QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Barts Health NHS Trust (Newham University Hospital)

Paediatrics

Risk-based Review (focus group)

Quality Review report

19 April 2017

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	Despite paediatric training at Newham University Hospital performing well in the 2016 General Medical Council National Training Survey (only one pink outlier was received for clinical supervision) and improving significantly since the 2015 results (when three red outliers were received for clinical supervision, handover and induction), concerns regarding the training provided in neonatology were raised in the 2016 London Specialty School of Paediatrics end of year survey. In particular, red outliers were received for: overall experience, structured learning, clinics and educational supervision. Furthermore, a senior officer at the Royal College of Paediatrics and Child Health informed the London Specialty School of Paediatrics of anonymous concerns that had been raised by a trainee based at Newham University Hospital. Health Education England therefore felt it was necessary to conduct a focus group and meet with the trainees, in order to further investigate and ascertain whether the learning and training environment was suitable for trainees.
Training programme / learner group reviewed	The quality review team initially met with the Clinical Lead for paediatrics, the College Tutor for paediatrics, the Clinical Lead for neonatology, the foundation Training Programme Director, the Clinical Director for children and women's health and the Director of Medical Education at Newham University Hospital. The team subsequently met with a number of foundation, GP, core and higher trainees within general paediatrics, neonatology and community paediatrics at the following grades: - Foundation Year 1 (F1) - Foundation Year 2 (F2) - Specialty Training Year 1 (ST1) - Specialty Training Year 3 (ST3) - Specialty Training Year 5 (ST5) - One Trust grade doctor attended the one-to-one session.
Quality review summary	Health Education England would like to thank the Trust for accommodating the Risk-based Review (focus group) as well as ensuring the sessions were well attended. The review team was informed of one area of serious concern in relation to bullying and undermining behaviours displayed by a small number of staff within the department, which was being followed up separately by the Postgraduate Dean and Head of Quality and Regulation, and Medical Director and Director of Medical Education at Newham University Hospital. During the course of the review, the quality review team was informed of a number of areas that were working well with regard to the education and training of paediatric trainees, as outlined below: - All of the trainees the review team met with were extremely complimentary of their general paediatric experience. It appeared to the review team that there was robust clinical supervision in place and that the overall culture was extremely positive. - All of the trainees the quality review team met with spoke very highly of the clinical lead and college tutor for neonatology and reported that they received robust clinical supervision and support from many of the consultants and Trust grades within the department (trainees gave

examples of some consultants completing baby checks when the department was extremely busy).

- The trainees reported that they were exposed to a wealth of clinical cases and training opportunities, within both general paediatrics and neonatology.

Areas for improvement within paediatric training were highlighted as follows:

- The trainees reported that they did not receive enough outpatient exposure or training opportunities within general paediatrics. The trainees commented that the rapid access clinic they undertook did not provide good training opportunities. They expressed a desire for a parallel list for the trainees with the consultant in a general paediatric outpatient setting.
- The quality review team was informed that there were no up-to-date clinical guidelines in place throughout neonatology, and that the trainees were often unsure as to which clinical guidelines they should be working to.
- The quality review team was informed that rota gaps were not well managed at HR level, despite the trainees trying to be proactive and warning of anticipated gaps etc. Examples were given of incorrect paperwork being sent to locums thus leading to loss of the locum cover. Furthermore, the majority of trainees reported being paid the incorrect salary at their beginning of their post – some as little as £300/month.

Quality Review Team			
HEE Review Lead	Dr Camilla Kingdon Head of the London Specialty School of Paediatrics	**External Clinician**	Dr Atefa Hossain Consultant Paediatrician, St George's University Hospitals NHS Foundation Trust
Scribe	Elizabeth Dailly Learning Environment Quality Coordinator	**Trainee/Learner Representative**	Dr Anastasia Katana PICU Fellow at Evelina London Children's Hospital
Lay Member	Jayam Dalal Lay Representative		

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

The Director of Medical Education (DME) informed the review team that as the nature of the anonymous concerns (mentioned above in the Background to Review section) were unknown, they had taken a broad approach and had met with all the trainees in order to investigate and understand any issues the trainees may have had. It was reported that the trainees raised no concerns in relation to patient safety. However, the DME stated that issues had been highlighted regarding the neonatology handover meetings and the Friday grand rounds that took place and trainees reported that the way in which they were conducted and the behaviour of some members of staff during the meetings, was not conducive to learning and provided limited educational merits. Following this, it was clear that substantial work had been undertaken to change the structure of the meetings, which had had a positive outcome.

