to be very good. The visit team was pleased to hear of the Trust's plans to increase labour ward cover to 94 hours, but felt that the department should be moving towards at least 100 hours cover, given the number of deliveries. The visit team highlighted the following areas for improvement: The visit team noted that the core trainees were so busy meeting service requirements on the ward that this often meant that their educational needs were neglected. The specialty training year one and year two (ST1 and ST2) trainees were unable to obtain sufficient exposure to certain important elements of training e.g. laparoscopy. When they worked on the labour ward, they felt that they received good obstetrics training but they were prevented from attending the labour ward very regularly due to their other service commitments on the ward; furthermore they often had to compete with fellows for experience on the labour

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	ward. The visit team felt that the department needed to focus on delivering dedicated training to the ST1s and ST2s. The visit team found that the core trainees felt unsupported during the gynaecology on call and that patient safety was at risk on some occasions. There seemed to be reluctance on the part of the core trainees to seek consultant expertise and instead there was an over-reliance on telephone advice from the senior higher trainee. There was also no regular acute gynaecology ward round. The visit team heard that although there was team cover in place for the patients, members of the team were often in the operating theatre or clinic. As a result, the core trainees felt isolated as the higher trainees were often occupied on the labour ward and therefore unable to offer more than telephone advice. The visit team required the Trust to introduce daily consultant-led gynaecology ward rounds; it was felt that this was important from a patient safety and educational perspective. The visit team heard that at times, due to the intensity of work on the labour ward, ward rounds became board rounds. The visit team required the Trust to introduce regular consultant-led labour ward rounds two or three times daily. It was felt that the planned consultant expansion would help facilitate this. Although the visit team heard of comprehensive teaching sessions, the trainees reported that they were mostly unable to attend the sessions due to their busy workload. Similarly, the trainees were on the whole unable to maximise the 'options' week due to gaps in the rota, which meant that they inevitably had to cover other service duties. The visit team felt that there was a slight disconnect between how the trainees were feeling about their training and the consultants' view of the training experience. The visit team suggested that a formalised local faculty group, with nominated trainee reps, would allow the trainees to raise any issues with their training to those in charge. In general, the visit team found that although there were many potential training opportunities available, both the core and junior higher trainees were unable to maximise them. Furthermore, since the labour ward was so busy, the visit team felt that this was compromising the gynaecology service. The visit team suggested that the Trust needed to consider different ways of working to ensure that the trainees' training needs were prioritised. The visit team felt that the expansion of consultant numbers was essential and suggested that the focus must be redirected to acute gynaecology and to ensuring that the trainees had exposure to standard gynaecology procedures.

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Visit team			
Lead Visitor	Mr Greg Ward, Head of London Specialty School of Obstetrics & Gynaecology	**Lead Provider Representative**	Mr Dilip Visvanathan, UCLP Training Programme Management Committee Chair
External Representative	Miss Catherine Wykes, Surrey and Sussex Healthcare NHS Trust	**Lay Member**	Mrs Jane Gregory, Lay Representative
Trainee Representative	Ms Susanna Crowe, Trainee Representative for UCLP	**Quality and Visits Officer**	Ms Jane MacPherson

Findings

GMC Domain	Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
1	OG1.1	**Rota** The college tutor described the following rotas to the visit team. • Core trainees – 13 people • Junior higher trainees – 10 people • Senior higher trainees – 9 people It was reported that there were six specialty training year one and two (ST1/2) trainees, six general practice (GP) trainees, one foundation year two (F2) trainee and one clinical fellow on the core rota. It was reported that there were eight higher trainees (ST3-7), one maternal medicine fellow, one adolescent gynaecology fellow and one gynaecology oncology fellow on the junior higher trainee rota. Three additional fellows worked on a part-time basis. The visit team heard that there were two vacant posts in the department and that the Trust struggled to replace them with good locums.		

