QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

King's College Hospital NHS Foundation Trust

Clinical Radiology

Urgent Concern Review (on-site visit)

Quality Review report

20 February 2017

Final Report

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Quality Review details

Background to review	The purpose of the Urgent Concern Review (on-site visit) to clinical radiology at King's College Hospital NHS Foundation Trust was primarily to investigate the significant deterioration in the outliers received by the Trust in the 2016 General Medical Council National Training Survey (GMC NTS). The Trust received nine red outliers within: 'overall satisfaction', 'clinical supervision', 'clinical supervision out of hours', 'reporting systems', 'supportive environment', 'workload', 'access to educational resources', 'feedback' and 'regional teaching'. In addition, the Trust received a further three pink outliers within: 'induction', 'adequate experience' and 'educational supervision'.
Training programme / learner group reviewed	Clinical Radiology
Number of learners and educators from each training programme	The quality review team met with trainees in clinical radiology at the following grades: - Specialty Training Year 1 (ST1) - Specialty Training Year 2 (ST2) - Specialty Training Year 3 (ST3) - Specialty Training Year 4 (ST4) - Specialty Training Year 5 (ST5) - Specialty Training Year 6 (ST6) The team also met with radiography trainees who were on placement at King's College Hospital NHS Foundation Trust. The review team further met with the educational and clinical supervisors for clinical radiology, as well as the College Tutor, Clinical Director, Training Programme Director, Director of Medical Education, Executive Director of Workforce Development, Medical Education Manager and Medical Director.
Review summary and outcomes	During the course of the on-site visit, the review team was informed of a number of areas of serious concern regarding the training environment in place for clinical radiology trainees, as outlined below: - The first area of serious concern identified was regarding the inadequate clinical supervision provided to the more junior trainees in general and in particular to all trainees in relation to the acute inpatient and Emergency and trauma CT (computed tomography) lists. The review team felt the supervision provided was insufficiently robust and as a result, an immediate mandatory requirement was issued. This stipulated that the Trust needed to ensure there was a named consultant responsible for the clinical supervision of the acute inpatient and trauma CT lists, for every session which ensured that an individual, named consultant was available on-site, within the department to support and supervise trainees and review CT scans. - Secondly, the review team felt there were issues of concern surrounding the on-call rota at night, particularly in relation to the lack of clear escalation policies in place and the on-call consultants' ability to access images from home. Furthermore, the review team was concerned about the lack of robust policy for the review (verification) of scans that had been performed by trainees out of hours (OOH), by consultants the following

morning. Trainees described instances in which not all scans were verified within 24 hours, as some were missed by the 'checking consultant' or not passed on to the relevant sub-specialist consultant for verification.

- It was apparent to the review team that a dysfunctional environment existed between the consultant body and the trainees, which varied depending upon the training grade of the trainee in question. Concerns regarding inappropriate behaviours and comments that had been made to the junior trainees, which had been previously highlighted were confirmed during the on-site visit. The review team felt that the examples of such behaviours made the learning and training environment unsuitable and inappropriate for the training of clinical radiology trainees.

However, the quality review team was also informed of some areas that were working well with regard to the education and training of clinical radiology trainees, such as:

- All of the radiographer students the review team met with were extremely complimentary of the training provided to them by the Trust and reported that they felt well supported by their supervisors.
- The quality review team was informed of the 'buddy up' system that was in place for ST1 trainees prior to starting their on-call shifts at night, during which they shadowed other trainees on-call. The trainees who had been involved were extremely appreciative and complimentary of the system and felt it equipped them for starting their on-call shifts.

The situation presented an unacceptable risk to the well-being of the trainees in clinical radiology at King's College Hospital NHS Foundation Trust and to the quality of education and training. Given the concerns raised at the visit to the Trust it was decided that Health Education England South London had no option but to suspend training of clinical radiology for ST1, 2 and 3 trainees as soon as practically possible.

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

During the initial meeting with the Clinical Director, Training Programme Director for clinical radiology and College Tutor, the quality review team heard that the Trust had been shocked by the 2016 General Medical Council National Training Survey (GMC NTS) results, but that the department reported that they had been supported by the Trust to work towards resolving the issues highlighted.

Trust Presentation

The Trust initially outlined the issues they felt had led to the poor results in the 2016 GMC NTS and highlighted;

- There were, at the time of the review, significant rota gaps and the Trust had had difficulties recruiting to Trust funded posts within the department. This had resulted in there being an excessively frequent on-call rota.
- The Trust stated that this had resulted in low morale throughout the department.
- The review team heard from the educational leads that the Trust had lost a number of more senior trainees within the department, which may have resulted in the more junior trainees feeling more vulnerable as the support previously given by the senior trainees was not available.
- Furthermore, the review team heard that due to the extremely sub-specialised nature of the department, often the supervision of trainees could 'fall between two specialties' which was a factor that Trust had not previously recognised or addressed.

