QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Barking, Havering and Redbridge University Hospitals NHS Trust (King George Hospital)

GP Programme – Urology

Risk-based Review (Education Lead Conversation)

Quality Review report

2 February 2017

Final Report

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Quality Review details

Training programme / Learner group	GP Specialty Training Programme - Urology
Background to review	The GP School had been made aware of concerns raised by trainees about the learning environment, clinical support, training opportunities, rota gaps, handover and escalation concerns from August 2015. The local programme director had held two liaison meetings with the education lead for the urology department in November 2015 and September 2016. At both meetings the issues above were highlighted and reassurance sought on specific actions in each of these areas. Foundation trainees had been withdrawn from the department in August 2016 and three Trust clinical fellows had been appointed. However, further concerns were received from current trainees in October 2016, which had led to the GP School making a recommendation to the Postgraduate Dean to seek an urgent concern review. Due to the urgent nature of the concerns, a decision was taken to arrange this in combination with a previously arranged Trust Liaison Dean / Director of Medical Education meeting on 11 November 2016. A number of follow-up actions were highlighted and agreed at this meeting, and it was proposed that a further education lead conversation would be arranged for early 2017 to review progress made against these actions. The Trust was informed that if no evidence of significant improvement was made by early 2017, it was possible that the GP School would recommend that training be ceased within the department from February 2017. A trainee survey had been conducted in September 2016, November 2016 and January 2017, which had highlighted that there had been some improvement in the overall training experience over the course of the three surveys (further details below).
HEE quality review team	Dr Rachel Roberts, Head of Primary Care Education and Development, Health Education England, working across North Central & East London Dr Naureen Bhatti, Head of School of General Practice, Health Education England, working across North Central and East London Dr Indranil Chakravorty, Trust Liaison Dean, Health Education England Jane MacPherson, Deputy Quality and Reviews Manager, Health Education England
Trust attendees	Professor Jayanta Barua, Director of Medical Education Mr Andrew Ballero, Clinical Lead, Urology Mr S Kulkarni, Education Lead Yvonne Aldham, Education Centre

Conversation details

Ref No	Summary of discussions	Action to be taken? Y/N
1.1	**Survey results** The review team informed the Trust attendees that a survey conducted by the programme director in January 2017 had resulted in an improved result compared with the September 2016 and November 2016 surveys. The earlier surveys had generated an average result of two out of five, whereas the January 2017 survey average result	

	had increased to 2.75. (A score of three was acceptable on the questionnaire rating scale, whereas a score of two was less than satisfactory). Improvements had been made in the following areas: • Appraisal and assessment • Feedback • Protected teaching • Senior doctor cover • Varied clinical workload • Rota compliance • Annual leave • Study leave • Effectiveness for delivery of GP curriculum • Clinical exposure to OPD (including seeing patients independently with supervision) • Overall educational experience Although the quality review team congratulated the Trust attendees on the improved result, they stated that further improvement was still required to bring the training posts up to the required standard.	
1.2	**Improvements** The Trust attendees highlighted a number of improvement projects which had been undertaken, as follows: Teaching sessions were now held on Fridays. Supervisor meetings had also been arranged. The Director of Medical Education (DME) commented that the new education programme had been set up by one of the higher trainees, but was delivered by the trainers. The teaching sessions were scheduled at the end of the consultant ward round, which meant that good attendance was more likely. The department had made a concerted effort to ensure that the trainees attended their clinical supervisor's weekly clinic so that they could benefit from good training opportunities during these clinics. The quality review team heard that consultants now started at 8am instead of 8.30am and that formal ward rounds would take place regularly as a result of this change. Some of the previous rota issues had been alleviated by the appointment of two long-term locums who were of a high standard and who were themselves aspiring GPs. An additional core-level Trust grade doctor had also been appointed and there were plans to recruit another. The department was also hopeful that an additional higher trainee-level Trust grade doctor could be appointed. The Trust attendees felt that support for the GP trainees had improved as a result of the above appointments. The DME commented that the structures and systems that were being put in place were still not fully embedded and were as yet fragile, but he highlighted the commitment from the managers to ensure that the improvements were made. An additional consultant urologist was also due to be appointed.	
1.3	**Handover** The Trust attendees informed the quality review team that despite their best efforts to put in place a formal orthopaedic handover, this had only just started the Monday prior to the review.	

