QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Homerton University Hospital NHS Foundation Trust

Obstetrics and Gynaecology

Risk-based Review (focus group)

Quality Review report

Date: 23 September 2016
Version (if required): Final Report

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Quality Review details

Background to review	Despite a risk-based review (on-site visit) to obstetrics and gynaecology (O&G) at Homerton University NHS Foundation Trust being undertaken in February 2015 it was felt that a further review was necessary in order to ensure there was a positive learning environment, suitable for trainees. The purpose of the risk-based review (focus group) was twofold. Firstly, the quality review team felt it necessary to explore the recent decline in the results of the General Medical Council National Training Survey (GMC NTS). This survey generated five red outliers for O&G specialty trainees, for 'access to educational resources', 'educational supervision', 'regional teaching', 'supportive environment' and 'work load'. Furthermore a pink outlier was also scored in 'induction'. This was the first year since 2012 that O&G had received any red outliers in the GMC NTS, but a pink outlier in induction had been received annually since 2013. Secondly, there were significant concerns about the number of maternal deaths in the department. The Care Quality Commission (CQC) conducted two inspections into the maternity and gynaecology services at Homerton University Hospital NHS Foundation Trust in lieu of these maternal deaths and the quality review team was keen to discover the effect these incidents had had on trainees.
Specialties / grades reviewed	The quality review team met with trainees in O&G, at the following grades: • Specialty training year 1 (ST1) • Specialty training year 2 (ST2) • Specialty training year 5 (ST5) • Specialty training year 6 (ST6)
Number of trainees and trainers from each specialty	The quality review team met with seven trainees. The quality review team met with seven trainers, including consultants in obstetrics and gynaecology. The quality review team also met with the interim college tutor, college tutor (currently on maternity leave), and the clinical lead for maternity, the clinical lead for risk and the associate medical director. At the feedback session, the review team also met with the Medical Director, the Director of Medical Education, the Head of Medical Education, the Chief Operating Officer, the Director of Organisational Transformation and Divisional Operations Director.
Review summary and outcomes	The quality review team thanked the Trust for accommodating the risk-based review (focus group). During the course of the review, the team was informed of a number of areas that were working well within O&G training at the Trust, such as: • The trainees reported that the multidisciplinary staff, in particular the midwives on the labour ward, were extremely supportive and that they worked well together as a cohesive team. • The trainees stated that the experience and knowledge gained on the labour ward was extremely valuable. • There was a strong and embedded risk management culture within the department and the clinical governance within the team had improved vastly. Trainees stated that they were made aware of all outcomes of serious incidents, maternal deaths and that they received regular feedback from Datix reports. • The trainees indicated that some consultants emailed personal feedback

	to them after shifts and that they often received constructive criticism, which they found to be extremely valuable. • All trainees stated they would recommend the O&G services at Homerton University Hospital NHS Foundation Trust to their friends and family. However the quality review team also uncovered two serious concerns during the review, as outlined below (one immediate mandatory requirement was issued to the Trust as a result): • The quality review team heard that higher trainees (at ST6 grade) were on occasion left alone to cover both the obstetrics and gynaecology services at night, when the rota required two higher trainees to be present (or that a consultant stepped in to fulfil the higher trainee role). • The Trust also had significant rota gaps within the middle-grade rota, which had a significant impact upon training and safe service provision. Furthermore, the quality review team also highlighted a number of areas for improvement, as follows: • The higher trainees stated that they were unable to complete their Advanced Training Skills Module (ATSM) training within early pregnancy and acute gynaecology. This was reportedly due to the trainer being on maternity leave at the time of the review. There was a significant concern that this would impact upon trainees' ability to complete their Annual Review of Competence Progression (ARCP) and achieve an outcome 1. • It was reported to the quality review team that there was insufficient locker space for trainees in which they could store valuable possessions. This had become a particular issue as there had been a series of thefts within the Trust. • The quality review team had concerns regarding the pastoral support received by the trainees, which could be improved. • It was reported that a higher trainee had ultimate responsibility for the rota, whereas the quality review team felt that a consultant should take executive ownership of the rota.

