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Pan-London Quality and Regulation Unit

Barking Havering and Redbridge University Hospitals NHS Trust Ophthalmology Specialty Focused Visit

Quality Visit Report

18 November 2015

Final Report

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Visit Details	
Trust	Barking, Havering and Redbridge University Hospitals NHS Trust
Date of visit	18 November 2015
Background to visit	The ophthalmology department at Barking, Havering and Redbridge University Hospitals NHS Trust was last visited in May 2013. In the 2015 General Medical Council National Training Survey (GMC NTS), ophthalmology at Barking, Havering and Redbridge University Hospitals NHS Trust received five red outliers including overall satisfaction, adequate experience and supportive environment. In addition to the GMC NTS results, the visit team was aware of a high consultant turnover within the department, and issues regarding trainee timetables being changed on a regular basis. It was necessary for the department to be visited in order to investigate these issues and ascertain what factors had led to the poor GMC NTS results, and how the Trust was addressing them.
Visit summary and outcomes	The visit team met with the senior management team in the morning, before meeting with the ophthalmology clinical director, operations manager, college tutor, educational lead and divisional director. Following this the visit team met with two higher trainees, and the clinical and educational supervisors before feeding back their findings to the Trust. The visit team was pleased to find the following good examples of training within the department: • There was excellent training supervision from individual consultants available for trainees. • Trainees received good access to leadership projects and these are well advertised to trainees within the department. • The department had the ability to deliver good sub-specialty training to trainees. • Trainees were happy with their casualty experience and they felt well supervised. However the following areas for improvement were identified by the visit team: • Cataract lists had been cancelled recently, with reports of cataracts being referred to community and ISCT ophthalmology services. There were concerns regarding trainees receiving appropriate cataract exposure and training whilst this was the case. • There had been repeated changes to the trainees' timetables which had affected their training experience as they had frequently been pulled from clinics to cover service gaps. This was also found to be the case in the last visit to the department in 2013. The visit team reported that it was essential for trainees to have a protected timetable which delivered all curricular requirements and protected job plans. Trainees reported that they would be happy to have a family member treated within the department, but stated that they may be frustrated with the long waiting times for glaucoma.

Visit team			
Lead Visitor	Miss Fiona O'Sullivan, Head of London Specialty School of Ophthalmology	**Lead Provider Representative**	Miss Emma Jones, Training Programme Director, Moorfields Eye Hospital NHS Foundation Trust

Specialty Representative	Miss Dhanes Thomas, Consultant Ophthalmologist, Moorfields at St Georges Hospital NHS Foundation Trust	**Lay Member**	Caroline Turnbull, Lay Representative
Scribe	Rishi Athwal, Deputy Quality and Patient Safety Manager		

Findings			
Ref	**Findings**	**Action and Evidence Required.** **Full details on Action Plan**	**RAG rating of action**
GMC Theme 1) Learning environment and culture			
O1.1	**Serious incidents and professional duty of candour** The visit team heard from the senior management team that the Trust had started to include trainees in quality improvement, and said that there was now a focus on learning from poor outcomes. The ophthalmology clinical director and college tutor reported that as a result of an incident, in which a trainee felt pressurised due to overbooked clinics, they were now appointing new nurses to the clinics. The ophthalmology trainees told the visit team that they were confident that they knew how to report incidents, although none of them had needed to complete a serious incident form during their placement at the Trust.		
O1.2	**Responsibilities for patient care appropriate for stage of education and training** Trainees told the visit team that there had been no occasions during their placements that they had felt they had been asked to complete work which was outside their level of competency. They stated that they always knew who to contact, and in casualty when there was not always a named consultant, there was still always support close by.		
O1.3	**Rotas** **On call** The ophthalmology clinical director and college tutor told the visit team that the trainees currently did not have to work on call. They reported that out of hours they advised patients to go to either Moorfields Eye Hospital NHS Foundation Trust or Whipps Cross University Hospital. The visit team was also told that there were no ophthalmology inpatients; the clinical director and college tutor stated that on the rare occasion that a patient with an eye condition was kept in overnight, an		