	The DME and other Trust attendees stated that they would take the necessary steps to ensure that this continued. They agreed that they would send a formal letter to the clinical lead and divisional directors informing them of the necessity of this handover. They had also asked the core / GP / foundation-level trainees to inform them if the handover did not take place. The DME also reported that handover would be audited.	Yes, see ref GP 1.3 below
1.4	**Induction** The DME stated that the induction manual had recently been updated with the help of one of the GP trainees who had modernised it and added applications. The DME and other trainers had also received training on the GP e-portfolio and had gained a better understanding of the GP trainees' curriculum needs.	Yes, see ref GP 1.4 below
1.5	**Future improvements** The quality review team suggested that in order to bring added value to the training posts, the Trust needed to make the posts seem much more appealing to potential GP trainees, who may be more likely to accept a less than ideal rota if they were able to access exceptional training opportunities. The quality review team recommended that the trainees should be given exposure to the following: 1) Exposure to a wider general surgery outpatient clinic experience, rather than just urology 2) Access to minor surgical lists (general surgery) The quality review team suggested that the Trust should capitalise on the hospital's surgical expertise by offering the GP trainees experience in the GP curriculum as relates to general surgery out patient clinics which would enhance their overall educational experience. The quality review team also suggested that if the Trust were able to accommodate these improvements to the training posts, the posts would no doubt be well regarded and the most ambitious, capable trainees would choose to come to the Trust to train. The quality review team indicated that these extra opportunities should be job-planned so that the trainees were able to access them more easily. It was suggested that the clinic experience was the priority and that if the trainees were able to access more outpatient clinic experience approximately three times per month, perhaps access to minor surgical lists could be arranged once a month. The quality review team stated that when considering which clinics to allocate the GP trainees to, it would be important to consider the consultant attached to each clinic, and that it may be necessary to re-educate surgical colleagues on the importance of giving the GP trainees some autonomy during the clinics so that they could see patients on their own (with consultant oversight).	Yes, see ref GP 1.5a below Yes, see ref GP 1.5b below

Next steps

Conclusion
The DME expressed optimism that it would be possible to give additional clinic exposure to the GP trainees but that he would need to discuss the minor surgery lists with the new divisional director and new divisional manager (neither of which attended the education lead conversation). The DME also stated that it would be necessary to discuss these potential changes with the service manager and the rota coordinator. The quality review team suggested that introducing the proposed changes to the trainees' job plan would take approximately two months and therefore requested an update on this in two months' time. The quality review team stated that the concerns about GP urology training had been raised by the programme director more than two years prior to the review, and suggested that in future feedback given by programme directors should be taken more seriously and acted on more quickly. The quality review team suggested that regular meetings should take place between the DME and the programme directors to monitor the situation and avoid any possible decline in standards.

The quality review team commended the DME on the improvements in induction and in particular on the decision to involve the trainee in the development of a new improved induction manual. It was recommended that this sort of good practice should be replicated in other departments, and that at the end of each placement, the GP trainees should be asked to make any changes necessary to the manual based on their experience.

It was agreed that the programme director would meet with education lead in three months' time to monitor the GP trainees' training experience. In the meantime, the programme director could survey the trainees again to see if the training experience continued to improve. The GMC National Training Survey results would also be analysed before summer 2017 to ascertain if any problems persisted.

Requirements / Recommendations

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
GP1.3	Ensure that the orthopaedic handover is robust and that it takes place on a daily basis.	Educational lead to write a formal letter to the clinical lead and divisional director advising them of the necessity of this. Handover should be audited, and evidence submitted.	R1.14
GP1.5a	Trainees should be given exposure to a wider general surgery outpatient clinic experience, rather than just urology.	Provide update on this in two months' time.	
GP1.5b	Trainees should be given access to minor surgical lists (general surgery).	Provide update on this in two months' time.	
GP1.6	Regular three-monthly meetings between the programme director should be set up to ensure that standards are maintained and improved.	Provide confirmation that this is in place.	

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
GP1.4	At the end of each placement each GP trainee should be asked to update the induction manual so that it continues to be fit for purpose on an ongoing basis. We recommend that this is replicated in other departments.	Please advise of any further development in this area.	R1.13

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

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Rachel Roberts, Head of Primary Care Education and Development, Health Education England, working across North Central & East London
Date:	17 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.