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Pan-London Quality and Regulation Unit

Imperial College Healthcare NHS Trust
Neonatology
Specialty Focused Visit

Quality Visit Report

3 November 2015

Final Report

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Visit Details	
Trust	Imperial College Healthcare NHS Trust (St Mary's Hospital and Queen Charlotte's Hospital)
Date of visit	3 November 2015
Background to visit	The neonatology department at Imperial College Healthcare NHS Trust comprised two units on two different hospital sites. St. Mary's Hospital contained the NHS level two neonatal unit and the private patient maternity ward, the Lindo Wing. Queen Charlotte's Hospital contained the NHS level three neonatal unit, which handled the most complex neonatal cases. The visit team needed to review how the department was managing education and training across two sites and the trainees' interactions with private patients. The neonatal department at the Trust practices a more non-interventional approach to neonatology than the majority of trusts in London; this has resulted in trainees regarding the training environment as less favourable for receiving adequate training exposure for practical procedures to gain the competencies for level three training. Consequently, the department had not enjoyed the prominence and positive reputation it once had. A Specialty Focused Visit was required to review the overall educational opportunities for trainees to enable curriculum competencies to be attained. The department had experienced serious bullying and undermining behaviour and this warranted a review of how the department monitored these types of behaviour, how it was dealt with and how supported the trainees were within the department.
Visit summary and outcomes	The visit team would like to thank all of those who attended and organised the visit from the Trust. The first session involved the visit team meeting with senior personnel and the consultant with the responsibility of leading the department. The visit team then met with four specialty grade (ST) trainees from the Queen Charlotte's site ranging from ST2 to ST8 and two trust grade doctors. There was also a video link to the five trainees at St. Mary's Hospital who were from training grades ST2 to ST7. This was followed by a session where the visit team met with eight educational and clinical supervisors from Queen Charlotte's Hospital and two from St. Mary's Hospital, the latter via a video link. The neonatology department had gone through a significant amount of change throughout the years and this had had a noticeable impact on the training available at the Trust. However, the progress that had been made within the department and the improvement to trainees' education, workload, and training was very good. The hard work of the college tutor along with the department must be commended especially during challenging circumstances. The visit team was pleased to find a department that was focused on providing high quality education and training and a consultant body that was not only supportive but also engaged with the trainees and aware of training issues. The consultant body was found to be proactive regarding teaching with many examples of excellent teaching that was also cross-site. The neonatal department at the Trust offered a non-interventional approach to neonatology. Although the visit team found that trainees, especially ST1 to 3 were concerned about attaining practical competencies such as intubation; the consultant body was trying to find solutions to this issue. The trainees did however value the excellent teaching and additional skills that were available throughout the department. The visit team found areas that could be improved upon to allow for increased exposure to training opportunities, such as the better use of health care assistants to set up improved organisation of baby checks on the post-natal wards at both hospitals, as well as midwives trained to undertake the majority of healthy term baby checks. There were plans to introduce a two-tier consultant rota that would allow for 24/7 consultant led service. The visit team had experienced a two-tier consultant rota in another trust and would like to see this neonatology department learn from previous examples to ensure respect and equality amongst the consultants. The visit team found the consultant body to be an open and supportive group, which the visit team would like to see continued when the two-tier rota is introduced. The visit team was also pleased to see that the bullying and undermining behaviour that had been prevalent in the department had been dealt with in a robust, professional manner. However, there were still cases of undermining and unprofessional behaviour reported by the trainees. In light of the

	environment of a neonatal department and the potential for high workloads and stress, the visit team urges the department to build upon the progress made and the initiatives already in practice, such as the trainees shadowing nurses, to encourage understanding between staff groups. There are three serious concerns raised by the visit. One was the room used for baby checks at St. Mary's Hospital, which was reported to be unfit for clinical work. This situation needed to be resolved such that a room dedicated to only baby checks and respecting patient confidentiality is found. The two other concerns involved the trainees' interactions with the private patient Lindo Wing. The visit team found that there was a lack of information given to trainees when called to attend deliveries in the Lindo Wing, which resulted in the unnecessary and incorrect prioritisation of patients, with private patients being given priority over more pressing NHS cases. This was found to be unacceptable and must cease. The last concern was deemed to warrant an Immediate Mandatory Requirement due to the patient safety concerns. The neonatology equipment at the Lindo Wing was found to be faulty on occasions, not maintained to the same standard as NHS equipment and unfamiliar to NHS trainees. This placed the trainees and patients at unnecessary risk and needed to be rectified immediately.