	ad hoc plan would be created. They said that the trainees would never be asked to come in. **Weekend ophthalmology service** The visit team heard that there were plans to introduce a weekend casualty service which would run from 9am to 4pm on a Saturday and Sunday. They indicated that the plan was that this would be staffed by middle grade trainees or a fellow and would be consultant supervised. The visit team was told that the introduction of the weekend ophthalmology service was in the top five of the surgical priority list. **Timetables** The visit team was informed by the divisional director responsible for ophthalmology that trainees timetables were being changed due to capacity and service gaps. It was understood that this was an unacceptable practice, and that the department would need to ensure this ceased immediately. Trainees told the visit team that there had only been one or two weeks when the timetable they were provided with had not been changed. The trainees stated that the department was good at protecting their theatre lists but said that the clinics were changed regularly. Trainees reported that they would sometimes be pulled out of clinics to attend casualty, but felt that even when they were moved to other clinics it was detrimental as it affected the continuity of their training experience. The visit team were informed by a trainee that the consultants had been very helpful in ensuring they were able to attend as many lists as possible per week, but stated that they were about to lose one of their lists to the new fellow joining the department. The divisional director told the visit team that due to the number of consultants within the department, the introduction of further fellows should have no impact on training opportunities. The visit team was informed that the college tutor set the trainee weekly timetables which met Royal College of Ophthalmology (RCOphth) guidelines. However the published timetable was changed very frequently by the ophthalmology rota manager in order to fill gaps caused by staff vacancies. In particular the need to staff the Eye Casualty was prioritised and trainees were frequently rescheduled to cover gaps in Eye Casualty. This disrupted the continuity of experience in subspecialty clinics which was essential for trainees to cover the RCophth curriculum. Educational and clinical supervisors told the visit team that their timetables were also changing and stated that this was due to severe short staffing. They stated that it was the rota manager who removed trainees from their scheduled timetable, but stated that this would usually be done weeks in advance. The visit team was told that there was a new rota coming into effect within the next month that should address this issue. There new consultants had joined the department in the last year and they had been working hard to resolve this. They indicated that the introduction of two new corneal fellows into the department who had a 50% allocation of their time in primary care meant that trainees should no longer be pulled out of their timetable to attend casualty. They stated that they were now at 100% so they had enough people in the department to cover	The unstable timetables for trainees with trainees frequently pulled from published timetables to cover service gaps must end. This issue was identified in the 2013 visit and is still affecting trainee experience in 2015. The department should formulate a long-term plan to manage leave and absence without disrupting the trainees' timetables (except under exceptional circumstances). The trainee timetables must meet RCOphth guidelines, must deliver regular training and experience in subspecialty clinics without disruption so that the relevant curriculum is fully covered during a one year placement. Timetables must also deliver twice weekly operating lists for each trainee and must provide surgical experience appropriate to the level of trainee; these lists must not be changed so that the progress of each trainee can be monitored by the clinical supervisor in charge of the nominated operating list.	Mandatory Requirement

