QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

University College London Hospitals NHS Foundation Trust (National Hospital for Neurology and Neurosurgery)

Neurosurgery

Risk-based Review (on-site visit)

Quality Review report

26 January 2017

Final Report

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Quality Review details

Background to review	The last quality review to the National Hospital for Neurology and Neurosurgery undertaken by Health Education England was in 2011, where the review team met with neurosurgery trainees at all levels and core surgical trainees (CSTs) undertaking a placement in neurosurgery. The review team found that the junior neurosurgery trainees and the CSTs did not have sufficient operative experience. The operative opportunities available to CSTs were diluted by the high number of trust-grade doctors in post and the workload of CSTs was found to be predominately focussed on service provision. It was identified that consultants and trainees were under pressure to complete lists as quickly as possible. Furthermore, the review team found that just one consultant attended handover. As a result, the unit was encouraged to increase consultant presence at handover. The results of the General Medical Council National Training Survey (GMC NTS) 2016 demonstrated five red and one pink outlier in neurology. Given the specialist nature of the Hospital, there was concern that the issues affecting neurology training would also impact the experience of neurosurgery trainees. Further to this, the neurosurgery GMC NTS results 2016 generated two red outliers (handover and regional teaching) and two pink outliers (educational supervision and feedback). As the hospital had not been visited in over five years and given the results of the GMC NTS 2016, a quality review of both neurology and neurosurgery was conducted.
Training programme / learner group reviewed	Neurosurgery
Number of learners and educators from each training programme	The review team met with three neurosurgery trainees ST1-2, one core surgical trainee and six neurosurgery trainees ST5-8. The review team also met with six educational supervisors.
Review summary and outcomes	The review team identified the following areas that were working well: • A lot of progress had been made in restricting excessive clinic duties for trainees and reducing the number of unsupervised clinics. • At the time of the review, there was no evidence of senior clinical fellows taking training opportunities away from trainees. Academic and clinical expansion may allow this to remain the case with more appointments but constant vigilance to this issue would be required. • There was a high level of satisfaction among junior and senior level trainees regarding access to operative training at an appropriate level and with good numbers of index procedures. • The regional teaching was well regarded by trainees, despite the red flag in the GMC NTS 2016. Local teaching and access to projects were also well developed; with the Queen Square Research Network particularly valuable. • Trainees reported that they enjoyed working with a high quality multi-professional team in theatre. However, the review team also noted the following areas for improvement: • Attendance of the outgoing on-call consultant at handover was educationally valuable and should be facilitated through job planning. • Surgical reception clerking by non-training junior doctors clashed with the morning handover. This was felt to constitute a potential patient safety issue as not all clinical teams were represented at the meetings.

	• The review team identified just a hint of a domineering atmosphere within the department, which might have been impacting higher trainees. • Local Faculty Groups appeared to have fallen away. These should be reintroduced and include wide trainee representation and management input, as described in the National Association of Clinical Tutors (NACT) guidelines. This forum should be used to agree the allocation of trainee/trainer allocations. • Although reduced, unsupervised trainee clinics were still taking place. All were agreed that trainees should not be left unsupervised in specialty clinics and there was general agreement that clinics should be cancelled during consultant leave. There was less consensus in the department that unsupervised follow-up clinics were inappropriate but the visiting team felt that such events did not constitute good quality training and should cease. • The trainers suggested that more time to train in clinics would be of value. The review team felt that addressing the very large burden of follow up clinic appointments might allow this to happen.

Educational overview and progress since last visit – summary of Trust presentation

The director of postgraduate medical education gave an overview of the educational governance structure within the Trust. It was reported that neurosurgery fed into the medical education committee for specialist hospitals. This was followed by a presentation from the departmental education lead.

The review team was informed that within the unit there were 24 consultant neurosurgeons, three junior neurosurgery trainees, one core surgical trainee and six higher neurosurgery trainees.