Visit team

Lead Visitor	Dr Camilla Kingdon, Head of London Specialty School of Paediatrics	**External Representative**	Dr Jonathan Round, Training Programme Director Lead
Trust Liaison Dean	Dr Chandi Vellodi, Trust Liaison Dean	**Trainee representative**	Dr Nick Ware, Vice Chair of the Trainee Committee
Lay Member	Kate Rivett, Lay Representative		
Visit Officer	Lizzie Cannon, Quality and Visits Officer		

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
GMC Theme 1) Learning environment and culture			
N1.1	**Patient safety** There was one major patient safety concern that warranted an Immediate Mandatory Requirement with immediate effect. This was substantiated by the reports from both the consultants and trainees that the equipment on the Lindo Wing was, different to the equipment used on the NHS wards, so unfamiliar to trainees, not maintained to the same standard and was not up to date to administer positive end-expiratory pressure (PEEP) or continuous positive airway pressure (CPAP). The consultants stated that this had been discussed on several occasions with the staff on the Lindo Wing but the incorrect equipment was still used as standard in the Lindo Wing. The visit team was concerned that this not only threatened patient safety but also exposed	The Trust is required to ensure the equipment on the Lindo wing is the same as and maintained to the same standard as the NHS equipment on the NHS St. Mary's and Queen Charlotte sites.	**Red** Immediate Mandatory Requirement

	the trainees to unnecessary risk. The trainees stated that when working at St. Mary's Hospital they were frequently called to the private labour ward on the Lindo Wing, with limited information regarding the nature of the delivery. The visit team heard that the midwives from the Lindo Wing would state that the private patient was an emergency, and would give no other information. This meant that trainees could not prioritise the patients and would potentially leave an NHS patient to attend the delivery in the Lindo, which was commonly an elective caesarean section, and not as serious as the NHS patient. The trainees stated that there was a clear prioritisation of private patients over NHS patients, which they had discussed with the consultants and reported as a serious incident through Datix. However trainees perceived that the Lindo Wing was not receptive to change. The visit team heard from the consultants that there were polices in place that outlined the information that needed to be communicated to allow for correct patient prioritisation. However, adherence to this policy was a cyclical problem that had to be addressed every couple of years and the consultant body would appreciate Health Education North West London's support in enforcing the policy. The trainees reported that the room allocated for baby checks at St. Mary's hospital doubled as a staff kitchen and trainees were frequently interrupted in the middle of baby checks with midwives using the microwave or removing food from a fridge. The trainees stated that although the parents never mentioned that this was upsetting, it was noticeably perturbing for the parents. The trainees stated that although there was not a patient safety concern there was the potential with frequent distractions for a test to be missed. The visit team found that the room for baby checks at St. Mary's Hospital was unfit for purpose and a new room should be found immediately.	The Trust is required to ensure that trainees are provided with adequate clinical information for every patient which trainees are called to attend on the Lindo Wing to allow for patient prioritisation. All staff members within the NHS and Lindo Wing must adhere to this policy. The neonatal consultants are required to devise a brief pro forma of exactly what information the trainees require prior to attending a delivery. The Trust is required to find a suitable room for baby checks at St. Mary's Hospital that is a designated clinical area and allows uninterrupted baby checks to be carried out.	**Amber** Mandatory Requirement **Amber** Mandatory Requirement
N1.2	**Serious incidents and professional duty of candour** The visit team heard that all the trainees were encouraged to report serious incidents and were shown how to at induction. There was a risk management meeting every month, participation emails, and a summary email of the meeting. The trainees stated that Datix forms were not filled out for all deliveries trainees attended at the Lindo Wing because the system was ineffective for bringing about the cultural changes they had identified as needing to be implemented to solve the inappropriate nature of calls to the Lindo Wing.		
N1.3	**Appropriate level of clinical supervision** The trainees stated that they received excellent support from the consultants and good clinical supervision from the consultants and higher training grades or equivalents. The visit team heard that there was consultant presence on both sites during the day. During the night there was consultant presence on the level three unit and one consultant on call at night for the level two unit.		

