QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

King's College Hospital NHS Foundation Trust (Princess Royal University Hospital)

Paediatrics

Urgent Concern Review – Focus Group

Quality Review report

Date: 15 June 2016

Final Report

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Quality Review details

Background to review	The urgent concern review focus group was arranged due to concerns raised at the Trust-wide Review on 24 May 2016 and an Immediate Mandatory Requirement was issued in relation to a potential serious patient safety concern posed by foundation trainees in paediatrics being unsupervised at high risk deliveries. Health Education England South London had then been made aware, by trainees, of other concerns, namely: • A serious incident involving two trainees that was not reported to Health Education England in October 2015 • Trainees' concerns regarding the lack of supervision available to trainees • Alleged bullying and undermining behaviour by consultants • Reported gaps in rotas • Reported concerns in regard to handover.
Specialties / grades reviewed	Foundation, general practice, core and higher trainees within paediatrics.
Number of trainees and trainers from each specialty	The visit team met with one foundation trainee, two general practice trainees, two ST1 paediatric trainees and three ST4 paediatric trainees.
Review summary and outcomes	The visit team found the following areas which required improvement. Junior doctor rotas • Immediate steps should be taken to ensure that the junior doctor rotas across the whole paediatric service are EWTD compliant. Trainees reported that whilst locums can be identified to work in the department, there are a number of shifts that they are not allowed to get cover for - this was particularly relevant to the twilight shift which they felt was a clinically important shift. The GPVTS trainees must be allowed to attend the Wednesday half day release sessions by including this in their rotas. Handover • Immediate steps should be taken to provide senior clinical oversight for both the morning and evening handover sessions. This is firstly to ensure it takes place in a timely way and the principles of effective handover are adhered to, but also to ensure that feedback is delivered in a developmental and formative way, conducive to learning and reflection. Trainees reported a consistently adversarial, belittling and undermining culture that was present during handover, especially in the mornings. In addition, handover frequently over runs, which then means the morning teaching session, is shortened. Induction • Immediate steps should be taken to ensure that a robust induction and training programme is put in place, and agreed with HEE, for new trainees joining the paediatric service at PRUH. The programmes need to be tailored to the trainees' needs e.g. GPVTS and F2 trainees are likely to have different requirements to Paediatric trainees. The visit team heard numerous examples of Foundation, General Practice and very junior paediatric trainees were being expected to attend complex deliveries, and carry out baby checks and other associated tasks, without appropriate

induction or training. This is not a pertinent matter now given that the current trainees have taught one another to do these tasks – however, this represents a serious patient safety issue for new trainees rotating into the department in the future.

Educational Supervision

- A review of educational supervision practice must be undertaken. Trainers need to be supported to understand their obligations to provide effective educational supervision to trainees. All trainers need to be provided with appropriate time in their job plan to carry out their educational role and effective monitoring mechanisms to ensure effective educational supervision need to be put in place. As a minimum it is expected that each trainee will have a formal meeting with their Educational Supervisor three times in a placement and the first meeting (induction meeting) must take place within a month of the post starting. In addition, there should be a proactive approach to supporting trainees to complete their supervised learning events (SLE).
- Immediate steps should be taken to ensure that an appropriate consultant-led educational programme is put in place for all trainees. These sessions should often (but not exclusively) be consultant delivered, should be protected and bleep free, and should be delivered in a manner which is conducive with good educational practice.
- Appropriate steps must be taken to provide educational and pastoral support to trainees in the paediatric department. Senior trainees are currently responsible for the delivery of key educational interventions and tasks such as designing and managing buddying systems, rotas, training and educational advice. These tasks are either inappropriate for trainees to be conducting in totality, or inappropriate for them to be conducting without support and oversight.

Clinical Supervision

- Whilst clinical supervision was available to trainees when requested, there is a need to review the manner in which a consultant led service is delivered in the department. There is a need for all the consultants to be visible in the clinical areas and accessible (not just two who were named by trainees as being ready and willing to get involved clinically) and for them to take the lead in intervening in clinical cases where their input is required. In addition, it would be expected of them to proactively check on, recalibrate and review the workload of trainees throughout the day time. Reports of a trainee carrying three bleeps (Emergency Department, Neonates and General paediatrics) during a busy day shift are not safe or sustainable. Trainees reported times when they had to make split second decisions about which bleep to respond to as the consultants were not consistently present on the 'shop floor'.