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		The senior higher trainee rota comprised the following: Foetal medicine unit – three Reproductive medicine unit – two Gynaecology oncology – one Urogynaecology – one The college tutor and clinical director reported that the senior ST6/7 trainees were allocated to the senior higher trainee rota as soon as it was felt that they were ready and sufficiently skilled. Normally, the higher trainees started on the junior higher trainee rota but then following an appraisal process, they were moved to the senior higher trainee rota.		
1	OG1.2	**On call** Consultant gynaecology on call cover was reported to be as follows: Monday to Friday - 8am to 5pm (teams of two to three consultants) – this was not dedicated cover since the consultants covered other areas including clinics. Gynaecology on calls and emergencies were reported to be supported by the gynaecology diagnostic and treatment unit which was open from 8am to 6pm including at weekends. There was only one core trainee on call at night with two higher trainees who covered the labour ward. The core trainees felt that this was insufficient particularly as they were expected to look after many patients and the higher trainees were usually too busy on the labour ward to help. The core trainees reported that it was very common for a patient to come in overnight who would not see a higher trainee or a consultant. The higher trainees were very	The Trust should introduce a dedicated consultant–led gynaecology ward round of all acute patients seven days a week. This is necessary from both a patient safety and educational perspective.	**Amber** Mandatory Requirement

		busy on the labour ward which was located eight floors away from the gynaecology unit. The core trainees reported that a higher trainee would usually undertake a ward round the following day but that consultants often would not see the patients. The trainees reported that there was no regular gynaecology on call consultant presence at the weekend. Some consultants came into the hospital but this was reportedly variable. The core trainees reported that the intensity of the on call was variable – at times they were extremely busy covering all the gynaecology patients as the senior higher trainee was busy on the labour ward, whereas at other times the night shifts were quiet. The core trainees reported that it was rare for them to call a consultant directly, that they felt uncomfortable doing so, and that usually the on call higher trainee would make contact with the consultant instead. The core trainees felt that their on call experience would be improved if two core trainees were on duty, particularly on weekend mornings. The higher trainees agreed that the core trainees were stretched on call. Some expressed a desire to provide more assistance to the core trainees on call but cited their own heavy workload on the labour ward as the obstacle to this. Some consultants seemed surprised to hear of the trainees' comments and reported that they had agreed as a consultant body to always conduct consultant-led ward rounds at the weekend. The clinical director stated that plans were in progress to provide dedicated gynaecology on call daytime consultant cover, including a daily ward round by a dedicated consultant.		
1	OG1.3	**Labour ward cover** It was reported that the Trust handled 6700 deliveries per year.	Following the planned consultant expansion, the Trust should ensure that regular consultant-led labour ward rounds take place two or three times daily.	**Amber** Mandatory Requirement

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		Consultant labour ward cover was as follows: Monday to Friday - 8am to 10pm Weekend – 9am to 3pm The clinical director reported that plans had been approved for two extra consultants to be recruited which would enable the department to increase labour ward cover to 94 hours per week. The visit team heard that the intensity of workload on the labour ward was high. The higher trainees reported that during the week the labour ward round at 8am often became a board round if the labour ward was too busy. There was also a regular ward round at either 5pm or 8pm. The higher trainees reported that the consultants were present on the labour ward until 3pm at the weekend and that most of the time a ward round took place. Some consultants did not understand why the trainees complained of being so busy particularly given the availability of a consultant on the labour ward from 9am to 3pm.		
1	OG1.4	**European Working Time Directive** The college tutor reported that diary card exercises had been carried out and that rotas had proved compliant. The trainees confirmed this.		
2	OG2.1	**Local Faculty Groups** The trainees did not seem to be aware of the existence of a formal local faculty group, (with nominated trainee representatives) through which they could raise concerns.	The establishment of a formalised local faculty group, with nominated trainee reps, would allow the trainees to raise any issues to those responsible for their training and education.	**Amber** Mandatory Requirement
6	OG6.1	**Induction** The college tutor reported that the induction process was very robust. At departmental		

