King's College Hospital NHS Foundation Trust

Ophthalmology

Risk-based Review (on-site visit)

Quality Review report

14/11/17

Final report

Quality Review details

Background to review	The Head of School has requested to undertake an on-site visit for ophthalmology following the poor GMC NTS 2017 results. At King's College Hospital, ophthalmology returned three red outliers (handover, induction and regional teaching) and six pink outliers (overall satisfaction, clinical supervision, clinical supervision out of hours, reporting systems, teamwork and adequate experience).
Training programme / learner group reviewed	Ophthalmology
Review summary and outcomes	There were two areas of serious concern, for which Immediate Mandatory Requirements were issued: • At Queen Mary's Hospital Sidcup, trainees were not aware of what to do in a clinical emergency with regards to the resuscitation or transfer of an acutely unwell patient, due to the lack of a site induction. • The trainees reported that blood tests and microbiology specimens from Queen Mary's Hospital had to be transported to another hospital, and were frequently lost. This represented a risk to patient care and safety eg. temporal arteritis. Three positive points were identified: • The trainees were positive about their educational supervision and their supervision in theatres. • The consultant-led out-of-hours advice good at PRUH and Sidcup, with a clear pathway of transfer of medical and surgical ophthalmic emergencies from those sites. • ST1s caseload is regularly audited at Queen Mary's Sidcup, and they are supernumerary for their first three months in training. Three areas for improvement were also identified: • The LFG needs to be embedded, and continued into the future. • The 18-Week Support team should be self-sufficient, managing their own complications, and be given access to computer systems themselves. They should not be involving the trainees, and should not be requesting passwords. • Locums should not be supervising ST1s, unless the college tutor is satisfied that they have had adequate training.

Quality Review Team			
HEE Review Lead	Miss Emma Jones, Head of the London Specialty School of Ophthalmology	**External Clinician**	Susie Morley, Consultant Ophthalmologist and Oculoplastic Surgeon
Trust Liaison Dean/County Dean	Dr Anand Mehta, Trust Liaison Dean, Health Education England South London	**Lay Member**	Robert Hawker, Lay Representative
Scribe	John Forster, Quality Support Officer Health Education England, London and the South East	**Scribe**	Elizabeth Dailly Deputy Quality and Reviews Manager Health Education England, London and the South East

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

The review team heard that following a previous patient safety issue regarding a child with cellulitis, the trust had firmed up the relevant pathway and they provided this. If a child was presented at the Princess Royal University Hospital emergency department after 6pm, the on-call team at Denmark Hill would be contacted, and the child would be transferred over. If patient care was needed, they would stay at Denmark Hill. The emergency itself would be dealt with at Denmark Hill, and it was reported that the non-ophthalmological emergency staff were aware of this.

After the GMC National Training Survey (GMC-NTS) indicated poor induction processes, the Trust overhauled the induction process, and written a manual so that all doctors were aware of what was required.

Also as a result of the survey, the review team heard that an LFG had been set up, and the first meeting occurred six weeks prior to the visit, and would be held every three months. The Trust reported that the first meeting had focussed on the GMC survey and emergency pathways, and that this had been fed back to the trainees.

Following the previous education lead conversation (ELC), the GMC survey was looked at very closely. The Trust reported that a lot of the issues raised had come as a surprise, and that all were being revisited. For example, following a discussion with trainees regarding clinical supervision, consultants had been encouraged to offer more proactive support in the clinical setting, reaching out to trainees at the end of sessions to ensure that they felt supported.

The Trust have appointed a clinical lead for the Ophthalmic Emergency services at Denmark Hill, and this Consultant is due to take up their appointment in January 2018.

Additional Educational Supervisors have been appointed, and all said they had appropriate time in their job plans to support their trainees, at 0.25PA per trainee.

It was reported that the shortage of operating lists for the number of consultants and trainees present at Denmark Hill was well recognised, and that the general manager in place at planned surgery was addressing the issue.