The presentation then outlined the various measures the Trust had taken to address the issues highlighted in the GMC NTS:

- The Trust commented that they had received feedback via a number of avenues regarding the training and education in the clinical radiology department, such as the GMC NTS, the London Clinical Radiology School Junior trainee forum survey undertaken in December, and feedback from meetings the Director of Medical Education had had with trainees, in the capacity as an external facilitator.

- The Trust stated that they had acted on this feedback, for example in regard to the changes that had been made to the on-call rota. To remain compliant with the European Working Time Directive and to ensure that trainees' training was not compromised by working fewer day-time shifts, the department had moved from a system in which two trainees were on-call overnight, to just one trainee being on call. The trainee on call at night was supported by three consultants on-call (interventional radiologist, neurology radiologist and general radiologist). It was reported that during this period, the trainee dealt with all emergency, acute trauma and neurology patient scans, but that the majority of the emergency work (non-trauma and neurology) that was done out of hours was outsourced to an external company.
- The Trust reported that a lunch-time department teaching session had been re-introduced, which took place three times a week and also that all clinical commitments were cancelled so trainees could attend regional teaching.
- In relation to clinical supervision provided for trainees undertaking the acute inpatient CT scan, the Trust reported that there had been ongoing discussion between trainee representatives, CT clinical leads and the consultant training body following the GMC NTS in an effort to improve CT supervision. Various changes had been implemented between September and December 2016 following discussions with the trainees, with progress discussed in the monthly Local Faculty Group meetings with trainee representatives. The Trust reported that although some positive feedback was received from trainees regarding the measures that had been put in place, following feedback received by the department from Health Education England in December 2016, further direct discussion between trainee representatives and the CT clinical lead took place in December 2016 and a consultant CT timetable with a series of named consultants for each sub-specialty for each session (abdomen, chest, vascular/renal, paediatrics and musculoskeletal scans) as opposed to one overarching consultant responsible for the session was designed. The Trust noted that this was necessary because of the organ-specific nature of the King's College Hospital radiology service. The Trust maintained that the trainees remained fully supported by several consultant radiologists on site for each CT sessions, with radiology trainees, both junior and senior, strongly encouraged to discuss any and all inpatient scans with consultants, providing safe, expert radiology opinion and individual teaching for the radiology trainee.

Quality Review Team			
HEE Review Lead	Dr Jane Young Head of the London Specialty School of Radiology	**External Clinician**	Dr Deborah Low Consultant Interventional Radiologist and Training Programme Director, Barts Health NHS Trust
Postgraduate Dean	Dr Andrew Frankel Postgraduate Dean, Health Education England South London	**Quality and Regulation Representative**	Ian Bateman Head of Quality and Regulation, Health Education England London and the South East
Scribe	Elizabeth Dailly Learning Environment Quality Coordinator, Health Education England London and South East	**Lay Representative**	Jane Gregory Lay Representative
Observer	Dr Catherine O'Keeffe Deputy Postgraduate Dean, Health Education England South London		

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
1	**Patient safety** It was apparent to the review team that both the inpatient acute and trauma CT (computed tomography) scan list was run predominantly by the trainees, with little or no consultant supervision, which could raise potential patient safety issues. The trainees reported that the inpatient CT scan could be run during the day by two trainees, who could be in Specialty Training Years 1 and 2 (ST1 and ST2), and that there was no named consultant who was dedicated to each list. The quality review team heard that the trainees provisionally reported the scans, which could then be accessed by other clinical teams throughout the hospital, and then had to go and find a consultant who was willing to verify the scans. The trainees indicated that there was no formal system in place by which they could ensure consultants verified the scans and that often, the trainees had to leave their post and the phones unattended, in order to try to find a consultant or a more senior trainee who was available and willing. Despite the fact the trainees reported that a new inpatient checking timetable had been initiated prior to the review, which set out a series of named consultants for verifying CT scans throughout the week, it should be noted that the trainees had not felt that this had had, at the time of the review, a significant improvement in relation to having CT scans verified and trainees still struggled to locate a consultant to verify scans. When discussing the CT in the Emergency Department (ED), the trainees reported a similar scenario, where one or two trainees ran the CT list, without consultant input or supervision. When discussing who verified the scans, the trainees indicated that, if there was no consultant or more senior trainee within the ED they would have to go to the main CT department to locate someone to verify the scans. The trainees further commented that not all of the consultants were comfortable reviewing trauma scans, so it was often difficult to locate someone willing to review these scans. The educational supervisors the review team met with indicated that they were, at the time of the review, working towards ensuring there was always a consultant or senior trainee	Yes, please see CR 1 below.

