NHS
Health Education England

Developing people for health and healthcare

Quality and Regulation Team (London and South East)

St George's University Hospitals NHS Foundation Trust

Interventional Radiology & Vascular Surgery

Conversation of Concern

Quality Visit Report

23 November 2015

Final Report

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Visit Details	
Trust	St George's University Hospitals NHS Foundation Trust
Date of visit	23 November 2015
Background to visit	Health Education England South London (HEE SL) had been in conversation with senior members of the Trust with regards to the quality of training provided to, and safety of, postgraduate medical trainees training in interventional radiology and vascular surgery at the Trust. It had been alleged that: • Consultant vascular surgeons and vascular surgery trainees at the Trust were failing to follow basic radiation protection requirements which placed themselves, other staff and patients at significant personal risk and potentially breached national requirements (IR(ME)R). • Patients were being subjected to unnecessary general anaesthesia, and were potentially being subjected to larger numbers of radiological procedures (i.e. the number of images generated per procedure was deemed excessive) and thus increased radiation dose. • Both vascular surgery and interventional radiology trainees were working within an environment where inappropriate behaviours were presented, specifically in vascular theatre, on the vascular ward and also in certain imaging settings where vascular patients were being imaged. • There had been a number of incidents where behaviours presented by both trainees, and consultants, represented serious examples of bullying behaviour. • Appropriate clinical challenge and joint decision making in regards to patient care was not regularly possible. • There had been a limited number of peripheral angioplasty, and an overall limited number of peripheral arterial cases being performed by interventional radiologists at the Trust.
Visit summary and outcomes	The visit team met with three interventional radiology (IR) trainees, 11 core clinical radiology trainees, 17 higher diagnostic radiology trainees, three superintendent radiographers, 11 senior radiographers, one vascular trainee, two national institute for health clinical lecturers, one out of programme research vascular trainee and one out of training experience vascular trainee. The visit team heard that both department's training environment were supportive to their own trainees. However, there had been a significant change in clinical practice within the past few months that was perceived as an imposed change by the interventional radiology department. In conjunction with this change there had been a reduction in collaboration and a significant reduction in the number of vascular interventional cases performed by the IR department. As a consequence the IR department did not provide a good environment to undertake training in vascular procedures. The current situation presented a potentially significant clinical and patient safety risk, with trainees practicing in a potentially unsafe environment. Trainees reported that procedures were carried out without appropriate radiation protection, and radiographers reported significant concerns in regards to poor radiation protection practice with likely increased radiation exposure to patients and operators. The impact of the current learning environment presented an unsustainable situation. The perceived culture of intimidation, bullying and harassment placed trainees in an untenable situation both personally and professionally. Further this presented a risk to patients through inadequate levels of joint working and collaboration. Trainees were faced with inadequate opportunities to access experiences that will meet the requirements of the curriculum, particularly in interventional radiology. If new trainees rotate in to interventional radiology the likelihood of their failing to progress in their training was significant. This was not an

	acceptable position to maintain once identified across the training programme. The Trust had been aware of these concerns, but had been unable to identify a sustainable solution. The current situation presents an unacceptable risk to the well-being of the trainees in these departments, and to the quality of education and training. Given the concerns raised at the visit to the Trust it was decided on the 23 November 2015 that Health Education England South London had no option but to suspend all training in the interventional radiology and vascular surgery posts at the Trust as soon as practically possible.

Visit team			
Lead Visitor	*Dr Andrew Frankel, Postgraduate Dean, Health Education South London*	**Quality and Regulation Representative**	*Ian Bateman, Head of Quality and Regulation (London and South East)*
GMC Representative	*Jessica Lichtenstein, Head of Quality Assurance, General Medical Council*	**GMC Enhanced Monitoring Associate**	*Professor Gillian Needham, Enhanced Monitoring Associate, General Medical Council*
Head of School	*Dr Jane Young, Head of London Specialty School of Radiology*	**Head of School**	*Professor Nigel Standfield, Head of London Specialty School of Surgery*
Visit Officer	*Victoria Farrimond, 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			
1.1	**Patient safety** The radiographers reported that they had witnessed peripheral vascular cases performed utilising non-standard techniques (compared to their interventional radiology (IR) colleagues) which seemed to lead to difficulties. The radiographers commented that the vascular surgery team were undertaking cases with sub-optimal equipment compared to that available in the radiology department. The vascular surgery theatre imaging intensifier was in a fixed position with a small field of view resulting in an increased scattered radiation dose. A larger number of radiographs needed to be taken to cover the vascular tree, of poorer quality and ultimately likely that patients were exposed to an increased dose of radiation. The radiographers reported that the vascular surgeons (at their request) had full control of the image intensifier during surgery, acting as primary operator preventing the radiographer(practitioner) from minimising the screening exposures	The Trust is to provide a report of an investigation into the radiation safety and health and safety issues highlighted in this report. The report should evidence the current practice within the operating theatres and compliance with IR99 and IRMER regulations. Within the report include the following: • Review of training of all groups of staff in radiation protection, evidence of staff complying with radiation safety, monitoring, results of monitoring and	Mandatory Requirement