	everything unless there was illness or leave, and that the next objective was to achieve 140% so that they could manage when trainees were away. However, a part-time consultant staff member was on unplanned leave, and they had no details on their likely return to work. The visit team heard from one of the consultants that they were trying to make the ophthalmology casualty exempt from the four hour waiting time target which would also help this issue. She also stated that management had been removing trainees from clinics without speaking to the consultant body, but stated that they were starting to have this conversation with them now, and recognising the impact of removing the trainees. **Cataract and Surgical experience** Senior Management told the visit team that there had been a £500,000 investment in new operating theatres at King George Hospital since the last visit in 2013, providing increased operating capacity in ophthalmology. The visit team was told by trainees that whilst there were cataract lists on their timetables they had only not been able to attend them all, as many had been cancelled. One trainee stated that they had only been able to attend four cataract lists a since August 2015 and said that they had to go and find these lists. Trainees informed the visit team that they had heard that a lot of the routine cataract procedures had been transferred to other providers, such as the Care UK list, or the community based Nuffield list. There was a mismatch between the two to three surgical lists the consultants said the trainees were timetabled for weekly and the actual one to two lists per week being provided for the trainees. The trainees were sometimes in a position where they were looking for extra lists. The training lists were being moved to different consultant supervisors, and this had also impacted on the progression of surgical confidence and consistency of training. **Rota** Clinical and educational supervisors informed the visit team that they had discussed with the trainees the possibility of one of them managing the rota. They felt that if management wanted to change the rota they would then at least have to go through a doctor in order to do so. However the visit team was concerned that having a trainee at the face of a difficult relationship may not be the best option.	Ensure that the number of fellows within the department is not taking learning opportunities away from the trainees.	Mandatory Requirement
O1.4	**Induction** The visit team heard from the senior management team that they had introduced a new induction programme which included the Trust core principles. Trainees told the visit team that they felt the local departmental induction was excellent, and they said that the consultants could not have done much more to introduce them fully to the department. A trainee that had been at the Trust previously echoed this, stating that it was a more formal process that it was when they were at the Trust in the past. All trainees indicated that they were given a timetable on their first day, but stated that there had been numerous changes to this.	The Trust's induction programme should be reviewed in light of poor IT induction.	Mandatory Requirement

	Trainees felt that the Trust induction was less useful than the local one and reported that they spent a lot of time learning about things that were not relevant to their job roles, such as blood transfusions, but spent no time learning about adult or child safeguarding. They reported that induction to IT functions in the Trust was particularly poor; trainees had difficulty with requesting investigations and accessing results despite the induction. Educational and clinical supervisors stated that they had made changes to the local induction, indicating that trainees had the chance to provide input into the trainee handbook that they were provided with. A factual error was made in the handbook that needed correction as there was no service level agreement for on call emergencies out of hours with Whipps Cross Hospital or Moorfields Hospital. They stated that they had received feedback that the IT element of the Trust induction was not meeting the requirements of the trainees, and stated that they had fed this back.		
O1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** **Cataract Surgery** The visit team was told by the clinical tutor and educational lead that cataract surgery was delivered at both Queen's Hospital and King George Hospital. They reported that there were a high volume of cases and that the trainees should have exposure to a lot of cataract experience. The visit team heard that at Queen's Hospital cataract procedures were conducted on the sub-specialty lists and the more routine cases were completed at King George Hospital. They stated that there had been very large waiting lists for these in the past but that they were now running low on cases for them, leading to some lists being cancelled in the previous six weeks. They stated that they expected this shortage of cases to be a temporary problem; however they said that there was a community ophthalmology list which had taken some of the cases. The visit team was also told that the ISTC list operated by Care UK was receiving cataract referrals directly from opticians; however they stated that they had won the bid to take over this contract but that this decision was currently being challenged. They felt that as they had now committed to completing cataracts within six weeks of referral that they would have access to more cases into the department. The college tutor said that senior trainees usually undertook 100 cataracts in a six month period at Queen's Hospital; the senior trainee present for the visit had undertaken 30 cataracts so far, in the three month period from August until November. The divisional director informed the visit team that they would be happy to go ahead with fewer cataract cases on each list rather than cancelling them, if the trainees were not receiving relevant cataract experience. He indicated that if this occurred, the trainees would have the time to get the most out of their cataract training as the lists would be small. **Trainee Experience** Trainees informed the visit team that they received good sub-specialty experience, with trainees noting good experience in oculoplastics and glaucoma. However it was discovered that junior	Cataract lists have been cancelled recently, with cases reportedly going to the community and ISCT. There are concerns regarding trainees getting adequate numbers while this is happening. The Trust must ensure that all trainees get adequate surgical experience with a minimum of two regular lists per week with one or at most two clinical supervisors so that surgical training is delivered in a consistent fashion and meaningful assessment of progress can be made by consultant trainers. The trainees' timetables should be appropriately matched to their <u>educational</u> needs i.e. they should not be expected to continue with clinics	Mandatory Requirement Mandatory Requirement