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		level, the trainees were given a comprehensive induction timetable and a tour of the wards. A survival handbook was also emailed to the trainees. The trainees confirmed that they had received an appropriate induction.		
6	OG6.2	**Educational Supervision** No issues were reported in this area. The trainees confirmed that they met with their educational supervisor.		
1	OG6.3	**Training** The core trainees reported that their rota was generally good but felt that they were expected to undertake a great deal of ward work. The ST1 trainees often felt like they were undertaking tasks which were more suited to a foundation year one (F1) trainee. They reported that they were not timetabled to attend basic gynaecology lists, nor did they have time to attend them. In general, the core trainees reported that they felt obliged to carve out their own training programme in their own time, but that training opportunities were not regularly offered to them. Some core trainees indicated that when they had raised issues about their rota, they felt that their concerns were heard and that attempts were made to resolve the issues. The trainees reported that they did not attend any clinics and therefore they found it difficult to undertake workplace-based assessments, particularly with consultants. The trainees had no rostered time to undertake laparoscopy training and felt obliged to undertake this in their own time. Similarly, there was no dedicated teaching programme for the trainees to learn how to perform procedures such as evacuation of retained products of conception (ERPC) / surgical management of miscarriage (SMOM). There was also no dedicated time on the rota for early pregnancy scanning. It was reported that scanning experience was generally not afforded to the trainees.	The department needs to concentrate on delivering dedicated training to the ST1s and ST2s as well as maximising training exposure at the ST3-5 level. The core trainee 'options' week needs to be protected so that the trainees can take advantage of this valuable training time. Core trainees should have the opportunity to attend clinics, spend more time on the labour ward, undertake laparoscopy training, scanning and ERPC training. In general the focus must be redirected to acute gynaecology and to ensuring that the trainees have exposure to standard gynaecology procedures.	**Amber** Mandatory Requirement

		The core trainees reported that they were allocated two 'options' weeks in a 13 week rota, which in theory allowed them to choose where they wanted to work depending on their specialty interest; however, they commented that this only worked in practice if there was adequate cover everywhere else. Some trainees reported that they had been unable to fully take advantage of this special week because they were asked to cover other duties. The core trainees reported that they were only allocated to work one in 13 weeks on the labour ward. During this week, they felt that they had the opportunity to gain good exposure to different cases, but commented that sometimes they had to compete with clinical fellows for this experience. Although the trainees had flagged up this paucity of labour ward experience with their supervisors, they had been told to make their own arrangements for example by swapping with general practice (GP) trainees so that they could attend the labour ward more regularly. They did not think that this was particularly fair on the GP trainees who also spent a lot of time on the ward. In the maternal foetal assessment unit (MFAU) much of the work took place out of hours which meant that the core trainees did not have exposure to these cases. The visit team heard that the MFAU was run by fellows. The core trainees reported that they received good training in caesarean sections. The academic opportunities for trainees were also reported to be good. The trainees commented that the working environment was good and that their consultants were supportive. In general, the core trainees reported that they would not recommend their post to other trainees mainly because they felt that they had to cover excessive service duties. They felt that they lacked the opportunity to gain exposure to interesting cases within their normal working day, and therefore had to spend time out of hours trying to catch up on the training that they had missed. The junior higher trainees reported that they had missed out on training opportunities in		

		recent months mainly because the department was short-staffed. The visit team heard that the junior higher trainee rota had four gaps. As a result, the trainees were either on call or covering clinics. Some trainees were worried about their ability to attain gynaecology competencies and maintain their skills as they were unable to gain exposure to certain procedures such as hysterectomies. The visit team heard that there were advanced surgeries taking place in some theatres which resulted in limited opportunities for the junior higher trainees to perfect their skills in gynaecology operating. Similarly, in urogynaecology, the trainees felt that they had limited opportunities given the complex nature of many of the cases. The sub-specialty trainees, on the other hand, felt that their training was excellent. It was reported that the trainees' rotas were created by one of the higher trainees.	There needs to be more senior input into the rota so that training opportunities are maximised. Opportunities for training must be formally timetabled so that trainees can access them within their working day.	**Amber** Mandatory Requirement
6	OG6.4	**Sub-specialty** The sub-specialty trainees had no complaints about their training. They confirmed they received very good training but confirmed that the workload was difficult for the more junior trainees.		
6	OG6.5	**Teaching** The college tutor reported that there were plenty of local teaching sessions available to the trainees such as: • Weekly obstetric case review • Monthly maternal medicine teaching • Monthly gynaecology pathology clinical review training – until April 2015 with plans to re-introduce • Fortnightly perinatal morbidity meeting • Female genital mutilation teaching • Monthly obstetrics and gynaecology (O&G) audit meeting	The trainees should be released to attend regional local and regional teaching. Formal arrangements must be made for their other commitments to be covered so that they are able to attend local teaching on a bleep-free basis.	**Amber** Mandatory Requirement