	within the ED, to ensure adequate clinical supervision was in place for the trainees, but due to the consultants' other commitments this had not been fully implemented.	
2	**Appropriate level of clinical supervision** The quality review team ascertained that the majority of the day-to-day teaching was delivered by the more senior trainees as opposed to the consultant body. The trainees described a system by which trainees at ST2 and above taught the ST1 trainees. The review team heard that previously the department had relied heavily upon the trainees at grade ST4 or ST5, not only to teach other trainees, but to provide the majority of the clinical supervision as opposed to the consultant body undertaking this role. However, at the time of the review, the Trust indicated that they had fewer trainees at ST4 or ST5, resulting in the loss of the 'middle tier' they had previously relied upon to provide support for the more junior trainees. The educational supervisors the review team met with acknowledged that as the department had a higher number of less experienced trainees than previously, they needed to make an adjustment in terms of the degree of supervision they were given. The quality review team ascertained that due to the structure and sub-specialty nature of the department, the consultants predominantly focused upon sub-specialty work and the general service provision was principally run by the trainees, resulting in a lack of clinical supervision for the trainees. All of the radiographer students the review team met with confirmed that they were provided adequate support from their supervisors and other radiographers and that from their perspective, there was an open and welcoming culture within the department. All of the trainees were extremely positive regarding their placement at King's College Hospital NHS Foundation Trust and would recommend the post to colleagues.	
3	**Responsibilities for patient care appropriate for stage of education and training** The quality review team heard that due to the lack of clinical supervision that was provided to the trainees by the consultant body, which had previously been provided by the 'middle tier' of trainees at grade ST4 or ST5, this had often resulted in the trainees, particularly those at grade ST1 and 2 having to undertake tasks and procedures that they did not feel comfortable doing unsupervised. The trainees reported instances in which they had to act beyond their level of competence; for example, they reported that they were left to run the fluoroscopy list alone without consultant supervision.	Yes, please see CR3 below.
4	**Rotas** When discussing the out of hours rota, the trainees reported that they only participated in the on-call rota when they were at grade ST2 and above, and that a 'buddy up', shadowing system had been introduced for the ST1 trainees, during which they shadowed the more senior trainees for a period on nights, to ensure they were comfortable undertaking the role. The trainees were extremely appreciative and complimentary regarding the system and felt it prepared them prior to starting their on-call shifts. When discussing the out of hours' workload, the quality review team heard that the majority of the inpatient reporting work was outsourced to an external company and that the trainees covered the trauma scans, any ultrasound requests, paediatric emergency screening, CT scans for stroke/thrombolysis, interventional radiology, emergency head and spine MRIs (magnetic resonance imaging) and then in their spare time reported routine plain films. The trainees indicated that the workload during these shifts fluctuated, especially in relation to the number of trauma scans that needed to be completed and the trainees the review team met with were not aware of the presence of an escalation policy to be activated for when multiple trauma or other urgent scans needed to be reported. When discussing the consultant supervision available to the trainees, they indicated that they could contact the on-call consultants via telephone, but that despite the fact that the Trust believed that all radiologists had access to remote reporting, the trainees' perception was that only some of the consultant body had remote access to the relevant images at home, so it was sometimes difficult to acquire a second opinion.	Yes, please see CR4.1 below Yes, please see CR4.2 below.

	Furthermore, in relation to the scans that were outsourced, the trainees commented that they took all the referrals for such scans and decided whether the request was appropriate before it was performed and sent to the external company to be reported. Additionally, the quality review team heard that clinical teams within the Trust would often contact the trainees with queries regarding the outsourced reports and ask for second opinions. The trainees indicated that there was no policy which adequately clarified the external company's responsibilities and those of the trainees. Furthermore, the trainees indicated that all of the reports that had been undertaken by the external company were then re-checked the following morning by a consultant. However, the Clinical Director confirmed that although the double checking process had previously been routine practice for the overnight MEDICA films, the audit demonstrated that such level of oversight was not necessary so the Trust had moved to a system whereby a random number of films were selected for review with the trainees for audit and teaching purposes. The quality review team heard that the scans undertaken by the trainees on-call were then in theory verified the following day by the designated 'checking consultant', so all scans were substantiated within 24 hours. However, the quality review team ascertained that regularly scans were missed by the 'checking consultant' and not verified. The trainees commented that on return from days in lieu after being on call, they often would discover that a scan had not been verified by the consultant. The review team felt there was a lack of communication from the consultants regarding which scans had been verified, especially if the designated 'checking consultant' had felt the scan should be verified by another sub-specialty consultant. The trainees did not report any negative impact that this had had upon patient care, but thought that it could result in potential patient safety issues. The trainees indicated that despite the changes that had been made to the on-call rota, their pay banding had not altered accordingly and that their attempts to raise this with the Trust and initiate a diary card exercise had, at the time of the review, been unsuccessful.	Yes, please see CR4.3 below. Yes, please see CR4.4 below.

