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Pan-London Quality and Regulation Unit

Imperial College Healthcare NHS Trust
Haematology
Specialty Focused Visit

Quality Visit Report

3 November 2015

Final Report

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Visit Details	
Trust	Imperial College Healthcare NHS Trust
Date of visit	3 November 2015
Background to visit	The Head of School of Pathology had concerns regarding the organisation and delivery of training at Imperial College Healthcare NHS Trust and requested to join the visit. The Head of School was keen to investigate how the delivery of efficient training in haematology was conducted across three sites. The General Medical Council National Training Survey highlighted a number of outliers in haematology and the Head of School wished to explore how these were being addressed.
Visit summary and outcomes	During the visit the visit team met with clinical and educational leads, 12 haematology trainees from specialty training year three to specialty training year seven level in addition to 15 consultants. The visit team found that there were good structures in place to enable dialogue and highlight issues in training. The visit team found that there was better higher management support than previously, e.g. dedicated human resources adviser. There was a good range of training opportunities available and enthusiasm from the consultants e.g. excellent morphology training opportunities. Collectively, the trainees felt that they could contact a consultant for advice at any point. However, the visit team noted the following areas for improvement: It was not clear to the visit team that all blood films were being reviewed in a timely fashion at the laboratory at St Mary's Hospital. The visit team required the Trust to conduct an immediate review of the outstanding blood films at St Mary's Hospital to ensure that there were no patient safety issues. If there were issues, the visit team required the Trust to provide an audit and action plan regarding how this would be addressed. The visit team found that there needed to be further clarity around the crisis escalation policy regarding who took responsibility for ensuring that there was adequate consultant engagement and cover for patient care. While the trainees were good at taking professional responsibility for the organisation of their training, the visit team felt that there needed to be greater input from educational supervisors and overarching leadership. The visit team required the Trust to ensure that there was no compromise to curriculum delivery even during times when there were staff shortages. Although there were good recent structures in place, for example the online tracker system, the visit team felt that they needed to be audited and followed through to ensure their effectiveness.

Visit team			
Lead Visitor	Dr Sarah Hill, Head of London School of Pathology	**External Representative**	Dr Deepti Radia, Consultant Haematologist, Guy's and St Thomas' NHS Foundation Trust
Deputy Lead Visitor	Dr Martin Young, Deputy Head of London School of Pathology	**Lead Provider Representative**	Dr Fatts Chowdhury, Consultant Haematologist, London North West Healthcare NHS Trust

Lay Member	Catherine Walker, Lay Representative	**Trainee Representative**	Dr Andrew Wilson, Trainee Representative
Scribe	Jane MacPherson, Deputy Quality and Visits Manager	**Observer**	Josie Turner, Quality and Visits Manager

Findings			
Ref	**Findings**	**Action and Evidence Required.** **Full details on Action Plan**	**RAG rating of action**
GMC Theme 1) Learning environment and culture			
H1.1	**Patient safety** The visit team heard that the trainee based at St Mary's Hospital was under a great deal of pressure as a result of staffing issues at this site. Although extra locums had been recruited, these were paediatric locums of varying quality with no haematology experience, and they were often only employed on a short-term basis. The visit team heard that consultants were approachable and were keen to ensure that trainees based there were appropriately supported. The bio-medical scientists based at St Mary's Hospital were also reported to be excellent. However, as a result of the staffing issues, it was not clear to the visit team that all blood films were being reviewed in a timely fashion at the laboratory at St Mary's Hospital. The quality of the trainee's training experience at St Mary's Hospital was also found to be diminished as a result of the staffing issues, since the trainee was unable to attend any teaching sessions.	The Trust must conduct an immediate review of the outstanding blood films at St Mary's Hospital to ensure that there are no patient safety issues. If there are issues, the visit team requires the Trust to provide an audit and action plan regarding how this will be addressed.	Red Immediate Mandatory Requirement
H1.2	**Serious incidents and professional duty of candour** The visit team heard that clinical incidents were reported on the clinical reporting system and that any incidents involving trainees were investigated with trainee involvement to ascertain if lessons could be learned.		
H1.3	**Appropriate level of clinical supervision** On the whole, the trainees reported that the quality of their clinical supervision was good.		
H1.4	**Rotas** At Hammersmith Hospital, the trainees described a department that was divided into three groups (a ward group, a laboratory/referrals group and a clinic/coagulation group), each staffed by four or five higher trainees. The Trust submitted a document to the visit team which outlined in greater detail the structure of the service. The trainees stated that they rotated around each group on a		