	trainees were only seeing one or two patients in the AMD clinic and were then having to do injections for the remainder of the clinic. Educational and clinical supervisors indicated that a trainee had recently had their timetable changed in order to ensure they were able to attain relevant experience in clinics. Trainees indicated that they had adequate supervision and felt supported when they were in casualty and stated that they did not see too many patients per shift. There was an example of good practice as a consultant supported all but one of the casualty sessions, and it was evident at the visit that a lot of work had been undertaken by the ophthalmic casualty consultants to achieve this. They told the visit team that the ward referrals were not in addition to their booked patients, and if they did ever need to go and see patients there was time to do so either at lunch or when the clinic finished.	where there is no further curriculum-based value, or additional skill to be gained. In particular trainees must not be expected to repeatedly perform routine intravitreal injections on the medical retinal firm. Trainees should have the opportunity to see and assess new and follow up patients and develop skills in diagnosis and formulate management plans for retinal patients. The educational lead and relevant clinical supervisor to ensure trainees are receiving an educational experience in their clinics and they are not made to conduct injections for the majority of it.	
O1.6	**Protected time for learning and organised educational sessions** **Leadership Course** The visit team was informed by the educational and clinical supervisors that there was a leadership course provided by the Trust which the ophthalmology trainees had access to. They stated that as part of this course there was a project for them to complete, and that it included six half day contact sessions and included shadowing of people within the management structure. Two of the trainees within the department told the visit team that they were enrolled on this course, but stated that it had been postponed until early 2016. **Teaching** Educational and clinical supervisors told the visit team that for one week in four there were regional teaching sessions held at the Trust. They indicated that on these days there was a clinical governance session followed by teaching which was usually in the form of a lecture. In addition to this the visit team was told that there was medical retina teaching once a month in the form of a journal club. There was also casualty teaching on a Friday lunchtime every two weeks, however not all trainees were able to attend this due to operating at a different site. Trainees were pleased with the content of the regional teaching indicating that it was curriculum-based and that each week they covered one of their learning outcomes. Trainees stated that they had no difficulty in attending this teaching and that it was often based at the Royal Free Hospital. They reported there were feedback forms available to them on the day.	Ensure that there is a minimum of one hour a week local teaching available to the trainees in addition to the regional teaching. Local teaching should be scheduled for a time when all trainees can attend.	Mandatory Requirement
GMC Theme 2) Educational governance and leadership			
O2.1	**Impact of service design on learners**		

	The visit team was informed by the clinical lead and college tutor that the department had 43,000 outpatients and 8,000 eye casualties, and 4300 operations, of which 2,500 were cataracts. The visit team was told that there were 9.5 full time equivalent consultants within the department and two long term locums. Since the last visit in 2013, the visit team heard that there had been a 30% consultant turnover and they stated that the department was still in a state of flux as a result of this. However they stated that they had attracted very good consultants to the new posts and had found that there were a lot of previous trainees applying to work within the department. The clinical lead and college tutor felt that the department was moving forwards as a result of this. The visit team heard that the department could offer good sub-specialty training in cornea, squints, glaucoma and medical retina. They said one of the trainees had specifically come to the Trust for squint experience.		
O2.2	**Appropriate system for raising concerns about education and training within the organisation** **Local Faculty Groups** Trainees informed the visit team that there had been one local faculty group meeting since they started in August. They indicated that this had occurred after their clinical governance meeting, and that they were asked how training could be improved within the department. Trainees reported that they had brought up the issue of the unstable trainee timetable and stated that they felt the consultants had listened to them, and that there had been an improvement since then. Clinical and educational supervisors told the visit team that the local faculty groups were scheduled to occur four times a year. **Clinical Governance** Trainees told the visit team that they felt the clinical governance meetings were useful and that they were learning experiences, as they were able to develop the 'soft skills' which were important for learning about how a department was run.		
O2.3	**Organisation to ensure time in trainers' job plans** Educational and clinical supervisors informed the visit team that they had recently been given programmed activities (PAs) in their job plans for education. They stated that there were two within the department for the educational supervisor and the 'deputy' educational supervisor.		
O2.4	**Systems and processes to make sure learners have appropriate supervision** The visit team was told by trainees that they were well supported by their consultants, however they indicated that there was a lot of politics between consultants and management. Trainees indicated that they had rarely been directly impacted by this, but there was one occasion mentioned when a trainee was pulled out of a clinic for what was felt to be political reasons.		

