QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Chelsea and Westminster Hospital NHS Foundation Trust

Foundation Surgery

Risk-based Review (focus group)

Quality Review report

23 February 2017

Final report

Developing people for health and healthcare

www.hee.nhs.uk

THE NHS CONSTITUTION
the NHS belongs to us all

Quality Review details

Background to review	In November 2016, Health Education England North West London conducted an on-site Review of surgery services at Chelsea and Westminster Hospital. A number of immediate mandatory requirements were issued in relation to workload and the balance between training and service provision. The General Medical Council was present at that review and placed the Trust's surgery provision into enhanced monitoring. This focus group was arranged to follow up on the Trust's management of those requirements in order to review their impact on the working environment of the new cohort of foundation trainees that rotated to surgery placements at the Trust in December 2016.
Training programme reviewed	Foundation surgery
Number of learners from each training programme	The review team met 12 trainees from the following specialties: **Foundation year one (F1)** • Two emergency surgery trainees • Two lower gastrointestinal (GI) surgery trainees • Two upper GI surgery trainees • Two trauma and orthopaedic surgery trainees • Two urology trainees **Foundation year two (F2)** • One emergency surgery trainee
Review summary and outcomes	The review team was encouraged to learn that the Trust had made a number of changes resulting in a positive impact on foundation trainees working at Chelsea and Westminster Hospital. However, a number of concerns were raised about the lack of consultant supervision of trainees working in urology, and the lack of planning made to ensure that urology patients were attended by a consultant on a daily basis. In addition, there remained a significant burden placed on trainees by unnecessary administrative tasks, with particular reference to the plastics and urology departments.

Quality Review Team			
HEE Review Lead	Dr Anthea Parry, Deputy Director of the North West Thames Foundation School	**Scribe**	Jennifer Quinn, Learning Environment Quality Coordinator, Health Education England North West London
Trainee/Learner Representative	Priya Patel, Darzi Fellow in Multiprofessional Foundation training, Health Education England North West 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
1.1	**Serious incidents and professional duty of candour** Trainees reported that all Datix reports that they had lodged were taken seriously and were well-managed, with feedback given where necessary.	
1.2	**Appropriate level of clinical supervision** **Urology** The review team was concerned to learn that this specialty offered no planned daily consultant-led ward rounds that trainees were able to attend, and that consultants were not present on a daily basis. The foundation year one (F1) trainees stated that when the F2 or core surgical grade 2 trainee (CT2) was onsite, those trainees would lead and no consultant-led ward rounds would take place. Over the three weeks prior to the focus group, trainees stated that consultant-led ward rounds took place approximately two days per week.	Yes – see F1.2 below

Trainees reported that consultants were supportive when available, but on occasion had only 30 minutes to review patients, limiting the number of patients seen and the educational value of the process.

On the occasions when the F1 trainees were the most senior doctor, trainees stated that there was no departmental management of consultant cover across the urology rota and they were responsible for finding consultants to review patients.

The review team was further concerned to learn that the F1 trainees had to act as the urology opinion for the hospital when the F2/CT2 was not onsite, which meant that they were required to assess patients in the emergency department (ED) and they reported that they were frequently the first doctor to attend a urology patient.

The review team heard that the lack of consultant and middle grade presence left F1 trainees to face acute situations alone when the F2 was in theatre – trainees stated that they felt that they did not know what to do in those situations.

It was reported that there was frequently no F2 (who worked part-time Monday to Wednesday) or registrar support, and the CT2 trainee was very often busy managing the on-call bleep; trainees said that they had worked with the CT2 trainee on average of one week per month. Trainees had been supported by a Trust staff grade doctor. However, this post was vacated in January 2017 and had not been replaced. The department was supposed to provide a locum on Thursdays and Fridays, but they were usually taken to cover night shifts or emergency surgery.

Emergency surgery

Trainees reported that a consultant-led ward round took place at least once a day on Monday to Friday, with all patients seen in the morning. Occasionally, consultants would undertake a post-take ward round after 5pm**.** The consultants would also review other patients who were unstable.

The review team heard that senior trainees would usually attend patients twice per day.

It was reported that in the event that an acute admission patient's condition deteriorated, trainees would always have support from senior doctors, with the level of seniority dependent on the severity of the patient's condition. At all times, a F2 or higher trainee would attend patients, including at the weekend, when higher trainees were onsite and would undertake ward rounds.

In the event that they were unable to access ward support from senior staff, trainees advised that there was always someone to contact, and that surgeons were always accessible; even in theatre consultants would communicate with trainees via the speaker phone to offer advice. Alternatively, trainees went to theatre, if necessary.

The review team heard that the higher trainee covering nights on-call was not always resident. However, there were guidelines in place with regard to how close to the site the on-call doctor had to be if they were off site. Trainees advised that the on-call higher trainee would always attend, if needed.

Upper GI surgery

Trainees reported that ward rounds took place daily and were usually led by a consultant, including at the weekend.