The education lead for neurosurgery advised that, per year, there were 23,000 new outpatients, 81,000 follow up outpatients and 5,300 inpatients. The unit conducted 3,600 operations per year. It was reported that there were 82 inpatient beds in the unit and there would be a further 16 introduced in 2017, 14 critical care beds and an additional six in 2017 and five operating rooms with a further two in 2017.

The following strengths were identified within the unit: a high number and variety of clinical cases; various research opportunities; support from medical and dental education services to run simulation courses; numerous endoscopy modules and a cauda equina course used in regional teaching.

The review team was informed that the unit had taken the following actions to address the handover red flag in the GMC NTS 2016: an electronic handover was distributed to all trainees; all cases were discussed with the on-call consultant before or at handover; the daily handover was stored on a shared drive; attendance monitoring took place using a register; a cultural change within the unit with more people attending handover and at least one consultant present 98% of time; trainees at all levels and the trust-grade higher trainee attending handover regularly; post-take and post-night trust-grade doctors were scheduled to attend handover, and ensuring that breakfast was available.

It was reported that the unit, working with the lead provider University College London Partners (UCLP), had taken the following actions to address the regional teaching red flag in the GMC NTS 2016: the 2017 training programme was distributed to trainees and rota coordinators; regular attendance monitoring and the reasons of non-attendance monitored; sessions tailored for the level of training and flexibility to choose appropriate sessions; focus on morale; teaching offered every month, except August, with all units involved.

The review team heard that to ensure the quality of training, all trainees, including those in the initial phase (ST1-3) of training had access to theatre sessions and outpatient clinics. The education lead for neurosurgery also reported that trainees were allocated to firms where there were no senior clinical fellows, to avoid competition for training opportunities.

It was reported that a guardian service (distinct from that required by the new junior doctor contract) had been launched in order to support the Hospital's zero tolerance stance on bullying and undermining. This service was run by an external organisation and could be accessed by anyone at any time. The review team heard that the trainees had been informed of this service at their induction.

The review team was informed that there were fortnightly meetings regarding the work schedules for the new junior doctor's contract. The Trust reported that they were engaged with programme leads to develop generic work schedules.

The Trust acknowledged that they had a high follow-up rate for outpatients. It was reported that the unit was intending to introduce more telephone clinics and have specialist nurses to conduct the follow-up clinics. The review team heard that steps were being taken to try and reduce the follow-up caseload, such as streamlining patient pathways and the trialling of a walk-in pre-assessment service. Part of the reason for the high follow up rate was the supraregional, quaternary caseload. For example, it was highlighted that the hospital undertook more deep brain simulation (DBS) operations than any other unit in Europe.

Quality Review Team			
HEE Review Lead	Mr John Brecknell Deputy Head of the London School of Surgery	**External Clinician**	Ms Fiona J.L Arnold Consultant Neurosurgeon, Imperial College Healthcare NHS Trust
Lead Provider Representative	Dr Hasan Rizvi Associate Director, University College London Partners	**Trainee Representative**	Gareth Kitson Darzi Fellow – Pharmacy Education, Health Education England
Lay Member	Caroline Turnbull Lay Representative	**Scribe**	Heather Lambert Quality Support Officer, Health Education England

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services.

1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.