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.

5	**Effective, transparent and clearly understood educational governance systems and processes** The quality review team heard that the trainees were aware that there were set guidelines in relation to radiation dosage, but that at ST1 level radiation protection did not form part of their induction or early training and as they were working largely unsupervised they had no senior guidance and no formal guidelines were disseminated within the department. The team were made aware of at least one incident where this had resulted in a patient being over-exposed to radiation.	Yes, please see CR5 below.
6	**Appropriate system for raising concerns about education and training within the organisation**	

	The quality review team heard that despite having raised their issues with their educational supervisors and members of the department, the trainees did not feel that their concerns had been appropriately dealt with.	
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.**		
7	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees indicated that there were certain consultants within the department who were extremely approachable and willing to offer advice and verify scans for the trainees, but that there were some who the trainees felt were more hostile, and would react negatively if they were approached by the trainees regarding scans. The quality review team ascertained that there was a cultural divide between the consultants and trainees due to the hierarchical nature of the department and that many of the trainees, especially those at grade ST1, had been subjected to inappropriate behaviour. For example, the trainees reported that some of the consultants did not know their names, or even that they worked within the department and that demeaning and belittling comments had been made in meetings with consultants and in the 'spots and error' meetings. This had had a significant negative impact upon trainee morale, as they often felt unappreciated and unsupported by the consultant body.	Yes, please see CR7 below.
4. 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.**		
8	**Appropriate balance between providing services and accessing educational and training opportunities** The trainees described a working environment which the quality review team encapsulated as being predominantly focused upon service provision as opposed to ensuring trainees accessed the requisite number of training sessions with senior supervision and received effective work-based supervision ensuring clinical learning opportunities were maximised.	

Good Practice and Requirements

Good Practice
N/A

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
CR1.1	There needs to be a named consultant responsible for the clinical supervision of the acute inpatient and emergency and trauma CT lists, for every session which ensures that an individual consultant is available on-site, within the department to support and supervise trainees and review CT scans.	The Trust to confirm that this system has been implemented.	R1.8

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
CR3	The Trust are to be clear that all lists will be supervised by a named consultant.	The Trust to produce an appropriate timetable of clinical activities that define where trainees are undertaking lists and who is supervising them.	R1.8
CR4.1	The Trust to ensure there is a clear escalation and management policy in place, in relation to the out of hours' work for situations where a series of emergencies occur concurrently.	The Trust to provide confirmation and evidence that such an escalation policy has been introduced and communicated throughout the department.	R2.3
CR4.2	The Trust to ensure that all consultants on-call can access images remotely at home, so they can discuss any issues with trainees.	The Trust to provide confirmation that all consultants undertaking on-call shifts have remote access to images at home and that this is regularly tested and supported.	R2.3
CR4.3	The Trust to ensure there is a robust system in place that ensures that all scans completed by trainees out of hours are verified by a consultant within 24 hours.	The Trust to provide the appropriate Standard Operating Procedure (SOP) that defines how this will occur and evidence of dissemination	R2.3
CR4.4	The Trust to undertake a diary card exercise for all trainees.	The Trust to provide the results from the diary card exercise and any subsequent changes made to the trainees' pay banding.	R1.12
CR5	The Trust to ensure that all mandatory standards and training relating to radiation safety are in place with regular audit, with clear systems of work and local rules, throughout the department. The Trust to conduct a review of this with their Radiation protection advisor.	The Trust to confirm that a review has taken place, with results and any actions taken to implement good practice.	R2.1
CR7	The Trust to ensure that inappropriate 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 and mentoring exercises which encourage professional behaviours within the workplace and confirm that this has occurred.	R3.3

		HEE requires assurance that any specific allegations of inappropriate behaviour towards trainees that the Trust has been made aware of are investigated under the Trust's internal procedures.	

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
	N/A		

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 Quality Review Team:	Dr Andrew Frankel
Date:	15 March 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.