N1.4	**Responsibilities for patient care appropriate for stage of education and training** The visit team heard that the trainees' responsibilities regarding private patients in the Lindo Wing were explained at induction. The trainees were informed that babies from the Lindo Wing were essentially NHS patients and within the trainees' remit. All ST trainees were expected to attend elective caesarean sections at the Lindo Wing. The trainees stated that from 8.30am to 5pm, the consultants would be responsible for all patients within the Lindo Wing but trainees would attend deliveries. Out of hours, the trainees were expected to attend to the Lindo Wing and the NHS wards. This can result in a conflict of clinical responsibilities, the prioritisation of which is made difficult by the lack of clinical information from the Lindo Wing and the expectations placed on the trainees to attend. The private post-natal ward, the Stanley Clayton ward, trainees and consultants were expected to carry out baby checks. The trainees stated that whenever the infusion rates of total parenteral nutrition (TPN) needed changing the trainees had to write a new prescription. This was thought to be an unnecessary addition to the trainees' workload, which could be fulfilled by a nurse. The trainees reported that they had raised the issue of a lack of cannulas on the post-natal ward at the junior-senior meeting. The trainees were told that a junior doctor should be responsible for checking stock and equipment levels in the stock room. The trainees stated that this was ineffective, as the trainees had no idea how to reorder stock and was an inappropriate task, which should be allocated to a health care assistant. The visit team heard that the Badger net platform for electronic notes had been implemented in late September 2015 and that the trainees stated was easy and efficient to use. The visit team was very happy to hear that the nurses were responsible for the daily patient updates.	The Trust must provide the written policy to trainees at induction which clearly outlines the duties expected of them in the Lindo Wing. The processes for prescribing TPN must be reviewed to reduce unnecessary re-prescribing at every rate change. The department is required to review the personnel responsible for maintaining adequate level of cannulas and other stock within the department. This is not an appropriate role for a trainee.	**Amber** Mandatory Requirement **Amber** Mandatory Requirement **Amber** Mandatory Requirement
N1.5	**Rotas** The visit team heard that the rotas had been merged for consultants, trainees, and nurses. This had been used effectively as a recruitment tool for nurses who were able to rotate through four areas, maintaining the nurses' level two and three skills and had brought the teams together. The consultants also stated the merged rotas had been beneficial for the consultants, by working together and sharing practice. The trainees stated that they were happy with the rota organisation and shift pattern, however concern was expressed that for ST2 and ST3 trainees there was not enough exposure to the tertiary unit at Queen Charlotte's hospital. The consultants were aware of the ST1-3 trainees' focus on attaining competencies and there was a plan to split the rota in March 2016, which would be European Working Time Directive (EWTD) compliant. The initial split would allocate St1-2 trainees to the level two unit at St. Mary's Hospital and then when the same trainees came back to the department for six months as ST3 trainees they would be allocated to the level three unit at Queen Charlotte's Hospital.		

	The visit team heard that the split rota would be possible from March 2016 because there would be enough staff on the rotas. However, the visit team was also told by the consultant body that there had been multiple failed attempts to recruit higher training grade equivalent trust doctors to the unit due to a combination of an overly stretched human resources department and a lack of suitable candidates. The visit team found that the consultant body was split in regards to splitting the trainee rota, with some consultants of the opinion that changes could be made to enhance the training opportunities at the two different sites, before considering splitting the rota. The visit team felt that the use of healthcare assistants, possibly introducing physician associates, having midwife run baby checks and more time spent in the intensive care unit, instead of the post-natal ward when at Queen Charlotte's would improve trainee experience and acquisition of all the required neonatal competencies. The visit team also heard that there would be a new two-tier consultant rota with the appointment of six new consultants. This rota would be made up of resident and non-resident consultants, with the former present out of hours for additional clinical supervision and educational opportunities for the trainees and the delivery of a 24/7 consultant delivered service. At another trust, the two tier rota system had been susceptible to a strict hierarchy which had impacted on the trainees and had limited the careers of the resident consultants and the training and management opportunities of the highest grade trainees. The consultant body stated that they had learnt from the other trust's experience and had a consultant from said trust now working within the department, helping them to ensure the proposed two-tier rota would be equitable and fair to all consultants.	The London School of Paediatrics fully support plans to enhance the quality of clinical supervision 24/7 and other strategies for enhancing educational opportunities. It is recommended that the Trust fully support the implementation of the resident consultant tier.	**Amber** Mandatory Requirement
N1.6	**Induction** All trainees stated that the local induction was good, but the Trust induction could be improved.		
N1.7	**Protected time for learning and organised educational sessions** The visit team heard from trainees that there was teaching every day which was excellent and there was cot side teaching too. The visit team commends the amount and varied cross site teaching in the department. The visit team heard that trainees were able to be involved with the on-going research of the department too.		
N1.8	**Adequate time and resources to complete assessments required by the curriculum** The trainees mentioned Dr Latha Srinivasan as an exceptional consultant who was very proactive and supportive when completing workplace-based assessments, (WPBAs). The trainees stated that for other consultants WPBAs were not at the forefront of the consultants' minds and the trainees had be quite persistent to get sign off of WPBAs.		
GMC Theme 2) Educational governance and leadership			