Trauma and orthopaedic surgery

Trainees advised that they covered multiple consultants and worked across a number of different teams but did not have to undertake orthopaedic on calls. The review team learned that consultants led the post-take ward round every morning.

	Trainees felt generally well-supported and stated that there was always a middle grade onsite and there was in place a good system of cross-cover. However, trainees felt that they received a lot of support from the dedicated ortho-geriatric consultant, who would step in to help trainees regardless of patient age.	
1.3	**Responsibilities for patient care appropriate for stage of education and training** **Trauma and orthopaedic surgery** Trainees reported that they had never been in a situation where they were the only member of the trauma team in the hospital and only attended trauma calls to observe.	
1.4	**Rotas** Trainees across all specialties reported that they had regularly stayed at least half an hour after the end of their shift to complete outstanding work. A number of trainees reported days where they had not left until over two hours after the end of their shift. It was acknowledged that this was often done to alleviate the pressure facing the incumbent trainee and it was felt unfair to hand over a long list of outstanding jobs. At the weekend, one F1 was on call covering all wards except trauma and orthopaedic surgery, which was described as unmanageable. **Emergency surgery** The review team learned that the current rota was supported by three trainees - two F1 and one F2. The review team heard that the department's F2 trainee held the bleep every day for general surgery and urology, and while they felt very well-supported in general surgery, they reported that the lack of middle-grade urology support left them feeling unsure and unsupported before having to approach consultants. It was reported that the F2 rota in its current form was unsustainable, with the same trainee being responsible for on-call work every day and had worked five in 12 long days in the weeks prior to the focus group. **Trauma and orthopaedic surgery** Trainees reported that they worked over their scheduled hours once or twice per week and had to start work before their shift start time (8am) as the trauma meeting took place at 8am, and they were expected to have the patient list ready in advance of this. The review team learned that trainees found it difficult to work to their scheduled midweek hours of 8am-4pm. Trainees advised that they were well supported by the higher medical trainees even though they were very busy; trauma and orthopaedic surgery trainees reported that they often stayed late to ensure that they did not hand over a long list of patients. **Lower GI** Trainees advised that the varying nature of their workload meant that they expected to have to stay late. They reported that they did not have F2 support and had to work up as well as manage their normal workload. In addition, when colleagues were on nights or on leave there was only one F1 on duty, leading to a significant increase in workload. **Urology** Trainees experienced a very heavy workload, with no middle grade support on their rota. Trainees advised that they were responsible for covering on calls for both general surgery and urology, carrying both bleeps during those shifts.	Yes – see F1.4 below

1.5	**Handover** The review team learned that the general surgery morning handover was attended by colleagues from emergency surgery, upper and lower GI surgery and urology and was led by either a higher trainee or consultant from emergency surgery. All higher trainees attended, as well as consultants from emergency and lower GI surgery. Trainees reported that the handover was rarely an educational experience. **Urology** Trainees advised that Mondays and Tuesdays were very busy days, as the weekend phone advice offered by the on-call doctor to the F2 trainee managing referrals was to admit patients (which trainees believed was often unnecessary). In the event that a patient could be discharged, the F1 would have to manage the follow-up process when they returned on Monday or Tuesday. The review team learned that it was a regular occurrence for trainees to come to work on Monday and find that weekend admissions would not have been seen by a senior doctor. Trainees had to add these patients to a list to be seen by the most senior member of staff, who was often the CT2 or alternatively, whichever consultant the trainees had sourced to review the urology patients. New urological patients admitted overnight during the week were also not routinely seen by a consultant.	
1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** **Urology** Trainees stated that they often felt like they were the departmental administrators, such was the burden of administrative work they had to undertake. It was reported that they had little time to do ward jobs and on theatre days, were frequently interrupted to complete discharge summaries and personally arrange outpatient follow-up appointments. The review team heard that this practice was not widespread among all consultants; however, trainees said that a number of consultants in the department expected the trainees to be their administrators. Trainees advised that they were also responsible for booking patients' post-surgical follow-up appointments. The process was further complicated by having to report each appointment booked by email to the urology department's administrative team. This task balance was reported to be just about manageable when both trainees were onsite, but when one was away the placement felt little like a training environment and was very highly pressured covering the bleep and attending the ED. **Plastic surgery** Trainees in this specialty similarly reported an administrative-heavy workload, spending at least one hour per day on such tasks and up to three hours on a Monday morning. The review team learned that trainees were responsible booking ward patient appointments for the following clinics: • hand therapy • paediatric patient dressings replacement • adult patient dressing replacement • routine follow-up outpatient clinics	Yes – see F1.6a below Yes – see F1.6b below

	Trainees reported that they also had to manage bookings for the ED patient list needing plastics dressing clinics, and had to call patients in addition to booking their appointments. On the whole, trainees felt that their day-to-day role offered little clinical experience and largely comprised documentation and appointment scheduling, whereas on calls offered the best learning experience. **Trauma and orthopaedic surgery** Trainees advised that they were not on the orthopaedic on-call rota – they covered the take but were not responsible for trauma calls. However, they did receive regular opportunities to gain experience and shadow the F2 on call during trauma calls. The review team learned that trainees were responsible for booking patient appointments (including calling patients to arrange) and scheduling theatre sessions. Trainees found the appointment booking time-consuming but felt that arranging theatre bookings was a good learning experience in its exposure to patient case history.	