O2.5	**Organisation to ensure access to a named educational supervisor** Trainees told the visit team that they had all had meetings with their educational supervisor and they all felt that they had agreed realistic learning agreements in place. Trainees indicated that they felt that they would be able to achieve what was set out in their learning agreements, but stated that if the timetables were fixed then it would be a lot easier. The two educational supervisors were sharing trainee meetings. Educational and supervisors reported that they had an educational element to their appraisal. They indicated that the introduction of the second 'deputy' educational supervisor into the team had been beneficial.	There is a need to make the 'deputy' educational supervisor a full educational supervisor in order to improve education within the department. There should only be one named educational supervisor for each trainee on a placement, unless there are exceptional circumstances where a trainee has to be transferred to another supervisor mid-placement. All educational supervisor meetings should be with their named supervisor, to ensure consistency.	Amber Mandatory Requirement
O2.6	**Systems and processes to identify, support and manage learners when there are concerns** The visit team heard that there was a trainee in difficulty within the department recently; however it was apparent that management of this trainee was sub-optimal. Completion of an Educational Supervisor report and handover of information to the educational supervisor at the receiving unit when the trainee changed placement did not occur. The visit team suggested that it was important for the Trust to develop structures within the department to be able to effectively manage these trainees.	A review of educational leadership in the department is recommended. Effective processes for managing trainees in difficulty must be embedded and evidence of these processes provided. The confidentiality of Educational Supervisor reports to be maintained by all educational supervisors. Educational supervisors should attend Annual Reviews of Competency Progression (ARCPs) and understand the outcomes from ARCPs, attend HEE London courses on managing trainees in difficulty and be aware of the processes of referral to occupational health, and what can be provided by the Professional Support Unit at London HEE. Educational supervisors must provide full documentation for all trainees by way of regular Educational Supervisor reports and the development of tailored professional development plans for all trainees. All relevant information should be communicated to the next educational supervisor, to the training programme directors and where appropriate to the Head of School.	Amber Mandatory Requirement

GMC Theme 3) Supporting learners			
O3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The visit team was informed by educational and clinical supervisors that there had been an issue with perceived bullying and undermining in the past, however they stated that they had conversations with both the supervising consultant and the trainee and it was felt to be a case of misunderstanding. Trainees reported to the visit team that there had been no issues with regard to bullying and undermining since they started at the Trust.		
GMC Theme 4) Supporting educators			
O4.1	**Access to appropriately funded resources to meet the requirements of the training programme or curriculum** **Access to educational resources** Clinical and educational supervisors informed the trainees that they had surveyed the trainees and as a result had bought more ophthalmic text books and journals. They said that they bought these journals based on what the trainees indicated that they wanted and needed.		
GMC Theme 5) Developing and implementing curricula and assessments			
O5.1	**Appropriate balance between providing services and accessing educational and training opportunities** Trainees reported to the visit team that the consultants were good at ensuring that they were not working outside of their level of competency. However they indicated that the understaffing meant that they were having to complete their own visions in clinics, but stated that the consultants also had to do this.		

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:	*Miss Fiona O'Sullivan*
Date:	*22 December 2015*