N2.1	**Impact of service design on learners** The consultants stated that since the two hospitals' services had merged in 2008, a lot of work had been undertaken to overcome difficulties of working across two different sites, in regards to service and training. The visit team was pleased to hear that the department had ensured that the guidelines were consistent across the two sites and there were monthly, multi-professional meetings to discuss and review the guidelines. The guidelines were then approved by a quality team and published on the intranet, which was accessible to all staff.		
GMC Theme 3) Supporting learners			
N3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The visit team was pleased to hear that the department had dealt with the bullying and undermining which had been present in the department in a robust manner. However, the trainees reported that although the consultant body was very supportive, there were a limited number of individuals within the nursing and midwifery staff who had displayed unprofessional and bullying behaviour towards other members of staff and trainees. The trainees did state that this was probably due to the high workload of the nurses and midwives and the stress they were under. The trainees stated that the behaviour had been discussed at the junior and senior meeting but no action had been taken and no feedback provided. The trainees stated that initially relationships with the nursing and midwifery staff could be frayed, however relationships improved as the trainees stayed in the unit and generally, the relationships between staff groups were good. The visit team heard that ST1,2 and 3 trainees would take part in a nurse shift to understand the nurses' role and the trainees thought more activities such as this could be implemented to help improve relations. The visit team was pleased to hear of this initiative taken by the department.	The department is required to review the bullying and undermining within the department.	**Amber** Mandatory Requirement
GMC Theme 4) Supporting educators			
GMC Theme 5) Developing and implementing curricula and assessments			
N5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The visit team heard from the trainees at St. Mary's hospital that although there was a cross-site rota, there was only 30 days in six months allocated to the level three unit at Queen Charlotte's hospital for tertiary experience. The trainees stated that the ST2 - ST3 trainees were consistently worried that they would not be able to meet the curriculum requirements for practical procedures such as intubation, because of the lack of time at the level three unit and because Queen Charlotte's used less invasive procedures. The visit team heard from the consultants that there could be a potential change, which would	The acquisition of the mandatory practical procedures is an important part of the Level 1 curriculum. With the planned rota changes, an audit of mandatory directly observed procedures (DOPs) should be undertake both before and after March 2016 to monitor this.	**Amber** Mandatory Requirement

	place ST1 and 2 trainees at St. Mary's hospital and the ST2-3 trainees at Queen Charlotte's Hospital. The trainees stated that they were not aware of this, but would welcome the change. The trainees did however state that intubation was only one competency and the department offered excellent opportunities to learn, including counselling patients' parents, cranial ultrasound and less invasive techniques. The consultant body stated that there was a large educational focus within the department with opportunities for education and training gathered from both sites with the successful use of video conferencing. The visit team heard that the grand round was viewed as an important educational element, which was multi-professional and communicated across site, via video conferencing.		
N5.2	**Appropriate balance between providing services and accessing educational and training opportunities** The ST1,2,and 3 trainees stated that at Queen Charlotte's Hospital the trainees were often placed on the post-natal ward, because there were gaps in the rota. The trainees stated that the post-natal shift was detrimental to trainees trying to attend teaching, because the shift was poorly organised. The visit team heard that during the post-natal ward shift the midwives organised the slots for baby checks throughout the day, which numbered 13 to 20 per day. However, except for one senior midwife who ensured total efficiency, there was a lack of organisation and prioritisation to the system. There was a breakdown in the appointment system and then multiple babies who needed checking at once. Poor organisation of clinics was also demonstrated at the visit when a trainee was asked to leave the visit to attend a patient clinic, where one baby was supposed to be reviewed however there were four patients instead. Some midwives were reported to undertake baby checks but this was sporadic. The consultants stated that the department was working towards midwife led baby checks from late November 2015 and full implementation in spring 2016. The trainees stated that this would ease the workload on the post-natal ward and benefit education and training, however they stated that in the interim timely and well managed baby checks could be achieved by the use of a health care assistant (HCA). The trainees stated that there was supposed to be a HCA assigned to each trainee to assist in locating the patient's notes and parents, while organising the baby checks, however this was never the case. This was the situation reported at both hospitals. The visit team enquired about the possible use of Physician Associates to complement the work of the HCAs, midwives, and trainees within the department, especially regarding baby checks. However, it was clear that the consultant body was unsure of the role of Physician Associate and how it could be implemented within the department.	The Trust is required to provide a review of the baby check system and develop solutions that will be implemented in 2016. This review should contain evidence of roles and responsibilities for trainees, midwives and healthcare assistants, the organisation of the baby checks and a timeline for full implementation of midwife led baby checks.	**Amber** Mandatory Requirement

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 Camilla Kingdon*
Date:	*08 December 2015*