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
O1.1	**Patient safety** The trainees at QMS reported issues with the treatment of blood tests, microbiology samples and imaging, and the frequency with which these get lost. The review team heard about the lack of a reliable internal system for delivering samples and receiving results, and that trainees often had to call a courier company personally, which was very time consuming. Two different sites were used to analyse microbiology and blood samples, and this added to the confusion in tracking results. The trainees reported a potential patient safety issue caused by the distances between sites, as after a two hour wait time at A&E at the south sites, two hours of travel time and further waiting periods, it could be six hours before the patient was seen. The review team heard that waiting times for transport had been so bad that trainees had ended up calling ambulances for their patients, and often family members needed to be called to make the journey. The trainee reported that they need to organise the follow up of patients who require an urgent follow at King's sites. This is due to follow up booking being undertaken centrally with no ability to book in at short notice. Trainees would then need to keep notes if paper based and see the patients as walk ins at the start of clinic. This is a risk that patients will be lost to follow up. Clinics were not felt to be overbooked despite the additional patients.	Yes, see O1.1 below
O1.2	**Appropriate level of clinical supervision** It was heard that trainees may not have a regular clinical trainer at the PRUH, as the previous, long-standing consultant had retired, and a replacement was yet to be found. This had resulted in locum or specialty associate doctors providing clinical supervision for the majority of sessions. The trainee was unaware whether the locums were college approved, but reported that the specialty associate doctors could sign off on assessments. The review team heard from the faculty that they tried to limit the locum doctors' contact with the trainees.	

	Concerns were raised with respect to the management of patients from locum doctors at Queen Mary's hospital. The review team heard that the use of locum doctors was widespread at Queen Mary's, and that their quality was variable, and didn't always hold British training certificates. The trainees described instances where locum Doctors did not follow the local protocols of standard management for microbial keratitis, and the risk that this could affect the practice of very junior trainees. Trainees reported on more than one occasion where they had doubted the patient management from a locum, and had escalated to a supervisor, who had agreed with the trainee. Trainees reported this could be nerve wracking, as this responsibility shouldn't fall to them as ST1s. It was heard that when a higher trainee wasn't present, they had to take the word of the locum, even when they felt that they were wrong, or were clearly going against protocol. Overall however, educational supervision by Educational Supervisors was praised as being proactive and supportive. One Kings trainee described that their trainer mentorship had exceeded their expectation, and valued the support in taking on additional responsibilities and tailoring their clinical opportunities. It was reported that the shortage of operating lists for the number of consultants and trainees present at Denmark Hill was well recognised, and that the general manager in place at planned surgery was addressing the issue.	Yes, see O1.2a below Yes, see O1.2b below
O1.3	**Responsibilities for patient care appropriate for stage of education and training** The trainees reported that a lot of the simpler cataract surgeries were being taken by 18-Week Support, the private company to which the surgical backlog was being given. This left the trainees with only complex, consultant-level cases. However, the faculty reported that this was not the case, and that straightforward cataract cases had been ring-fenced for the trainees. The trainees praised the fact that they are not put onto on-call shifts until they have been in the post for three months, in order for them to build confidence and acclimatise to the role.	
O1.4	**Rotas** The trainees reported that while they were aware that they were not to come in if they had had less than five hours of sleep after a night on-call, they did not know the correct protocols for this.	
O1.5	**Induction** The trainees at Queen Mary's Hospital and the Princess Royal University Hospital reported that they had not had departmental inductions. The review team heard that at Queen Mary's this meant that the trainees did not know what to do in a clinical emergency with regards to the resuscitation or transfer of an acutely unwell patient, and that 222 was unavailable.	Yes, see O1.5 below
O1.6	**Protected time for learning and organised educational sessions** The review team heard of a number of protected teaching sessions, though it was reported that due to the long distance and journey time between the Sidcup site and Denmark Hill, the trainees were often unavoidably late, especially when coming from casualty on a Friday afternoon. Though there is local teaching, 20-minute presentation on Tuesday at PRU and FFA teaching intermittently on a Friday at QMS, this needs to be built on to meet the requirements of one hour of local teaching weekly. The trainees valued the Friday afternoon teaching at Kings, and they felt the learning opportunities were enriched by the high consultant and multi-professional attendance.	

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.