	two month basis. The allocation process was conducted by three rota coordinators (trainees) who took into consideration the level of training of each trainee. The rota coordinators stated that their role was very difficult and time-consuming and had no real consultant involvement, although a consultant ultimately approved the rota. They stated however that previously the rota had been organised by managers who had not taken into consideration the trainees' training needs; therefore they felt that the trainees themselves were best placed to arrange the rota. At Hammersmith Hospital the trainees worked 24 hours on call and had a zero day the following day. Essentially there were four trainees on call at any one time. The trainees reported that their on call was non-resident but busy as they covered three sites. They could be called every 15 minutes over a 24 hour period. The trainees commented that although their on call rota was supposed to be one in 12, in reality they worked one in eight or nine. Although a diary card exercise had been conducted in July 2015 the trainees were unsure of the outcome. The visit team heard that consultants regularly came in on Saturdays and Sundays to do ward rounds and that they were always available on the phone. The visit team heard that St Mary's Hospital offered predominantly a paediatric transplant-based service. At St Mary's Hospital, only one haematology trainee was currently in post although two trainees were supposed to cover the day unit and the ward. In total the rota comprised two paediatric haematology higher trainees, two adult haematology higher trainees and one staff grade but at the time of the visit, due to staff shortages and sick leave, there were only 1.5 staff members in post. Trainees based at St Mary's Hospital covered the evening and weekend on call but did not work nights. They were responsible for paediatric inpatients and were on a one in five rota. The visit team heard that there were no higher trainees at Charing Cross Hospital. The chief of service reported that at the time of the visit the department had a full cohort of individuals in the training posts (which included trainees and clinical fellows), although she acknowledged that there had been gaps in the past due to sickness and maternity leave. She also stated that plans were in place to fill the likely gaps in the rota from February 2016. The unit training lead stated that the opportunities for training and education were immense. He reported that by organising the department into different groups, this allowed the trainees to benefit from all of the Trust's highly specialised services. He reported that consultant support was excellent since six consultants were available on a daily basis across the different sections of the service. He also reported that the department had been on a continuous recruitment drive over the previous six months to try and address the gaps in the rota. Clinical fellows had been interviewed on a monthly basis and the department was now able to tap into international recruitment. Nevertheless, the chief of service stated that international recruitment took an inordinate amount of time and that the Trust recognised that there was a need to over-supply. Additional funding to recruit four clinical fellows was therefore now available. The Trust was also looking at alternative ways to cover the rota, e.g. training nurses and developing a physician assistant programme, both of which would be a long-term rather than a short-term solution.	The Trust should conduct a new diary card exercise to ensure that the trainees' rota is compliant and make appropriate changes, if necessary.	Amber Mandatory Requirement