	The radiographers reported that their attempts to advise or reduce patient and operator radiation exposure were frequently ignored. The vascular surgery trainees stated that the hybrid operating theatre was currently in construction and that this has enhanced radiation protection equipment (such as lead glass shields). The radiographers commented that the quality of imaging in the vascular surgery theatres was poor and that they had witnessed the surgeons struggling to obtain the correct imaging. The visit team heard that up to five guide wires could be used during a case, reflecting difficulties experienced by the operator. There was however no way of checking this as the equipment came from the vascular surgery budget. The radiographers stated that they recorded the dose of radiation a patient was exposed to. The visit team heard that there had been sufficient peripheral intervention cases carried out within vascular surgery theatres to look at the dose averages, audit and compared with interventional radiology. The average was stated to be double that recorded for cases in interventional radiology and this audit had been sent to the radiation protection advisor at the Trust. The radiographers reported that there had been insufficient radiation protection equipment (lead skirt around the table, lead glass shields to protect the face) in the vascular theatres for the change in case load which risked increased exposure to the surgeons and other personnel in theatres. The radiographers were not aware of any prior risk assessment for the change in practice. The vascular surgery trainees stated that they had been made very aware of radiation protection procedures by their trainers as they did not want to cause harm to the patient or themselves. The radiographers commented that since September 2015 when all peripheral arterial cases moved to the vascular theatre the number of amputations had increased. The radiology trainees expressed concerns regarding patient outcomes. The trainees cited examples of clinical situations where patient outcomes were considered sub-optimal as a result of patient mismanagement and lack of referral between the consultant groups/departments. The vascular surgery trainees reported that since October 2015, there had been an increase in the number of patients who had their operations cancelled due to radiographers being unavailable. On one occasion having initially been informed a radiographer was available a patient had been anaesthetised and then the radiographer informed the vascular team that no one was available. The visit team heard that vascular surgery team had wheeled a patient into the computed tomography (CT) scan room itself without prior discussion. On this occasion there was a trauma patient expected and this could have delayed that patient's care. After discussion with the radiology trainee the vascular trainee left with the patient but did explain they thought CT was	any reporting of concerns with the actions taken • Review and evidence the patient safety concerns regarding patient radiation dose, general anaesthesia frequency in both IR and vascular surgery and whether image quality is optimum for the investigations performed • Evidence risk assessment previous and current within vascular theatre relating to the procedures being performed and the personnel working in theatres The Trust is to review the investigations and feedback mechanisms for serious untoward incidents occurring within IR and VS within the last two years. The Trust is to produce a clear standard operating procedure that defines how IR and vascular surgery trainees are involved in MDT meetings relating to interventional procedures that they have been involved in.	Mandatory Requirement Mandatory Requirement