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**	
2.1	**Effective, transparent and clearly understood educational governance systems and processes** The review team was concerned to learn that a number of trainees had stopped exception reporting due to frustration at their reports being ignored, and in a number of cases not remunerated, despite reporting. It was reported that despite a recent meeting being held with senior consultants and rota coordinators to discuss the process, nothing had been changed; trainees advised that they had never received acknowledgement or feedback on any reports they had made. More generally, trainees felt that supervisors did not know how to manage the exception reporting process and they had no idea how or when these reports would be paid.	Yes – see F2.1 below
2.2	**Impact of service design on learners** All trainees reported that they often experienced delays with imaging requests created by a bottleneck with morning requests being managed when the department opened at 9am.	

3. 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.**		
3.1	**Appropriate balance between providing services and accessing educational and training opportunities** The review team was informed that all trainees managed private patient work as those patients were added to the same list as NHS patients. All trainees reported that the introduction of increased phlebotomy support had significantly improved their workload. **Urology** trainees stated that they felt their main purpose was service provision, and did not feel like they were learning much from their placement. They said that they received teaching the day before the focus group and felt like trainees for the first time in their placement. They also reported having a heavy administrative workload and not enough support; they were required to follow up patients post-surgery and generally did not feel as protected as other specialties in the hospital. **Lower GI** trainees reported they did not receive any formal teaching, and consultants were often too busy to teach informally. The review team also heard that trainees did not attend the take, spending most time undertaking jobs on the ward.	Yes – see F3.1 below

Good Practice and Requirements

Good Practice

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	N/A		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
F1.2	The Trust is required to ensure that junior trainees are not left unsupervised without consultant support both in and out-of-hours. The Trust is required to ensure that there is a named consultant at all times for trainees to call to access in-person clinical supervision and support. The Trust is required to ensure that there are planned consultant ward rounds that trainees are able to attend, including daily consultant review of new patients admitted overnight.	The Trust must provide details of all revised urology rotas clearly showing evidence of onsite consultant support and consultant attendance at ward rounds. The Trust is required to provide feedback from trainees at local faculty group meetings regarding the frequency of and consultant attendance at ward rounds. The Trust is required to create standard operating procedures for urology ward rounds. The Trust is required to submit an interim management plan detailing how it will resolve these issues by Friday 3 March 2017.	R1.8
F1.4	The Trust is required to review and revise the F2 and core surgical trainee on-call rota to ensure that F2 trainees receive appropriate senior support and are not on call on a daily basis.	The Trust must provide details of all revised on-call rotas, clearly demonstrating evidence that F2 trainees are receiving an exposure to an appropriately balanced workload of ward-based and oncall duties.	R1.12
F1.6a	The Trust is required to ensure that trainees are not undertaking unnecessary administration tasks at the expense of completing tasks of educational value. The Trust is required to establish administrative support as a matter of urgency to relieve the significant burden on trainees of booking outpatient appointments.	The Trust must review and revise its administrative processes with regard to the booking of outpatient appointments, submitting details of its plan to resolve this issue as evidence. This item should be monitored at LFG meetings, with the submission of minutes and associated trainee feedback as evidence.	R5.9h
F1.6b	The Trust is required to ensure that F1 trainees are not providing acute urology patient reviews and specialty opinions without appropriate supervision.	The Trust is required to provide details of rotas and feedback from discussions at local faculty group meetings demonstrating that urology trainees are not working without appropriate supervision, with particular reference to the review of acutely unwell patients.	R1.8
F2.1	The Trust is required to review its exception reporting process and structure, ensuring that all authorising staff are aware of their responsibilities and that trainees are encouraged to report as per the requirements of their new contract.	The Trust is required to establish a governance structure for trainees to raise concerns about exception reporting and their new contract with the Trust Guardian. Compliance with this action should be monitored through LFG meetings, with the provision of minutes as evidence.	R1.1

F3.1	The Trust is required to ensure that trainees are not tasked with any routine private patient work that is of no educational value and/or in any way compromises their training experience, with particular reference to increasing workload.	The Trust must provide a robust plan and private patient protocol that offers clarity on trainee responsibility with regard to the provision of care for private patients. The protocol must demonstrate that equitable educational requirements are applied to the management of private patients as to that of NHS patients, e.g. to be of educational value, and to be undertaken with consultant clinical supervision.	R5.9h

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**

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Anthea Parry, Deputy Director of the North West Thames Foundation School
Date:	16 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.