Ref	Findings	Action required? Requirement

		Reference Number
NS 1.1	**Patient safety** The review team heard that surgical reception clerking by non-training junior doctors clashed with the morning handover. It was quite clear that no training grade doctors were included in this arrangement. However, the trainees reported that this impacted on the continuity of care for patients because not all of the clinical teams were represented. Although the review team heard that this had not resulted in a patient safety incident, it was felt that there was the potential for this to happen.	Yes, see ref no. NS 1.1 below
NS 1.2	**Appropriate level of clinical supervision** It was noted that there had been a lot of progress in reducing the number of unsupervised clinics within the unit. However, the review team heard of some instances in which clinics were not directly supervised by a consultant. The higher trainees reported that, at times, consultants would leave clinics early or arrive late. The review team heard that if a consultant was on annual leave, their clinic was not always cancelled or covered by a consultant. Although the trainees identified that the neuro-oncology clinic was particularly good, it was highlighted that the afternoon consent clinic and the Wednesday afternoon spinal clinic were not directly supervised. The review team heard that there had previously been an instance in which a higher trainee had conducted a tertiary clinic unsupervised. All of the trainers present agreed that this was not acceptable practice. Although none of the trainees reported that they felt out of their depth, some reported that it was not always clear of who to contact in an emergency. The review team heard that the trainers had a range of views on what a supervised clinic was. Although some of the trainers reported that they always had a higher trainee with them and would cancel their clinic if they were unable to attend, others reported that they felt general clinics could be run by higher trainees without consultant supervision, so long as the consultant was accessible. It was reported that the level of supervision offered at a clinic was often tailored to the needs and capabilities of the trainee.	Yes, see ref no, NS 1.2 below
NS 1.3	**Rotas** The review team heard that the core surgical trainee (CST) was placed on a ward-based core rota. The CST felt that this was appropriate as they had no prior neurosurgical training and they were able to access more ward and on-call experience. The review team heard that for the CST a lot of their time was self-directed. However, the CST reported that that this did not reduce their ability to attend theatre (three sessions per week on average) and clinics. The review team heard that there were 14 posts on the core rota. It was reported that 11-12 of these posts were filled by a combination of Trust-grade doctors, locums and the CST. The trainees felt that this provided a good level of cover on the ward. The review team heard that there were also five specialist nurses in the unit. The review team heard that some higher trainees found it difficult to attend the 8.00am handover every day due to conflicting responsibilities with good quality training opportunities, such as pre-theatre team briefings and multi-disciplinary team meetings. None of the trainees were prevented from attending the handover meeting on the majority of days.	

NS 1.4	**Handover** The 2011 visit had recommended the presence of multiple consultants at the daily handover meetings. The review team identified that great progress had been made in improving the handover process. The trainees reported that an initiative to convene a catered handover meeting in a meeting room daily at 8.00am had resulted in a highly valuable experience that improved morale and provided great learning opportunities, including the chance to discuss cases in detail. Both the trainees and trainers reported that for the majority of meetings, there was at least one consultant at handover. However, the review team heard that the post on-call consultant rarely attended the morning handover. The trainees reported that this caused the leadership in handover to suffer and sometimes resulted in the on-call consultant's patients not being discussed. Some of the trainees reported that the topics covered at handover were random. Furthermore, it was identified that the handover did not always include the discussion of admissions, as this was included on a paper handover. Overall the visiting team heard that the educational quality of the sessions was improved when the post on-call consultant was at the meeting. The review team learnt from the educational supervisors that there was a willingness from the consultant staff to attend the handover meetings but that an obstacle was presented by job planning arrangements.	Yes, see ref no. NS 1.4 below
NS 1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The review team heard that local teaching was well developed. The more junior trainees reported that they received daily teaching from 7.30am to 8.00am and weekly teaching on a Thursday afternoon. It was noted that the 7.30am teaching resulted in a longer working day for trainees. However, the trainees reported that they felt privileged to have this teaching available to them and all of the trainees stressed that they would like this to continue. The specialty training year one to two (ST1-2) neurosurgery trainees reported that they had many opportunities available to them such as operative training and clinics. These opportunities were highly valued by the trainees, who felt that they were able to develop certain skills at the hospital that they could not develop in other units at their level. The trainees commented that this was a very progressive approach to training. The review team was pleased to hear that all of the trainees were able to access regional teaching and that this teaching was well regarded by trainees. The review team noted that there was a high level of satisfaction among the majority of trainees at all levels regarding access to operative training at an appropriate level. However, the review team heard that for trainees in the open microscopic pituitary team, there was little opportunity for operative training. The trainees' experience largely consisted of assisting the consultant operator. One factor involved was the high case load per operating list which did not allow time for training. The review team heard that there were four senior clinical fellows within the spine, epilepsy and functional teams. The trainees reported that efforts had been made by the unit to ensure that they were protected from jobs that had fellows, in order to maximise the availability of operative training. There was no evidence to suggest that the use of senior clinical fellows in theatre was restricting the availability of operative training for trainees. The review team heard about plans for academic and clinical expansion accompanied by the appointment of more senior clinical fellows. It was felt that such appointments would require constant vigilance to ensure that surgical access for trainees did not deteriorate as a result.	Yes, see ref no. NS 1.5a below Yes, see ref no. NS 1.5b below