Educational overview and progress since last visit/review – summary of Trust presentation
Regarding the red and pink outliers from the 2016 GMC NTS, the trainers, college tutor and clinical leads were well aware of the issues regarding the trainees' 'workload'. The quality review team was informed that the Trust had a shortage of trainees in the O&G department and that only seven whole time equivalents (WTE) were covering a 16 person middle grade rota. This was due to a combination of reasons such as a number of people leaving and moving on from the department (for example for maternity leave or taking up consultant posts in other Trusts) and because there were a number of HEE trainees who worked less than full time without slot share partners. Despite having advertised repeatedly for clinical fellow posts to help fill these rota gaps, the Trust had had limited success in appointing new members of staff. The Trust reported they had created an action plan that was being followed in relation to the rota gaps, which the quality review team requested to see a copy of. Furthermore, the Trust recognised that the problems with the rota had a direct impact on higher trainees' protected time for education and training, however the Trust had tried to accommodate for this as much as possible. In attempt to ensure higher trainees had protected time, they had compromised and taken certain service activities out of the trainees' job descriptions, such as the postnatal ward round and decreased working at weekends. In relation to the pink outlier for 'induction', the college tutor stated they had recognised and attempted to address such issues. For example previously, some trainees were required to attend the departmental induction in the day and then work a night shift, which was now not the case. The Trust also reported that trainees were provided with the induction handbook approximately six weeks before the induction took place and that it was multi-professional. In relation to the maternal deaths that had previously occurred at the Trust, it was reported that this had led to a strong and well embedded risk management culture throughout the department, as the clinical governance of

O&G had come under much scrutiny. The Trust stated there were regular weekly meetings at a multidisciplinary level to discuss case management and share lessons learned from any reported incidents.

However, the Trust was unaware of any issues relating to 'educational supervision' and stated that all trainees had named supervisors who they met with regularly and that this issue had not been raised in the local faculty group.

Quality Review Team			
HEE Review Lead	Dr Sonji Clarke Deputy Head of the London Speciality School of Obstetrics and Gynaecology	**Lay Member**	Jayam Dalal Lay Representative
Trust Liaison Dean / County Dean	Dr Indranil Chakravorty Trust Liaison Dean, Health Education England North East London	**Scribe**	Elizabeth Dailly Learning Environment Quality Coordinator
Observer	Vicky Farrimond Learning Environment Quality Coordinator		

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
O&G1.1	**Patient safety** The quality review team heard that despite the trainees' rotas specifying that at night there should be two higher trainees covering the obstetrics and gynaecology (O&G) services, in some instances when the Trust was unable to secure locum cover, one trainee was left to cover both services. The trainees reported that often a consultant would step into the role of the second higher trainee on site, but on the occasions when this did not occur, they felt this was a significant patient safety issue.	Yes. See O&G1.1 below.
O&G1.2	**Serious incidents and professional duty of candour** The quality review team heard that in light of the CQC inspections and increased	

	scrutiny of the clinical governance systems in the department in the wake of the previous maternal deaths, there was now a strong and embedded risk management culture within the department. All trainees reported they felt encouraged to report incidents and some commented that the depth of investigations into such incidents in the department was superior to those in any other Trust they had previously worked in and that risk was taken extremely seriously. In relation to the most recent maternal death, in July 2016 one of the higher trainees who took part in the investigation stated the whole process was extremely well managed and that this was remarked upon by the external investigation panel, who gave positive feedback about the Trust's handling of the incident. The trainees all reported that they knew how to complete Datix forms and that they would be provided with feedback from Datix forms that would be investigated further.	
O&G1.3	**Appropriate level of clinical supervision** The quality review team was informed by the trainees that there was a good level of clinical supervision on the labour and postnatal ward during the day and that there was a consultant on site between the hours of 8.00am and 10.00pm. Furthermore, the trainees reported they felt extremely supported by the nursing and midwifery staff on the labour ward and by the Matron in particular.	
O&G1.4	**Rotas** The quality review team heard from all of the trainees that there were significant rota issues as at the time of the review due to there being only seven trainees covering a 16 person middle grade rota. The trainees reported that when there was a consultant absence, the consultant's clinics, ward rounds and caesarean section lists were not always covered or cancelled and that the higher trainees were expected to cover these services, which they found extremely difficult due to the rota gaps. The quality review team heard that the higher trainees could not attend their special interest sessions. The trainees were supposed to have two such sessions every week, but there was no flexibility or space on the rota to ensure they could attend these sessions. Furthermore, the trainees reported that the rota issues also meant they were unable to attend any regional teaching. In regard to the organisation of the rota, the quality review team was informed that this responsibility fell to a higher trainee and that the amount of work they were doing on the rota detracted from their education and training. The college tutor acknowledged this was a concern and that the Trust was currently in the process of recruiting an administrative member of staff to coordinate the rota. Furthermore, it was also indicated that no consultant had executive responsibility for the rota. The Trust informed the quality review team that they received a disproportionate allocation of less than full time trainees to the department in October 2015 and asked what could be done by Health Education England to prevent this in the future. The quality review team informed the Trust that they needed to raise this issue with the Training Programme Director as they assigned trainees to the Trust, not the London Specialty School of O&G.	Yes. See O&G1.4a below. Yes. See O&G1.4b below. Yes. See O&G1.4c below. Yes. See O&G1.4d below
O&G1.5	**Adequate time and resources to complete assessments required by the curriculum** The experience and knowledge received from time spent on the Labour ward was reported by the trainees to be extremely beneficial and the quality review team heard trainees were exposed to a plethora of conditions. The higher trainees who were undertaking their advanced training specialist module (ATSM) within early pregnancy and acute gynaecology were concerned that they would not complete this module due to there being no available consultant led scanning lists they could attend and that they were not supernumerary within the early pregnancy clinic. The quality review team heard that the ATSM within labour	Yes. See O&G1.5 below.