	The trainees felt that there were still some gaps in the rota and they believe that they could have been filled given that many were anticipated. They were however aware that their consultants had said that they had exhausted all methods to try and fill the rota. The visit team heard that if it was not possible to cover the rota, there was no real escalation policy in place. Although this had happened only on rare occasions, the trainees felt that the onus was on them to resolve any issues in this area. The trainees acknowledged however that on occasion their consultants had recognised their flexibility in ensuring the rota was covered. The clinical and educational supervisors commented that they were more than happy to help if needed, but that the process would be for the higher trainee to call them to request assistance.	There needs to be further clarity around the crisis escalation policy regarding who takes responsibility for ensuring that there is adequate consultant engagement to guarantee cover is provided for patient care. If trainees are unable to resolve cover issues, it should be clear that this responsibility then lies with the consultants to manage and resolve.	Amber Mandatory Requirement
H1.5	**Induction** The trainees reported that the induction at Hammersmith Hospital had improved following complaints about its quality. The visit team heard that the induction at St Mary's Hospital also involved lectures about the paediatric oncology service. The clinical and educational supervisors informed the visit team that the trainees had a formal haematology induction and also attended a haematology emergency training day within their first 10 days in the Trust. Trainees were reportedly not expected to cover the on call rota until they had completed this training. Nevertheless some trainees commented that if they were not assigned to the laboratory post early on in their year at the Trust, they often found the on call difficult as they felt that they had not undertaken sufficient training especially in morphology and identification of potentially serious illness.	Ensure that all trainees are sufficiently trained in laboratory work prior to undertaking their first on call rota and that this is signed off by a supervisor.	Amber Mandatory Requirement
H1.6	**Handover** The visit team heard that on many occasions the working day continued beyond 5pm. The person on the 24 hour on call made contact with each of the teams to accept the handover of patients. The trainees reported that the only formal sit-down consultant-led handover took place on Fridays prior to the weekend. The trainees felt that the handover process was effective and that there was appropriate communication. The visit team heard that everyone involved had access to patient lists.		
H1.7	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience**		

	In general the trainees reported that their work undertaken was appropriate to their level of training.		
H1.8	**Protected time for learning and organised educational sessions** The visit team heard that there was a weekly teaching session every Wednesday morning. There were also many other teaching sessions throughout the week including a grand round. The trainees felt that although teaching opportunities were available, they were not always able to take advantage of them due to their busy workload. For example, there was a designated coagulation meeting that some trainees had attended rarely despite having been in post for three months. The trainees commented that when the department was short-staffed, a trainee was often removed from one of the specialist clinics. They felt that they therefore missed out on valuable training opportunities in specialist areas. Similarly, exposure to laboratory work was also reduced during times of short-staffing. The clinical and educational supervisors felt that when the rota was fully or almost fully staffed, it was easier for trainees to attend all the teaching sessions available to them, which included pan-London training days. The trainer in charge of the morphology-based teaching on Fridays stated that he adjusted the teaching to the individual trainees' needs. The visit team heard that regional teaching sessions included dedicated part one teaching and dedicated part two teaching which also incorporated viva practice The visit team was also informed that every team had a consultant-led teaching round every day.	The Trust must ensure that there is no compromise to curriculum delivery even during times when there are staff shortages. While the trainees are good at taking professional responsibility for the organisation of their training, there needs to be greater input from educational supervisors and overarching leadership. The Trust should map attainment of curriculum competencies to the initial training and learning agreement (which should be signed by each trainee and educational supervisor during their initial meeting).	Amber Mandatory Requirement
H1.9	**Adequate time and resources to complete assessments required by the curriculum** Some trainees felt that they were not always able to meet their curriculum requirements, for example they said they had limited opportunities to use some equipment and felt that sometimes further experience in the laboratory was required.	See above.	
GMC Theme 2) Educational governance and leadership			
H2.1	**Effective, transparent and clearly understood educational governance systems and processes** The visit team heard that trainee representatives attended some governance meetings. It was reported that each discipline had its own quality meetings that happened every four to six weeks and that trainee representatives attended these meetings.		
H2.2	**Service design (impact on learners)**	The Trust should provide clarification on the management of paediatric haematology at St	Amber Mandatory