NS 1.6	**Protected time for learning and organised educational sessions** The higher trainees reported that they were never pulled out of theatre to provide cover elsewhere in the unit.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity.

2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.

2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.

NS 2.1	**Impact of service design on learners** The review team heard that the ratio of follow-up outpatients to new outpatients was at a rate of 4:1. The higher trainees felt that rules regarding follow-up patients were not as strict as they had experienced in other units. Many of the trainees commented that some of the follow-up appointments were unnecessary and provided little educational value. The trainers acknowledged that within some sub-specialty clinics the majority of appointments were for follow-up patients. Some trainers reported further follow-up appointments were often issued by trainees if they were seeing patients that they did not know. The trainers commented that more time to train in clinics would be of value.	Yes, see ref no. NS 2.1 below
NS 2.2	**Appropriate system for raising concerns about education and training within the organisation** The trainees described a subtle local cultural element which the review team encapsulated as a “domineering atmosphere”. Tangible examples included: - Some of the higher trainees reported that there had been an issue in engaging the management regarding the needs of trainees. The review team heard of an instance in which a trainee had raised an issue via email, and was met with a response suggesting that the trainee could always go to another unit. The review team heard instances in which trainees’ log books were being discussed in an open forum, despite trainees requesting that this did not happen. This had resulted in some trainees feeling that their confidentiality had been breached. The trainees reported that they had not attended a local faculty group (LFG) since commencing their placement at the hospital. This contrasted with the view of the education lead, who reported that LFGs were still continuing at the site and had taken place in the neurosurgical offices. The review team heard that at the beginning of the year, the trainees would submit their logbooks to the education lead who would identify each trainee’s needs and deficiencies and subsequently allocate their placement. This would then be discussed in a consultants meeting. However, some of the higher trainees reported that they	Yes, see ref no. NS 2.2a below Yes, see ref no. NS 2.2b below

	would like more of a say in their training allocations within the department. There was a feeling that the good jobs were allocated to the popular trainees.	
NS 2.3	**Organisation to ensure access to a named clinical supervisor** All of the trainees reported that out of hours, it was clear who was on-call.	
NS 2.4	**Organisation to ensure access to a named educational supervisor** All of the trainees reported that they had an educational supervisor, had signed a learning agreement and had identified their training needs for the next year.	

3. Supporting and empowering learners

HEE Quality Standards

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.

3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.

NS 3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The review team heard that the on-call room previously had no bed and trainees were sleeping on a crash trolley. The trainees reported that this issue had now been resolved. It was reported that the core trainees worked in a very small room that was not appropriate in size. It seemed to the review team that the management team were not always sufficiently aware of issues affecting trainees.	Yes, see ref no. NS 2.2a below
NS 3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The review team heard that none of the trainees had experienced bullying within the unit. However, the trainees were aware that there had been a recent incident in which a trainee had experienced bullying and undermining within the Hospital. It was reported that this issue was in the process of being investigated.	
NS 3.3	**Academic opportunities** All of the trainees reported that they had access to research project work. The review team heard that the Queen Square Research Network met quarterly to discuss the research projects available to trainees and this was noted as being of particular value. Some of the trainers reported that they would like to expose trainees to more academic exercises, such as guest lecturers.	
NS 3.4	**Access to study leave** The review team heard that the Neurosurgical Intensive Care Unit rota had fixed annual leave and no study leave. Some of the trainees reported that they had not yet had to request study leave to attend teaching, but questioned the possibility of having study leave requests accepted on this rota.	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.