	ward was being completed by trainees during their normal labour ward sessions on the rota due to trainees' inability to access their special interest sessions each week. Furthermore, it was reported the scanning opportunities for junior trainees to complete their competencies were also non-existent. The trainees reported that when they covered the consultant clinics on their own, they often came across conditions and scenarios that they could then have had signed off their curriculum. However, because they were the most senior doctor in the department, this could not occur. This also happened when the trainees worked at night, when there was no consultant presence. Previously there was Post Certificate of Completion of Training (Post CCT) fellow cover at night, which meant the trainees' curriculum requirements could be signed off.	
O&G1.6	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** The quality review team was informed that although each trainee had a named educational supervisor, the quality of the educational support provided varied from consultant to consultant. Some trainees confirmed that their supervisors were extremely proactive and that they had very positive relationships with them. However others felt they had not built a good rapport with their supervisors and one stated they had not had a meeting since their supervisor left to go on maternity leave and was not aware of who was covering their educational supervision. Despite this, most trainees stated they could identify someone in the department to go to with specific problems, even if that was not necessarily their educational supervisor. The trainees were particularly complimentary about one consultant.	Yes. See O&G1.6 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.**		
O&G2.1	**Impact of service design on learners** The quality review team was informed of a series of thefts that had occurred at the Trust, during which staff bank cards were stolen. The trainees further indicated that despite the fact the Trust had already installed some lockers for staff in which they could store their valuable possessions, there was an insufficient number for trainees to be able to store their items securely.	Yes. See O&G2.1 below
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.**		
O&G3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The quality review team was informed that the trainees all had an extremely positive relationship with their last college tutor, who was on maternity leave at the time of the review. Unfortunately they did not feel they had the same relationship and level of support from the interim college tutor. However, it should be noted that it was	Yes. See O&G3.1 below.

	reported to the quality review team that the interim college tutor did not have sufficient time in their job plan for this role (please see section O&G4.1)	
O&G3.2	**Behaviour that undermines professional confidence, performance or self-esteem** Trainees at all levels reported that the atmosphere in the department was not always conducive to a supportive working environment. Although the majority of trainees reported that they had not experienced any bullying from their colleagues, the quality review team was informed that some members of staff were intimidating and that there was a clear hierarchy amongst the consultant body, which although helped with cohesion could on occasion have a negative impact upon the learning environment.	Yes. See O&G3.2 below.
O&G3.3	**Regular, constructive and meaningful feedback** The quality review team was informed that trainees often received feedback in different formats. For example consultants emailed trainees if they were involved in an incident which had been reported, weekly meetings occurred which discussed case management, trainees received feedback from Datix and tips relating to particular issues which were prevalent in the department (such as pressure sores) were emailed to all staff. Trainees also reported that they found the objective and in some instances feedback on negative aspects given to them extremely valuable. Instead of only receiving positive feedback they were also given constructive criticism and areas of improvement to work on, which they found extremely beneficial.	
GMC Theme 4) Supporting educators		
Standards **S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.** **S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.**		
O&G4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The quality review team was informed that the interim college tutor did not have Supporting Professional Activities (SPA) protected time in his job description to carry out this role. This reportedly impacted upon trainees as they felt they did not receive the same level of support as previously. The quality review team was informed that he had been appointed to the role within 18 months of becoming a consultant.	Yes. See O&G4.1 below.
GMC Theme 5) Developing and implementing curricula and assessments		
Standards **S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.** **S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good Medical Practice and to achieve the learning outcomes required by their curriculum.**		
O&G5.1	**Opportunities for interprofessional multidisciplinary working** It was reported to the quality review team that there was an excellent relationship between the multidisciplinary members of staff within the department. The trainees stated that they had experienced the least amount of animosity between midwives and doctors at Homerton Hospital NHS Foundation Trust than in any other Trust they had worked in. They indicated that the nursing and midwife staff and the matron on the labour ward in particular were extremely supportive and that it was a	

	positive environment to work in.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
N/A			

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
O&G1.1	The Trust must ensure that the obstetric and gynaecology (O&G) department at night is manned by two higher trainees or with resident consultant presence, if that is not possible.	The Trust must provide assurance that whenever there is only one higher trainee on the rota to cover both obstetrics and gynaecology services at night and appropriate locum cover cannot be found; there is a resident consultant present.	R1.12

