QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Barking, Havering and Redbridge University Hospitals NHS Trust

Foundation surgery

Risk-based Review (focus group)

Quality Review report

17 October 2017

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	Due to the significant number of red and outliers that were received in relation to foundation surgery at Queen's Hospital in the 2016 General Medical Council National Training Survey (GMC NTS) (for overall satisfaction, clinical supervision, adequate experience, supportive environment and access to educational resources), a focus group was initially undertaken by Health Education England (HEE) in November 2016. Following this, the decision was made to remove the foundation year 1 (F1) trainees from the general surgery department, until significant improvements had been made regarding the learning and training environment regarding foundation doctors. Subsequently, an Education Lead Conversation occurred in March 2017, during which the Trust and general surgery department presented to HEE the Transformation Plan to address the issues that had previously been raised by trainees and highlighted in the 2016 GMC NTS. HEE therefore reintroduced foundation doctors into the post, and it was decided that an on-site visit would then be undertaken by HEE in June 2017, in order to ascertain whether the improvements set out in the Transformation Plan had been delivered and whether the learning environment was suitable for trainees to continue to be placed in the general surgery department at Queen's Hospital. Following this, it appeared that there had been significant improvements within the department and the learning and training environment was suitable for trainees. It was felt that HEE needed to meet with the new cohort of novice trainees who had started in the department to ensure that the changes the Trust had made were sustainable and to gain further feedback from the new cohort of trainees.
Training programme / learner group reviewed	Foundation surgery
Quality review summary	Health Education England would like to thank the Trust for accommodating the Risk-based Review (on-site visit) as well as ensuring the session was well attended. During the course of the on-site visit, the quality review team heard of one area of serious concern, for an immediate mandatory requirements was issued: - The review team was informed by the foundation surgery trainees that a weekend paper handover system was in place, whereby the trainees had to fill in a separate sheet of paper for every patient in the department, every Friday night, which often resulted in them staying extremely late, that was then put in a folder for the weekend staff, and then filed into the patients' notes at various times during the weekend following a ward round. The system presented patient safety concerns, as trainees were concerned that patients and clinical tasks/ treatment were likely to be missed for several hours during the day. The Trust was required to review the weekend handover process and ensure safety of documentation and present plans that a robust, auditable (preferably electronic) handover system is in place. The review team was further informed of a significant number of improvements that had been made, and areas that were working well with regard to the education and training of foundation doctors within the surgery department at both Queens Hospital and King George Hospital, as outlined below: - The review team ascertained that there had been a huge improvement in the department at Queen's Hospital since the initial focus group in 2016. The trainees confirmed that they felt supported by the consultants and

	higher trainees within the department and that they could always access advice and clinical supervision during the week. - The trainees indicated that they had never worked beyond their competency and that they were always aware of who to escalate to. - The trainees based at King George Hospital also confirmed that they felt well supported and that good supervision was provided from the consultants and higher trainees within the department. - The trainees based at Queen's Hospital confirmed that they were able to attend theatre and clinics and that they received protected time to attend such teaching sessions. - The review team was informed by the trainees based at Queen's Hospital that regular teaching sessions were provided on Tuesdays and Thursdays, which were consultant led. - All trainees confirmed that they had met with their educational and clinical supervisors. In addition, areas for improvement regarding the training of foundation doctors within general surgery were highlighted as follows: - Many of the trainees stated that even though they were aware of how to exception report, they had been actively discouraged from doing so by consultants in the department. - The trainees reported that the rota was managed in a sub-optimal way, and that the rota coordinator in question needed further support. The trainees informed the review team that the consultants within the department were aware of the issues. - The review team was informed that the workload at the weekends at Queen's Hospital was extremely high and that often there were many locums who worked within the department, who did not have a good knowledge of the systems in place. The trainees felt less support and supervision was provided than during the week.

Quality Review Team			
HEE Review Lead	Dr Keren Davies Director of North East Thames Foundation School	**GP Representative**	Joyti Sood GP Associate Dean Health Education England North East London
Trust Liaison Dean	Dr Indranil Chakravorty Trust Liaison Dean Heath Education England North East London	**Trainee Representative**	Dr James De Boisanger Trainee representative
Lay Member	Robert Hawker Lay Representative	**Scribe**	Elizabeth Dailly Deputy Quality and Reviews Manager Health Education England London and the South East
Observer	Ed Praeger Learning Environment Quality Coordinator	**Observer**	John Forster Quality Support Officer Health Education England London and the South East

	Health Education England London and the South East		

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
FS1.1	**Appropriate level of clinical supervision** The trainees based at Queen's Hospital reported that they felt well supported by the core and higher trainees within the department as well as the consultant body. The review team was informed that there had been a change in ethos and culture, and that the consultants were proactive at discovering and trying to resolve any issues the trainees had. This was echoed by the trainees based at King George Hospital, who reported that they also received a good level of support from the higher trainees and consultants within the department. All trainees confirmed that that they were never expected to work outside of their competency and could always access senior support from the higher trainees or consultants if necessary. The trainees indicated that the clinical supervision provided at weekends was less readily available, especially if the consultants or higher trainees were in theatre. However, trainees reported that they had never faced a situation when they could not escalate and access senior support and review when necessary.	
FS1.2	**Responsibilities for patient care appropriate for stage of education and training** The trainees based at Queen's Hospital confirmed that they were not part of the management and care of vascular patients, as per the Transformation Plan that was implemented by the surgical department following the removal of trainees from the department in 2016.	