	The chief of service reported that due to the difficulty in delivering training on many sites, there was very little programmed activity at Charing Cross Hospital. Most training was conducted at Hammersmith Hospital with limited outpatient clinics at St Mary's Hospital. In the past the trainees had struggled with travelling between sites. The chief of service stated that the centralisation of the service had improved the training experience. The trainees indicated that they had specific base sites, most at Hammersmith Hospital with some being based at St Mary's Hospital where paediatric pathology training took place. The visit team was informed about the plans to establish a pathology hub in north-west London, possibly at the Charing Cross Hospital site. However, financial restraints meant that plans were still in their infancy. The visit team heard that for the time being haematology specialist services would remain at Hammersmith Hospital.	Mary's Hospital between the paediatric and haematology specialists so that there is no adverse impact upon the trainee experience.	Requirement
H2.3	**Appropriate system for raising concerns about education and training within the organisation** The unit training lead reported that there was a local faculty group which met every month and he reported that minutes were taken during this meeting.		
H2.4	**Systems to manage learners' progression** The unit training lead reported that the department had become much more objective in providing feedback to trainees. The visit team was informed about the department's dedicated online tracker system which was used by clinical and educational supervisors. A progress report was provided every six to eight weeks by a trainee's clinical supervisor which was in turn fed back to the educational supervisor and unit training lead. Most trainees seemed unaware of this new system and how they could input into any feedback process. The unit training lead reported that he met with the trainees regularly (on a monthly basis). During these meetings, different aspects of training were discussed. These meetings were all reported to be minuted.	Although there are good recent structures in place, the trainees need to be made aware of these and they need to be audited and followed through to ensure their effectiveness and compliance with information governance. Ensure that there is transparency for all trainees involved.	Amber Mandatory Requirement
H2.5	**Organisation to ensure access to a named clinical supervisor** The clinical supervisors reported that they met with each trainee every month and completed a form which was put on the online tracker system. In general, the consultants felt that they were getting better at providing feedback.	See above.	
GMC Theme 3) Supporting learners			
H3.1	**Behaviour that undermines professional confidence, performance or self-esteem** No issues were reported in this area. The trainees reported that they felt very well supported.		
H3.2	**Timely and accurate information about curriculum, assessment and clinical placements**	Ensure that trainees receive timely and accurate	Amber

	Some trainees reported that they did not receive timely information about their clinical placement prior to arriving at the Trust, nor were they contacted in advance by the department to find out about their experience elsewhere in order to inform their placement to maximise their educational and training needs.	information about their clinical placements at the Trust prior to their arrival in post. Information regarding the trainees' experience should inform their initial rotas.	Mandatory Requirement
H3.3	**Regular, constructive and meaningful feedback** The trainees reported that they received regular informal feedback.		
GMC Theme 4) Supporting educators			
H4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The visit team was informed that all the educational supervisors had completed compulsory training. In addition, some had completed face-to-face teaching organised at the Trust and online modules. The visit team heard that trainers had a regular appraisal. The postgraduate centre staff were reportedly adept at ensuring that everyone was appropriately appraised and had completed their required training. The clinical and educational supervisors reported that they felt well supported as trainers. They commented that the Trust had recognised the difficulties the department had faced in trying to recruit locums quickly and had therefore allocated a dedicated human resources person to the department.		
H4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The clinical and educational supervisors confirmed that they had sufficient time in their job plans to meet their responsibilities.		
GMC Theme 5) Developing and implementing curricula and assessments			
H5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** None of the trainees interviewed had completed more than one or two workplace-based assessments during their post to date with seven trainees not having completed any at all. The trainees felt that there were limited opportunities to complete them whereas the educational supervisors stated that they often reminded the trainees to complete them but also felt that the trainees needed to take responsibility for their own training.	See Ref H1.8 above. In addition, educational supervisors should encourage trainees at their monthly meetings to ensure that workplace-based assessments are being carried out in a timely fashion in the event that trainees are not adequately proactive.	Green Recommendation
H5.2	**An educational induction to make sure learners understand their curriculum and how their**	All trainees must have an educational meeting	Amber

	post or clinical placement fits within the programme Some trainees reported that they only had a meeting with their educational supervisor approximately one month after they had started, by which time they felt it was too late for them to change clinical placements as they had already been rostered into the programme. Other trainees commented that there was a certain amount of movement within the first month with some people changing jobs, if requested.	within 2 weeks of starting at which their educational needs are mapped to the opportunities available within the department to determine their clinical placements.	Mandatory Requirement
H5.3	**Regular, useful meetings with clinical and educational supervisors** The trainees reported that they had met with their educational supervisor. The clinical and educational supervisors reported that they met with each trainee at the start, middle and end of their placement but were happy to meet with their trainees on an ad hoc basis as required.		

Good Practice	**Contact**	**Brief for Sharing**	**Date**

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Sarah Hill*
Date:	*8 December 2015*