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
O&G1.4a	The Trust is to ensure that when consultants are absent or on annual leave, their clinics, ward rounds and caesarean section lists are either cancelled, reduced (to a level that is appropriate for training) or covered by another consultant.	The Trust to undertake an audit of clinic sessions, ward rounds and caesarean section lists in which trainees are working alone and those that have consultant oversight/input over a two month period and submit the results to Health Education England (HEE). The Trust should also submit an action plan for dealing with deficiencies in this area. Compliance with this action should be monitored through local faculty group (LFG) meetings. The Trust to submit minutes from LFG meetings, at which there is trainee representation, where clinics are discussed and actions followed up on.	R1.8
O&G1.4b	The Trust is required to ensure that trainees are released from their rota in order to attend their ATSM sessions and regional teaching.	The Trust is to provide copies of the higher trainees' rotas which show ATSM sessions within their plan. The Trust must ensure there is appropriate cover so that the trainees can attend teaching sessions. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings, at which there is trainee representation, where ability to attend ATSM sessions and regional teaching is	R1.12

		discussed and actions followed up on.	
O&G1.4c	The Trust is required to ensure a consultant has executive ownership of the rota and that an administrative member of staff is appointed to assist with this responsibility.	The Trust is to confirm who the consultant executive lead for the rota is.	R1.12
O&G1.5	The Trust must ensure that there are consultant led gynaecology scanning lists higher trainees can attend in order to complete their advanced training specialist modules (ATSM) and that core trainees have the scanning opportunities necessary to complete their competencies.	The Trust should provide written confirmation that the trainees can access consultant led scanning sessions and provide copies of trainees' rotas showing they are able to attend such sessions. The Trust should implement measures to increase the opportunities higher trainees have to attend such scanning lists and opportunities available to core trainees. A report demonstrating how this issue will be rectified, including any relevant clear timescales should be submitted to HEE. This may include access to training in other Trusts. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings, at which there is trainee representation, where consultant led scanning lists are discussed and actions followed up on.	R5.9
O&G1.6	The Trust must ensure that each trainee knows who their current educational supervisor is and that initial and end of placement meetings are organised and carried out for all trainees.	Trust to produce ePortfolio report demonstrating that all trainees have undertaken initial and end of placement meetings with their current educational supervisor. This report should be submitted to HEE. Compliance with this action should be monitored through LFG meetings. The Trust to submit LFG minutes, at which there is trainee representation, where the provision of educational supervision is discussed and any actions taken followed up on.	R1.18
O&G2.1	The Trust must ensure there are adequate numbers of lockers in which the trainees can store their possessions.	Trust to confirm in writing that an adequate number of lockers have been installed. Compliance with this action should be monitored through LFG meetings. The Trust to submit LFG minutes, at which there is trainee representation, where this is discussed.	R2.3
O&G3.1	The Trust is required to provide faculty development in relation to pastoral care for trainees.	Trust to confirm they have offered HEE facilitated faculty development relating to pastoral care and 'providing feedback' training to all consultants and senior	R3.2

		midwives. The Trust should then provide a list of who attended this training. Compliance with this action should be monitored through LFG meetings. Trust to provide LFG minutes in which trainees discussed this issue. The Trust may wish to also survey trainees anonymously. HEE would recommend the Trust makes contact with HEE's Education Team Development Service to request additional support in this area. HEE can provide further contact details.	
O&G3.2	The Trust must ensure that intimidating behaviour ceases as it is not conducive to a supportive learning environment and is not in keeping with the General Medical Council's standards of good medical care and professional behaviours.	The Trust is required to undertake team building exercises in encouraging professional behaviours within the workplace and confirm that this has occurred. HEE would recommend the Trust makes contact with HEE's Education Team Development Service to request additional support in this area. HEE can provide further contact details.	R3.3
O&G4.1	The Trust must ensure the interim college tutor has the necessary time set out in their job plan in order to adequately carry out the duties associated with the college tutor role	The Trust should review the job plan of the interim college tutor and ensure that this role is allocated one SPA. The Trust is to provide confirmation this has occurred.	R4.2

Recommendations

Req. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
O&G1.4d	The Trust should raise the issue of having a high proportion of less than full time trainees allocated to the department with the Training Programme Director.	Trust to confirm they have raised this with the Training Programme Director and outline any steps that have been agreed to address this.	R1.12

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

Requirement	Responsibility
N/A	

Signed

By the HEE Review Lead on behalf of the Review Team:	Dr Sonji Clarke Deputy Head of the London Speciality School of Obstetrics and Gynaecology
Date:	21/10/2016