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		• Weekly O&G teaching for general practice, foundation and ST1 • Weekly regional meeting • Weekly general practice teaching off-site • Weekly reproductive medicine evening meeting • Self-directed core teaching Clinics were reported to be cancelled for the monthly O&G audit meeting so that the trainees could attend. For other sessions, cross-cover arrangements were reportedly in place. The college tutor reported that a newsletter was distributed every week to everyone so that they knew which teaching session was due to take place and where. The core trainees reported that they had curriculum-based teaching at 5pm on a Tuesday afternoon, but that this was not attended by consultants. The core trainees reported that they were unable to attend most of the aforementioned teaching sessions as they were on the labour ward early in the morning when the sessions took place. Some core trainees expressed difficulty in being released to attend the regional teaching too, owing to their heavy work commitments. The higher trainees also reported that they were unable to attend the teaching sessions due to their heavy workload. They confirmed that they were released for regional teaching.		
6	OG6.6	**Curriculum** Some of the core trainees reported difficulties in ensuring that they had sufficient WPBAs signed off, particularly as they did not attend clinics.		

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6	OG6.7	**Evacuation of Retained Products of Conception (ERPC)** The visit team heard that there was an ERPC from 5pm to 8pm. Prior to April 2015, a junior higher trainee attended the list on a Monday or Tuesday afternoon. Due to insufficient staffing numbers, core trainees who were signed off as competent by On-site Assessment and Training (OSAT) were then asked to cover the ERPC list unsupervised. When the core trainees found out that many of the cases were not straightforward they flagged this issue with their rota coordinator, the college tutor and the clinical director, who subsequently removed this duty from the trainees' rota. As a result, the core trainees were unable to gain exposure to ERPC procedures unless they attended this list in their own time. The visit team heard that there were plans to change the ERPC list from September 2015 so that it took place within the trainees' working day.		
6	OG6.8	**Study leave** The trainees reported that the Trust was very supportive of study leave particularly prior to examinations.		
6	OG6.9	**Undermining** The visit team heard that one incident of undermining had been highlighted in the 2014 General Medical Council National Trainee Survey (GMC NTS). The clinical director reported that part of the half-day audit teaching sessions had been used to provide multi-disciplinary training to the doctors, nurses and midwives, so that staff members were more aware of what constituted bullying behaviour. No issues were reported in this area by the trainees.		
7	OG7.1	**Consultant expansion** The clinical director reported that a business case was in progress for three additional		

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		gynaecology consultants to be appointed and that the recruitment of two obstetrics consultants had already been approved.			
Good Practice			**Contact**	**Brief for Sharing**	**Date**
N/A					
Other Actions (including actions to be taken by Health Education North Central and East London)					
Requirement			**Responsibility**		
N/A					
Information and reports provided to the team prior to the visit					
DME Annual Report	*No*	Regulator Reports/Data	*Yes*	LFG Reports	*No*	MEM minutes	*No*
GMC Survey - trainees	*Yes*	GMC Survey - trainers	*No*	Previous visit reports & action plans	*No*		
PVQs - trainees	*Yes*	PVQs - trainers	*No*	Result of school survey	*No*		
Signed					
By the Lead Visitor on behalf of the Visiting Team:		Mr Greg Ward			
Date:		4 August 2015			