5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.

5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.

5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.

NS 5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** It was reported that the majority of higher trainees had access to a variety of cases and were able to get their log books signed. The review team heard that the unit offered access to functional neurosurgery that was not done in as great a volume elsewhere. Most of the higher trainees reported that within the last six months they had each completed between 120 and 150 cases. The review team heard that trainees also had access to index procedures. However, it was noted that some of the higher trainees had difficulty in accessing endoscopic and pituitary cases.	
NS 5.2	**Opportunities for interprofessional multidisciplinary working** The trainees reported that they enjoyed working with the spine consultants and a high quality multi-professional team in theatre.	
NS 5.3	**Appropriate balance between providing services and accessing educational and training opportunities** Some of the trainees reported that previously they had attended four clinics per week. However, all of the higher trainees reported that at the time of the review they were attending an average of two clinics per week. The review team heard that trainees were now protected so that they could not exceed a given number of clinics in a week. Furthermore, all of the trainees agreed that the clinics were of educational value.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The Queen Square Research Network which meets quarterly to discuss the research projects available to trainees was noted as being of particular value.	College Tutor	Please complete the attached proforma and return to the Quality and Regulation Team.	31 March 2017

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
NS 1.1	Surgical reception clerking by non-training junior doctors, clashes with the morning handover. This was felt to constitute a potential patient safety issue as not all clinical teams were represented at the meetings.	Please review the early morning activities of the non-consultant medical workforce to ensure that all clinical teams are represented at handover.	R1.14
NS 1.2	Unsupervised trainee clinics should cease. All outpatient activity by neurosurgical trainees should be directly supervised by a recognised and approved trainer.	Please provide correspondence confirming acceptance of this point of principle by the department. A standing item on the agenda of the local faculty group would represent a good mechanism for monitoring compliance going forward. Please provide copies of minutes as evidence.	R1.8
NS 1.4	Attendance of the post on-call consultant at handover is educationally valuable and should be facilitated through job planning.	Please provide evidence of progress towards this goal.	R1.14
NS 2.2a	Local faculty groups should be reintroduced and include wide trainee representation and management input as described in the NACT guidelines. This forum should be used to agree the allocation of placements, to raise awareness of training issues with the management team and as a way of monitoring the quality of training. The spirit of openness and collaboration engendered may well address the subtle cultural issue identified.	Please provide formal minutes of regular LFG meetings.	R2.7
NS 2.2b	The discussion of the content of trainees' portfolios in an open forum without their consent is inappropriate and should be ceased.	Please provide an undertaking to respect the confidentiality of trainees' portfolios.	R3.3

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
NS 1.5a	There is a high volume pituitary practice at Queen Square which represents a valuable training resource. However, the trainee assigned to the open microscopic pituitary team had relatively little access to operative training.	Please review the open microscopic pituitary lists with a view to developing their potential as a training resource.	R1.15

NS 1.5b	Although there is no evidence at present of senior clinical fellows being given priority access to training opportunities to the deficit of the experience of type one trainees, the Trust is advised to be vigilant to this risk during a planned academic and clinical expansion.	Please include a standing item on access to operative training in the agenda of the local faculty group and provide minutes as evidence.	R1.15
NS 2.1	Although it is acknowledged that the special nature of the workload at Queen Square often leads to an unusually high follow up ratio, the visiting team felt that addressing the burden of follow-up clinic appointments might contribute to the management of unsupervised trainee clinics (as required in NS 1.2 above) and make more time to train in clinic.	Please provide a response to this recommendation from the departmental leadership team.	R2.3

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Mr John Brecknell Deputy Head of the London School of Surgery
Date:	28 February 2017

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.