	expecting them. The diagnostic radiology trainees reported that the emergency department was under pressure and when patients were referred to the vascular surgery team they could be waiting to be seen for some time prior to imaging. This resulted in the emergency department breaching the four hour waiting rule. The radiographers reported that they had witnessed patients being treated in the theatre whom they believed should have been treated in the IR department. The vascular surgery trainees stated that if there was an unexpected complication and it was felt interventional radiology could help they would contact the department and there were specific consultants in the radiology department who vascular surgery still had good relationships with. The radiology trainees commented that no scans requested by the vascular surgery team had ever been refused as the patient comes first.		
1.2	**Serious incidents and professional duty of candour** The radiology trainees reported that the serious incident reporting system was robust. If there was a serious incident the department was incredibly supportive and the trainees received copies of the final report. The vascular surgery trainees reported that recently they had submitted datix incident forms when a radiographer was not available to provide support for post-procedure imaging. Another incident involved a superintendent radiographer informing the surgeons that the elective theatre list was not staffed by a radiographer as they had used their radiographer sessions for that week. The vascular trainees reported that the department was committed to transparency and good governance.		
1.3	**Rotas** The diagnostic trainees commented that there was an on-call policy for dealing with CT scans on non-emergency patients at a weekend, which the vascular surgery trainees were aware of. On a Saturday the in-patient list was undertaken and on a Sunday only emergency work was carried out. The trainees stated that there were incidences when the vascular team demanded their patients have a CT before being discharged on Sunday which was not how the policy worked.	Ensure that all staff working weekends are aware of the on-call policy for non-urgent cases.	Mandatory Requirement
1.4	**Handover** The radiology trainees reported that the handover usually worked well as it was a formal handover process.		
GMC Theme 2) Educational governance and leadership			
2.1	**Appropriate system for raising concerns about education and training within the**		

	organisation The radiology trainees stated that they reported incidents involving the vascular team to their consultants. The radiology trainees commented that the consultants were supportive and encouraged the trainees to place clinical incidents in writing, which was then sent to the clinical director. This information was then sent to the vascular trainees' educational supervisor and the radiology trainees did not hear anything further. The visit team heard that many trainees did not report all incidents as they felt the Trust was not pro-active in dealing with the concerns raised.	Ensure that all staff are aware of the policy for reviewing complaints and the actions taken.	Mandatory Requirement
2.2	**Systems and processes to make sure learners have appropriate supervision** The diagnostic radiology trainees and vascular surgery trainees all commented that they had good supervision and support and they knew who to contact through the structured process that was shared with the trainees when they started at the Trust. The visit team heard that the radiology department circulated information on who trainees could contact to check CT scan information if consultants were not immediately available.		
GMC Theme 3) Supporting learners			
3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The radiology trainees reported that they all wear radiation badges, which were changed every month. The radiology trainees commented that they would be informed if they had a high level of exposure. The radiation badge records were accessible to the trainees. The vascular surgery trainees stated that they all wear radiation badges which are checked every three months. The trainees were unaware if anyone had ever been informed of a high level of exposure. The October 2015 starters still had not received their radiation badges. The vascular surgery trainees reported that they were trained in radiation protection and the Trust was the only one they had worked at that asked if they would like lead glasses when they started. The vascular surgery trainees were able to participate in radiation safety courses at the Trust.	Ensure that all staff are aware of the radiation protection policy and that staff are informed if there is a high level of exposure. The Trust is to clarify the radiation protection equipment provided to staff within IR and vascular surgery and whether equipment has been issued to individuals and on what basis.	Mandatory Requirement Mandatory Requirement
3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The diagnostic radiology trainees reported that since they started there had been a strained relationship with the vascular surgery team. The trainees commented that they could be abrupt and discourteous when placing requests often demanding work to be undertaken. The visit team heard that when placing requests the vascular surgery trainees sometimes commented that the consultant wanted the scan carried out "we will tell you why later". For the		