In relation to the local teaching provided to trainees, the review team was informed that the Friday teaching often had not been bleep free and that trainees often struggled to attend. To mitigate these effects, it was reported that local teaching sessions were now provided every day to ensure trainees could attend, and that the department had restructured and readjusted the programme in response to the feedback trainees provided about which sessions they enjoyed. Furthermore, it was reported that the Royal Society of Medicine regional teaching days and regional simulation training days would be incorporated into the trainees' rotas when they rotated, and that their rotas would be built around those dates.

The Director of Medical Education confirmed that they would provide a strong degree of oversight within the department, to ensure the necessary cultural changes took place.

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** All trainees reported that they were aware of how to report serious incidents. However, not all had received feedback from Datix forms that had been submitted regarding serious incidents they had been involved in.	
1.2	**Appropriate level of clinical supervision and support** The quality review team heard that the general paediatric consultants and middle grade doctors provided excellent clinical supervision and were extremely supportive. The trainees provided examples of consultants clerking patients within the emergency department if the workload was extremely onerous. Similar sentiments were echoed by the trainees with regard to many of the consultants within neonatology, who also provided such support, and further examples were given of consultants completing baby checks if the department was extremely busy. Furthermore, the foundation and GP trainees all reported that they felt extremely well supported within their role and that they could all approach someone within the department if they needed to raise any concerns. However, the review team was informed that this was not true of all consultants within the department and that the amount and quality of clinical supervision varied depending on who was providing the supervision. Furthermore, the trainees commented that some consultants were often unreceptive and resistant when trainees recommended management plans, even if they were in line with national guidelines or were recommended by the National Institute of Clinical Excellence (NICE). The trainees then felt they subsequently had to make unnecessary, extensive clinical notes in order to ensure they were not then 'scapegoated' if any errors or adverse effects subsequently took place as it was reported that some members of the consultant body perpetuated a blame culture throughout the neonatology department.	
1.3	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** All of the trainees the review team met with, reported that they received a wealth of training exposure in both general paediatrics and neonatology and commented that	

	they were exposed to a broad range of pathologies and clinical cases. However, within neonatology, the trainees felt that the opportunity for teaching and learning was not optimised and that the department would greatly benefit from having trainees at level Specialty Training Year 8 (ST8) to provide further bedside teaching and support for the more junior trainees, as the majority of trainees within the department were ST1-ST3. The trainees informed the review team that a 'SHO' led ward round took place with some of the consultants within neonatology, which the trainees found extremely valuable and provided them with good training opportunities. However, trainees at all levels reported that they received insufficient exposure to outpatient clinics. Although in general paediatrics the trainees undertook a rapid access clinic, trainees sensed that service provision outweighed educational benefits, and they indicated that the clinic provided few learning or training opportunities. The trainees suggested that a parallel clinic run for the trainees, with the consultants would be extremely beneficial. Furthermore, the trainees stated that they received no clinic exposure within neonatology. It was reported that during their induction trainees were informed that would be able to attend clinics, but that in practice due to the combination of gaps on the rota and people working part time, they were not able to attend. The trainees reported that within neonatology, often the midwives did not perform the baby checks on the postnatal ward, and that instead this was the responsibility of the junior trainees. However, the trainees stated that many of the midwives were trained to do so but that no guidelines were in place regarding which babies they could check.	Yes, please see P1.3a below. Yes, please see P1.3b 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.

2.1	**Impact of service design on learners** When discussing the guidelines that were in place, the review team heard that the general paediatric guideline folder was well organised by sub-speciality and up to date. However, unfortunately this was not the case in relation to the clinical guidelines within neonatology. The trainees reported that not all the relevant guidelines were in place and established within the department (for example, some of the trainees the review team met with stated that there was no antibiotic guideline when they started their post) and that they felt that some of the guidelines that were in place and available, were, at the time of the review, significantly out of date. One trainee further stated that due to this, they were having to use the guidelines from the Royal London Hospital. The review team was informed that trainees had previously offered to update some of the guidelines, but that this had been resisted by a member of the consultant body and that an updated guideline for the postnatal ward had been completed by a trainee in 2016, but had still not been implemented at the time of the review. The quality review team was informed that the Human Resources (HR) processes within the Trust were poor, and that the trainees felt they contributed to some of the vacancies within the department. The trainees were under the impression that there had been instances in which individuals had been offered a job, and HR had failed to send them the correct paperwork, which had resulted in people taking positions	Yes, please see P2.1a below. Yes, please see P2.1b below.