SI reporting

- Immediate steps must be taken to ensure that all clinical and serious incidents are a) reported via the Trust incident reporting system, b) reported to HEE in line with Responsible Officer Guidelines, c) dealt with from a pastoral perspective in line with expected practice. Expected practice is that trainees are provided with pastoral support, are debriefed as soon as is practicable, and certainly within hours/days of the incident. Trainees reported no support or opportunity to debrief having witnessed their first ever child death, or first death as the registrar in charge of the shift – and how terrible that made them feel.

Trust leadership

- The Trust is recommended to consider the immediate implementation of senior clinical oversight for the paediatric service at PRUH whilst steps are taken to improve the current situation.

Quality Review Team			
Lead Visitor	Dr Camilla Kingdon, Head of London Specialty School of Paediatrics	**HEE Representative**	Ian Bateman, Head of Quality and Regulation Team, Health Education England London and South East
Trust Liaison Dean	Dr Helen Massil, Trust Liaison Dean, Health Education England South London	**GMC Representative**	Alex Blohm, Education and Quality Assurance Programme Manager, General Medical Council
Scribe	Vicky Farrimond, Learning Environment Quality Coordinator, Health Education England London and South East		

Findings

GMC Theme 1) Learning environment and culture

Standards

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Ref	Findings	Action required? Requirement Reference Number
P1.1	**Patient safety** The trainees reported that when the rotation started a foundation year two (F2) trainee who had never worked within paediatrics was on nights with a locum higher trainee. The trainees deemed this to be unsafe as the F2 could not assist with deliveries, cannulas, heel pricks or other practical procedures, leaving the locum middle grade to effectively man the entire service. The visit team heard that the core paediatric trainees were provided with new-born life support (NLS) training by the School of Paediatrics prior to starting within the department however; this was not offered to the general practice (GP) trainees. GP trainees reported trying to access a NLS course themselves however as the rota was only sent one week prior to starting they were unable to access time off for the course. The visit team heard that in the past three months there had been several occurrences when a high risk delivery and retrieval in ED took place at the same time. The visit team heard that the core trainees were not fully confident with high risk deliveries and should not be attending the delivery of a baby at 32 to 34 weeks as they were not familiar with pre-term resuscitation. This meant that all these deliveries needed the higher trainee present too – even if they were also simultaneously needed in ED.	

P1.2	**Serious incidents and professional duty of candour** The visit team was informed that trainees were encouraged to submit Datix reports. Nonetheless the trainees did not receive any feedback from Datix reports and had no local pastoral support following serious incidents. The visit team heard that trainees would not be made aware of how an incident investigation was progressing and that trainees would be asked via email to submit a statement regarding the incident. The trainees commented that they did not feel confident discussing incidents with their consultants as the consultants tended to talk to each other regarding the incident. Trainees did not feel supported to approach them to further discuss what had taken place. The trainees reported that the nurses would be de-briefed following incidents. The trainees stated that they supported each other following incidents.	Yes, see P1.2 below
P1.3	**Responsibilities for patient care appropriate for stage of education and training** The GP and foundation trainees reported that not all of them had had exposure to paediatrics prior to starting at the Trust. The trainees reported that when they started on postnatal ward, if the workload permitted, the most senior higher trainee showed the trainees how to complete new-born examinations. The trainees reported that they watched how to carry out a new-born examination and then the higher trainee observed them undertaking this before they were alone on the ward. If however it was very busy, this did not take place. One F2 trainee described not knowing how to complete a new-born examination and feeling clearly out of their depth. It wasn't until the next day that a more senior paediatric trainee was able to help them and provide suitable support. The visit team heard this could easily happen to any new foundation or GP trainee as there was little induction provided on the roles they would be required to undertake. The visit team heard that the consultants seemed to have a lack of awareness of the issues regarding the competencies of GP and foundation trainees whom many had never worked within paediatrics beforehand. The visit team heard that when the trainees asked consultants for support they would assist the trainees.	Yes, see P1.3 below
P1.4	**Rotas** The trainees commented that staffing in the department had improved since March 2016. The visit team heard that before this the department would not know which core trainee would arrive each day. The visit team heard that the trainees had attempted to have their rolling rota monitored as they did not think it was European Working Time Directive (EWTD) compliant. The visit team was informed that there were five higher trainees within the department, two were full time, one was a Trust grade equivalent who did not work nights, one community trainee who covered nights and weekends and two less than full time trainees working at 70% and 80% respectively. The higher trainees were meant to be on a one in seven rota. The trainees commented that they did not receive their rota with sufficient advance notice. The less than full time trainees informed the visit team that the rota had changed a few weeks after they started at the Trust. The rota had improved since the trainees took over the running of the rota from the consultant eight weeks ago. The trainees now directly approached the staffing coordinator with a list of locum staff required for each week. The trainees commented that they were rarely asked to cover locum shifts. The visit team was informed that the rota gaps were being filled more regularly with locums which was improving the staffing issues. The visit team heard that the department was unable to put out short shifts to locums such as the twilight shift so the only person who could work this shift was the Trust grade equivalent. The trainees reported that some mornings they would be asked to cover the night shift if there were	Yes, see P1.4 below