FS1.3	**Rotas** All of the trainees the review team met with confirmed that they were aware of how to exception report and had been encouraged to do so by the Education Team and the Guardian of Safe Working during their induction. However, a number of trainees commented that they felt they were actively discouraged from reporting by the consultant body, as many of the consultants often viewed the exception reports in a punitive manner and felt that they reflected negatively on the department and consultant named in the exception report. However, the trainees based in colorectal surgery at Queen's Hospital indicated that they were encouraged to exception report by the consultants within the department. Generally, the trainees indicated that they left on time or did not stay more than an hour late. However, the trainees reported that they routinely had to stay up to two hours late on Friday evenings to complete the handover document for the weekend. The trainees indicated that the workload at weekends greatly increased and that the department was extremely busy. The trainees reported that there were significant issues in relation to how the rota was managed and felt that the rota coordinator(s) needed additional support, expertise in rota management and clinical oversight to understand safe staffing and training needs. The review team was informed that some days there was a large amount of core trainee support available, but that on others there were no core trainees within the department. Furthermore, the quality review team was informed of an occasion when despite the fact that the rota coordinator had been made aware that there would be no higher trainee available three months before the out of hours shift in question and the department had contacted them repeatedly to remind them, no higher trainee cover was organised. The review team heard that the trainees had raised this concern on multiple occasions and that the consultants in the department were aware of the issue.	Yes, please see M1.1 below
FS1.4	**Induction** All of the trainees the review team met with confirmed they received a Trust and departmental induction.	
FS1.5	**Handover** The trainees based at Queen's Hospital reported that the electronic handover system in place at the Trust did not work well in relation to the weekend handover that needed to take place, and that as a result a previous higher trainee who worked within the department had introduced a paper based system whereby a sheet was created for each patient detailing a summary of their history, their recent imagery and observations and their management plans for the weekend which was then kept in a handover folder and used by the on-call team. The pages were then filed in the patients notes at the end of the weekend. However, given the large number of patients in the department the trainees indicated that they had to create such sheets for up to 50 patients, which took an extremely long time and resulted in them staying late every Friday evening. The trainees indicated that there was then a separate folder for all outlier patients. The review team was informed that the system raised patient safety concerns, as it led to patients / papers being lost and as there were a large number of locums within the department during the on-call shifts, it was difficult for them to find patients using the system.	Yes, please see FS1.5 below
FS1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The trainees reported that they received good exposure to a wide range of cases within the department and that there were good training opportunities present within the department.	

FS1.7	**Protected time for learning and organised educational sessions** The trainees based at Queen's Hospital confirmed that they received dedicated, protected time to attend theatre lists and clinic sessions and that they were encouraged by the consultants to attend additional lists and sessions if the workload on the wards allowed it. The review team also heard that there was dedicated F1 teaching sessions held every Thursday, that was led by a core trainee but overseen by a consultant. Furthermore, local teaching sessions were provided for the entire surgery department on a weekly basis, which the trainees found interesting and beneficial. The trainees based at King George Hospital also confirmed that they received weekly local teaching sessions, during which they took in turns to present case-based discussions.	
FS1.8	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** Trainees at both sites confirmed that they had met with both their clinical and educational supervisors, and that they could access them easily.	
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.**		
FS2.1	**Impact of service design on learners** The trainees indicated that they often experienced issues in relation to the phlebotomy department. The review team heard that at weekends the trainees often had to prioritise which patients most urgently needed bloods taken as the phlebotomy department did not have enough staff and could not bleed all patients. Furthermore, the review team was informed that samples were regularly lost.	

Good Practice and Requirements

Good Practice

N/A

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
FS1.5	The Trust must review the weekend handover process and ensure safety and present plans that a robust, auditable (preferably electronic) handover system is in place.	The Trust to evidence what changes have been made to the weekend handover system.	R1.14
M1.1	The Trust is required to appoint clinical rota leadership, plus rota manager with oversight of both the medicine acute and ward cover rota, as well as the anaesthetic and surgical rotas. The Trust must deliver a plan to provide a communal rota that is visible and accessible to all trainees, meeting the training hours requirement and that enables the trainees to facilitate swaps and take leave.	The Trust to confirm that the review of the rotas has taken place and that the issue has been appropriately addressed.	R1.12

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

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 Keren Davies
Date:	06 November 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.