O2.1	**Impact of service design on learners** The trainees reported that there was an issue with the booking of cataract lists, as DNAs and other problems were common, meaning the lists were rarely full. The review team heard that the central booking office were too busy to fill these gaps at short notice. This caused two main problems: Firstly, it severely limited the number of operations that trainees had exposure to, and secondly it caused waiting times to be a lot longer than they needed to be, currently 9 months for cataract surgery, leading to increased dependence on 18-Week Support. The trainees reported that they had looked for an audit of same-day cancellations, but the data indicated that these were severely under-reported, as only 20 had been recorded for a period of 10 months. The trainees said that they knew this was not the case. When the central booking office had been asked for the surgical lists for the next two months, they had responded that they were too busy dealing with the 18-Week Support surgeries to provide them. The trainees reported that the 18-Week Support service were not self-sufficient, often producing complications which were passed on to the trainees and consultants in the department, adding to their workload. The review team also heard of an incident where a fellow had been asked for their Medisoft password by a member of 18-Week Support, which comprised a security risk. The trainees reported that 18-Week Support's services had been stopped at Queen Mary's Hospital as a result of the high rate of complications. The trainees described the difficulty in access to an emergency ophthalmic operating theatre out of hours. Of note, a patient requiring temporal artery biopsy had to be referred to another trust for the procedure resulting in delay in their biopsy. The faculty advised that the delay in purchase of an operating microscope was the primary cause for this but confirmed that a new microscope was due for delivery. Previously there had been lack of suitably trained Ophthalmic nurses out of hours, but this had been addressed.	Yes, see O2.1 below
O2.2	**Systems and processes to identify, support and manage learners when there are concerns** The review team heard that a local faculty group (LFG) had recently been established, and they had conducted their first meeting six weeks prior to the visit. This would allow the faculty to communicate with the trainees, and discuss any concerns the trainees might have. The Trust reported that they planned to hold an LFG meeting every three months.	Yes, see O2.2a 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.**		
O3.1	**Regular, constructive and meaningful feedback** The trainees praised the feedback received. The review team heard that there had been a complaint where a trainee had been receiving poor supervision from locum doctors in one clinic. They had escalated this to their educational supervisor, and reported that it was resolved quickly and effectively. The review team heard that the educational supervision was good, and that the trainees met with their supervisors every week. The review team heard that the feedback around exception reporting could be improved, and that there was no mechanism in place to feed back for time off in lieu.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
Multi-professional attendance at weekly teaching at kings.			
ST1s caseload is regularly audited at Queen Mary's Sidcup, and they are supernumerary for their first three months in training.			

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
O1.1	The Trust to establish a clear pathway for specimens with a good tracking system and feedback.	Please can the trust provide evidence that the system detailed in the pro forma is undertaken, with anonymised tracking forms for 5 recent ESR samples and 5 recent microbiology samples.	R2.3
O1.5	The Trust must ensure that a pathway for the acutely unwell patient at Queen Mary Sidcup site is communicated to all trainees.	Please can the trust provide evidence that the Ophthalmology trainees at QMS and PRU have read the policy. Please can the trust provide evidence that the Ophthalmology trainees at QMS and PRU have ILS training as detailed to be appropriate for emergency patient care in the transfer policy.	R1.1

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
O1.2a	The Trust to ensure that the College Tutor is satisfied that all locum staff supervising trainees have had adequate training.	Letter from college tutor to confirm that any locum staff supervising trainees have had appropriate training and are Royal College of Ophthalmologists approved trainers. Appropriate training would be at minimum, the Training of the Trainers course, or the London Deanery Clinical Supervisors eLearning module.	R1.8
O1.2b	The Trust to ensure that there is a mechanism by which consultants and trainees are able to pro-actively manage operating lists at the Denmark Hill site to maximise operating opportunities for trainees.	The Trust to provide evidence, for example the standard operating procedure or LFG minutes.	R2.3
O2.1	The Trust to ensure that complications caused by the external 18-Weeks Support service were not passed on to the Trust.	Incident reports to be completed by trainees if complications that arise from surgeries performed by the 18-Week Support service are seen by trainees. Please provide an audit of these over a two-month period.	R2.3
O2.2a	The Trust to ensure that the LFG meetings are further embedded and continued into the future.	Trust to provide minutes of LFG meetings held at each of the sites.	R2.7

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Miss Emma Jones
Date:	29/11/17

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.