	rota gaps. Once a trainee had been asked to go home at 4pm in order to return to do the night shift. The visit team was informed that the weekday staffing within the department should include three higher trainees to cover the special care baby unit (SCBU), paediatric ward, emergency department (ED) and clinics. The core trainees covered the SCBU, postnatal ward, paediatric ward and long-day cover. The foundation year one (F1) was supernumery. The trainees reported that there was rarely a higher trainee to cover the ED and this resulted in the clinics being cancelled or the higher trainee covering the ward would also cover ED. The visit team heard that there had been occasions when there would be only one higher trainee in the department. The visit team heard that there had been instances when there would be only one core trainee in the department throughout the day and they would be expected to cover the wards, ED and carry the delivery bleep. The trainees reported that 8.30am to 5pm the workload was busy however could be managed. From 5pm to 9pm when the rota reduced staffing to one higher trainee and two core trainees this workload became intense and unmanageable. The visit team heard that the rota at night consisted of one higher trainee and one core trainee; the trainees felt that this was an unsafe rota. The higher trainees reported that they would often be called to three different areas and they would have to make a rapid assessment of which patient was the priority. The trainees stated that the consultant rota was short staffed and due to this they do try to help and alleviate some of the workload for consultants.	
P1.5	**Induction** The visit team heard that the trainees received a full day of Trust induction and the following day had their departmental induction. The GP trainees reported that they had a two hour local induction session on the structure of the department and they were shown the resuscitation equipment. The trainees were shown the resuscitation equipment but did not have sufficient support to ensure they understood how to use the equipment confidently to be able to attend deliveries. The trainees reported that they had tried to create a sign-off period through a buddy system when new trainees start within the department however this had not been supported by the consultants. The trainees tried when possible to pair up a new trainee with a more experienced trainee to provide them with support and to assist them in building up their competencies and confidence for their first few weeks within the department. The visit team was informed that the higher trainees had to support the GP trainees more at a weekend with deliveries and baby checks and tried their best to be there to support them however this was detrimental to the higher trainees' training. The trainees reported that the induction to the computer system could have been improved.	Yes, see P1.5 below
P1.6	**Handover** The visit team was informed that the handover commenced at 8.30am every morning except on Wednesday when handover started at 8am to allow time for departmental teaching. The visit team heard that the handover would regularly take one to two hours. The trainees reported that the handover was usually led by the higher trainees although this was sometimes led by the core trainees as they may have additional knowledge concerning the patients. The trainees commented that one or two consultants would be present at handover.	Yes, see P1.6 below