	elsewhere. The trainees further reported that they were frequently paid at the wrong banding whenever they rotated within the Trust, despite informing HR prior to rotating about the changes.	
2.2	**Appropriate system for raising concerns about education and training within the organisation** The trainees reported that 'junior/senior' meetings took place monthly, which the review team inferred as constituting the Local Faculty Group (LFG), during which a trainee representative was present and raised any concerns that the trainees had. However, it did not appear to the review team that one dedicated trainee attended each meeting and that instead it was organised on an ad hoc basis, in that whichever trainee was available attended. Furthermore, it was reported that this could be arranged at very short notice and the selected trainees' workload was not always taken into consideration when they were told they should attend.	Yes, please see P2.2 below.
2.3	**Organisation to ensure access to a named educational supervisor** The quality review team heard that one general paediatric trainee's educational supervisor worked predominantly within neonatology, and only undertook two 'hot' weeks within general paediatrics every year. This resulted in the trainee not spending much time with their supervisor, and therefore raising any concerns or issues with other members of the department as opposed to their supervisor. However, it should be noted that the trainee felt extremely comfortable to do so, considering how approachable the consultant body within general paediatrics was, and the amount of support offered.	Yes, please see P2.3 below.
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.**		
3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** It appeared to the quality review team that insufficient debriefing opportunities and processes were available for trainees following upsetting cases.	Yes, please see P3.1 below.
3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees reported that within neonatology, although there were some very enthusiastic consultants who were extremely supportive, this was not universal, and they provided many examples of behaviour, directed at trainees, Trust grade doctors and other consultants, that was not conducive to a positive learning and training environment.	
3.3	**Regular, constructive and meaningful feedback** The trainees stated that they often received feedback from the consultant body within general paediatrics and some within neonatology, that they found extremely beneficial. An example was given of a central line extravasation where the consultants used it as an opportunity to derive important learning points and at no point was the clinical team made to feel guilty or bad. In fact, this episode had clearly led to service improvement and was viewed as being highly constructive. In contrast, though the review team was informed that constructive feedback was not provided by all consultants within neonatology, and that instead of working with the trainees to identify areas they could improve on, or how situations could have been managed differently some consultants within the department would often 'blame' the trainees for any mistakes they made.	

Good Practice and Requirements

Good Practice
N/A

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
P1.3a	The Trust to ensure that all trainees have adequate outpatient exposure and to review the current arrangements with regard to this. The Trust should consider whether a parallel clinic list with a consultant can be organised.	The Trust to provide confirmation and evidence that all trainees (most particularly ST4+), within both general paediatrics and neonatology, access the requisite number of clinics during their placements.	R1.12
P2.1a	The Trust to ensure that up-to-date clinical guidelines are in place within neonatology.	The Trust to confirm such guidelines are in place and are easily accessible, and provide copies. The Trust to monitor the impact of this on trainees' experience through the monthly Local Faculty Group (LFG), and provide minutes of a group in which this issue is discussed with trainee representation.	R2.3
P2.2	The Trust to ensure a nominated trainee representative is selected and given appropriate notice of each LFG meeting that takes place.	The Trust to provide the name of the trainee rep and confirm that a schedule of the LFG meetings has been sent to the trainee in question.	R2.7

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
P1.3b	The Trust to review the practice of midwives undertaking baby checks, and create guidelines regarding when this is appropriate and when midwives should undertake baby checks.	The Trust to provide the outcome of this review, any subsequent changes that have been made and should submit a copy of the guidelines.	R1.9
P2.1b	The Trust to review the HR policies relating to trainees' pay when they rotate within the Trust.	The Trust to confirm such a review has taken place and detail any changes that have subsequently been made to the HR policy.	R2.3
P2.3	The Trust to review whether it is possible to ensure that general paediatric trainees' educational supervisors work predominantly within general paediatrics.	The Trust to provide the outcome of this review, and whether such an arrangement is possible.	R2.15
P3.1	The Trust to ensure that adequate debriefing opportunities are available for all trainees.	The Trust to confirm and outline what debriefing arrangements are in place.	R3.2

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
The London Specialty School of Paediatrics to assess whether it is possible for a Specialty Training Year 7 or 8 (ST7/8) trainee post to be introduced at Newham University Hospital.	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Camilla Kingdon
Date:	22 April 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.