	radiology trainees working within the trauma scanner it could be hard to prioritise patients when they did not know all the patient information. A diagnostic radiology trainee commented that when he was scrubbing into interventional radiology he took a call from a vascular trainee to book a patient into the diary for a procedure. When the trainee explained he was scrubbing and would take their details and call back later the vascular trainee commented that if the trainee did not provide them with a date and time there would be "big trouble". The radiology trainee reported that if they were not already busy they would have taken down the details, checked the diary and booked the patient in. The visit team heard that the vascular surgery team regularly requested CT aorta scans whilst providing little information to the radiology team. When the radiology team asked for further information the vascular team said they did not need to know this and they will look at the scan results without need for the radiologists report. The diagnostic radiology trainees commented that when they had called the vascular surgery team to inform them of the outcomes of scans they could be abrupt and hang up the phone. A number of diagnostic radiology trainees indicated that they had been belittled and humiliated in front of the trauma team by vascular surgery trainees. The visit team heard that trainees that were interested in interventional radiology enquired how much time they would get working on vascular surgery cases. The radiology trainees commented that the vascular surgery team were not welcoming and regularly made unfavourable comments about radiologists and belittled the reports and recommendations. The radiology trainees stated they were expected to carry our post-procedure checks on patients who had peripheral IR procedure on the wards. When the trainees had proceeded to document that they had seen the patient the vascular surgery consultants had queried why they were there, usually in front of other staff which could be embarrassing for the trainee. The visit team heard that there had been an occasion when an additional case was added to the radiology list where there were discrepancies between the duplex scan result and request form. On this occasion when the interventional radiology trainee contacted the vascular trainee to enquire if the symptoms were new, the vascular surgery higher trainee stated that this case had been discussed several times and to get on with the case. When the trainee could still not work out the information from notes they went up to the ward to see the patient. When they arrived at the ward the consultant, chief nurse and vascular trainee were at the desk so the trainee showed them the duplex form and enquired about the information. The vascular consultant then told the trainee to leave the ward for swearing and that they had clearly "come to pick a fight". The trainee later found out the vascular consultant had made allegations that they were aggressive towards the vascular surgery team. The visit team heard that over three quarters of the radiology trainees reported that they had been bullied and humiliated by the vascular surgery team. Many of the trainees had not reported all occurrences as it happened so often and they had lost faith in the system.	The Trust is to identity actions to be taken to ensure that bullying and undermining behaviours are not displayed in relation to any staff or students working within vascular surgery and IR.	Mandatory Requirement

	The radiographers commented that they regularly overheard comments within the vascular theatre which were inappropriate and unprofessional. The vascular surgery trainees reported that there had been deterioration in relations between two departments, which made communication difficult. The trainees commented that they did not have a problem contacting radiology and they never received an obstructive response. The vascular surgery trainees commented that a lot of the issues between the departments were at consultant level and did not involve the vascular surgery trainees. The visit team heard that the vascular surgery trainees had been told not to go to the radiology department alone, to prevent unsubstantiated allegations being made against them.		
GMC Theme 5) Developing and implementing curricula and assessments			
5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The vascular surgery trainees stated that the training at the Trust was of a high quality and this was reflected by the highly supervised training provided by the consultants. The trainees commented that they had not seen such consultant engagement with the national vascular surgery registry before. The visit team heard that due to the lack of exposure to training opportunities the radiology trainees (particularly the IR trainees) at the Trust may not be able to achieve the outcomes as set out in the curriculum.		
5.2	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** The interventional radiology trainees commented that they chose to come to the Trust due to the strength of the department and the international reputation of consultants that work within it. The initial teaching and exposure to cases were good. There were a couple of cases a day then in September 2015 there was a sudden shift in activity. The trainees had previously had opportunities for training in up to five peripheral vascular cases per week. The example was given of having scheduled a patient and called for them to be sent to IR they found out that the procedure had already been carried out in the vascular surgery theatre. The trainees went from carrying out multiple cases to one a week, this significantly impacted on the training opportunities. The interventional radiology trainees reported that there was no prior communication regarding the shift of workload from interventional radiology to vascular surgery. The interventional radiology trainees stated that the department carried out a lot of peripheral endovascular procedures and trainees carried out around ten procedures a week then following the shift of workload this dropped significantly.	The Trust must provide details on how the change in service delivery and theatre cases was planned. The Trust should evidence how IR service impact and the impact on training of vascular surgery and IR trainees was evaluated.	Mandatory Requirement

	The interventional radiology trainees commented that they did not have access to endovascular aneurysm repair (EVARS). The interventional radiology trainees reported that they had not asked to go into vascular surgery theatres, however they got the impression they would not be able to do so. The vascular surgery trainees commented that the interventional radiology team were not routinely invited to vascular surgery theatre. The vascular surgery trainees stated that they received a full range of experience at the Trust and had completed a wide range of endovascular aneurysm repair, peripheral and intervention procedures. The vascular surgery trainees reported that they were receiving good endovascular, endovenous and peripheral vascular training with close consultant supervision. The visit team heard that some diagnostic radiology trainees had decided not to train in interventional radiology following their experience at the Trust.		

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 Andrew Frankel, Postgraduate Dean, Health Education South London*
Date:	*18 December 2015*