	The trainees reported that the handover currently seemed better and was taking less time. Although this was felt to be due to the ward being less busy. The Monday morning handover was extended to include time for higher trainee assessment although this was hampered due to the higher trainees not always having a sufficient overview of the patients. Due to the handover taking so long the trainees missed out on their departmental teaching as there would not be enough time for this to take place. The trainees reported that many of the questions raised in the handover could have been dealt with during the ward round. The trainees stated that the department had recently printed and laminated handover guidance and rules which was hoped to ensure handovers would run more to time. The trainees reported that dependent on the consultant at the handover they may learn about interesting patient cases at handover however this was a rare occurrence as there would often be conflict between the consultants regarding decision making and patient treatment plans. The trainees commented that the 4.30pm handover length depended on the consultant who was present at the handover. The trainees reported that there were always one or two consultants present.	
P1.7	**Protected time for learning and organised educational sessions** The visit team heard that the departmental teaching had improved over the past three weeks and this was aided as the department was not as busy. The visit team was informed that the senior higher trainee and a consultant arranged the departmental teaching although this was mainly led by the senior higher trainee. Prior to this there had been no organised departmental teaching. The departmental teaching took place on a Tuesday afternoon and Wednesday morning. The trainees reported that the Wednesday morning departmental teaching worked well as long as handover finished within a timely fashion. The trainees commented that the teaching was mainly led by the trainees as there were not many consultants who wished to talk about their sub-specialty interest. The visit team heard that consultants were present for teaching and would provide further explanations on cases if required. The visit team was informed that the GP trainees were unable to attend their mandatory GP teaching due to staffing within the department and their mandatory teaching was not on the rota.	Yes, see P1.7 below
P1.8	**Adequate time and resources to complete assessments required by the curriculum** The visit team heard that the GP trainees had focused their first two months on cannulating babies and dealing with emergencies and so had not had much opportunity to focus on their GP topics which they had to meet. The core trainees reported that they attended three clinics in nine weeks. The core trainees reported that they received 2.5 days of clinics in nine weeks these were general outpatient and prolonged jaundice clinics. The higher trainees reported that they attended three clinics in seven weeks. The higher trainee clinics were removed from the rota from June 2016 as there was not enough staff to cover these clinics. The clinics were now provided ad-hoc when there were three higher trainees on the rota. The visit team heard that even then the clinic could be cancelled due to annual leave or sick leave. The trainees commented that the clinics were always supervised by a consultant. The visit team heard that the rapid access clinics had a four week waiting list and these clinics were ad-hoc due to staffing issues.	

	The trainees commented that when they attended clinics the quality of education and training was dependent on the supervising consultant. The trainees reported good experiences where patients were reviewed prior to the clinic and at the end of clinic which enabled case based discussions. The visit team was informed that in the last month it had been easier for trainees to have workplace based assessments (WPBAs) signed off. Previously, trainees had to chase consultants to complete and sign-off on their WPBAs.	Yes, see P1.10 below
P1.9	**Access to simulation-based training opportunities** The visit team heard that the ED consultant organised simulation training on a Tuesday afternoon once a month which the trainees found really useful. The trainees reported that the teaching the day prior to the visit was the only time the trainees had had their bleeps taken from them for teaching. The trainees reported that due to the rota and workload usually only half of the trainees were able to attend.	
P1.10	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** The trainees reported that for many of them it took them three months to have their initial meeting with their educational supervisor. The trainees commented that they had to chase their educational supervisor to get this meeting in the calendar as the educational supervisor did not approach them.	Yes, see P1.10 below
GMC Theme 2) Educational governance and leadership		
Standards **S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.** **S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.** **S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.**		
P2.1	**Impact of service design on learners** The visit team heard that the trainees were unaware of the Trust-wide Review to the Trust on 24 May 2016. The visit team heard that the named lead for their education and training was the college tutor however the trainees reported that the person who they would approach regarding their education and training was the senior higher trainee. The trainees commented that the nurses and midwives provided the trainees with great support. The visit team heard they provided the trainees with pastoral support, feedback on their patients and activity and also gave the trainees positive feedback. The trainees also report that the ED consultant they regularly worked alongside was incredibly supportive.	Yes, see P2.1 below
P2.2	**Appropriate system for raising concerns about education and training within the organisation** The visit team heard that there was no forum or meeting in which the trainees and consultants came together to discuss education and training. The trainees reported that once a month on a Tuesday afternoon there was a	

	consultant meeting.	
GMC Theme 3) Supporting learners		
Standards **S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.**		
P3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The visit team heard that there was little pastoral support offered to trainees. The trainees commented that they had not had any pastoral support following incidents such as the death of a patient. The trainees reported that they found it hard following an incident especially if it was their first patient death and they struggled to discuss this. The visit team heard that the trainees would not be debriefed following an incident with a patient they were treating and the trainees commented this could make them question if they had missed a diagnosis. The trainees reported that they supported each other following incidents or when they required pastoral support.	Yes, see P3.1 below
P3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees raised concerns regarding the behaviour of consultants within the handover. The visit team heard that trainees would be regularly interrupted within their handover and have their treatment of patients criticised. The trainees reported that this was a common occurrence that they had become accustomed too. The trainees reported that following working a night-shift with little chance for break they dreaded attending handover as they knew the feedback would be negative and would end their shift with them feeling low and unsupported. The trainees stated that when they asked for feedback on their performance at handover it would usually always be negative there was no support, encouragement or positive feedback provided. The visit team heard that some trainees had been told to "toughen up as this was how it was on a night-shift". The trainees reported that they had to support and comfort each other following handover as some of the comments would upset trainees and they would go home and then worry about what was said and not rest. The visit team was informed that the culture was ingrained within the department and it would take more than ensuring the rota was fully staffed to change the behaviour trainees were exposed too.	Yes, see P3.2 below

Mandatory Requirements

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Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
P1.2	The Trust is to ensure that all clinical and serious incidents are reported via the Trust's incident reporting system, reported to HEE in line with Responsible Officer Guidelines and dealt with from a pastoral perspective in line with expected practice. The Trust is required to ensure that all trainees are actively encouraged to report all clinical and serious incidents.	The Trust is required to review all clinical and serious incidents reported that involve trainees and ensure that these are reported to HEE. The Trust should ensure that all trainees are provided appropriate pastoral support. This should also be monitored through the LFG and minutes submitted.	R1.1, R1.2, R1.3, R1.4
P1.3	The Trust is to review the manner in which the consultant led service is delivered in the department. Consultants should be visible and accessible to trainees.	The Trust is required to review the consultant rota to ensure there are always consultants present, visible and accessible to trainees. Where this is not possible the Trust should have a clear escalation policy and contact numbers of the on-call consultants. This should also be monitored through the LFG and minutes submitted.	R1.6, R1.7, R1.8
P1.4	The Trust is to ensure that the trainees' rotas across the whole paediatric service are EWTD compliant. The rotas should also include foundation and GP trainee mandatory teaching sessions.	The Trust is required to review the trainees' rotas across the whole paediatric service. The Trust should carry out an out-of-hours monitoring exercise to ensure the rota is EWTD compliant. The rota review should ensure that all mandatory teaching for foundation and GP trainees is included within the rota and they are released to attend. This should also be monitored through the LFG and minutes submitted.	R1.12
P1.5	The Trust is to develop and implement a robust induction and training programme for new trainees joining the paediatric service at PRUH.	The Trust is required to develop an induction programme which is relevant to each trainee's needs at different stages of training. The Trust is to ensure that the induction takes place prior to any trainees starting within the department and is protected time. Please provide the induction agenda, programme, evidence of attendance and trainee feedback on the induction process.	R1.13, R5.9
P1.6	The Trust is to ensure that there is consultant presence at morning and evening handover.	The Trust is required to ensure consultant presence at morning and evening handover. This is to ensure handover takes place in	R1.14

		a timely fashion, principles of effective handover are adhered to and feedback is delivered in a developmental and formative way, conducive to learning and reflection. This should also be monitored through the LFG and minutes submitted.	
P1.7	The Trust is to develop and implement an educational programme with appropriate consultant-led teaching.	The Trust is required to develop an educational programme for trainees. These sessions should often (but not exclusively) be consultant-led. These sessions should be bleep free and delivered to meet each trainee's needs at different stages of training. This should also be monitored through the LFG and minutes submitted.	R1.16,
P1.10	The Trust is to review the educational supervision provided to the trainees. This is to ensure that trainers have sufficient time within their job plan to carry out educational activity.	The Trust is required to review and ensure that educational supervisors have adequate time within their job plan to carry out their educational role and effective monitoring mechanisms need to be put in place to ensure effective educational supervision.	R1.21
P2.1	The Trust is to consider the immediate implementation of senior clinical oversight for the paediatric service at PRUH.	The Trust is required to notify HEE who is in charge of the senior clinical oversight for the paediatric service at PRUH.	R2.1, R2.2
P3.1	The Trust is to ensure that all trainees within paediatrics receive appropriate educational and pastoral support.	The Trust is required to ensure that appropriate steps are taken to provide educational and pastoral support. These could be areas such as educational interventions and takes such as designing and managing buddying systems, rotas, training and educational advice.	R3.2
P3.2	The Trust must ensure that bullying and undermining behaviour ceases as it is not conducive to a supportive learning environment and is not in keeping with the GMC's standards of good medical care and professional behaviours.	The Trust is required to provide evidence of an investigation into this type of behaviour (especially within handover) and the steps the Trust and department will take to ensure this does not happen. This should also be monitored through the LFG and minutes submitted.	R3.3

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
Health Education England to write to the Trust regarding paediatrics being placed within the GMC enhanced monitoring process.	Ian Bateman, Head of Quality and Regulation Team, HEE London and South East

Signed	
By the Lead Visitor on behalf of the Visiting Team:	Dr Camilla Kingdon, Head of London Specialty School of Paediatrics
Date:	14 July 2016