QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Barts Health NHS Trust
(Whipps Cross University Hospital)
Foundation Surgery, Trauma and Orthopaedic Surgery and General Surgery

Risk-based Review (on-site visit)

16 January 2018

Final report

Developing people for health and healthcare

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Quality Review details

Background to review	The Risk-based Review on-site visit to Whipps Cross was proposed due to the significant deterioration in the site's General Medical Council (GMC) National Training Survey (NTS) results in 2017. In trauma and orthopaedic surgery, four red outliers were returned for: overall satisfaction, handover, induction and educational governance. Eight pink outliers were further received for: clinical supervision out of hours, reporting systems, teamwork, adequate experience, curriculum coverage, educational supervision, feedback and study leave. However, a green outlier was returned for workload. It should be noted that in 2016 only one red outlier was received (for local teaching). In relation to foundation surgery F1, two red outliers were received for: educational governance and feedback. No red outliers were received for surgery F2.
Training programme / learner group reviewed	Foundation Surgery, Trauma and Orthopaedic Surgery, and General Surgery
Number of learners and educators from each training programme	• 15 foundation trainees, either currently or previously in surgery. • Three core surgical trainees from general surgery. • General surgery trainees from ST3 to ST8 • Orthopaedic trainees from ST3 to ST8. • Seven supervising consultants from T&O and general surgery.
Review summary and outcomes	There was one serious concern raised at the review: • A patient safety concern was presented to the review team from most of the groups spoken to, regarding the tracking of patients around the hospital. This appeared to affect the general surgery team more than T&O. It was reported to be a fairly frequent occurrence that patients would be potentially lost from firm lists and therefore be missed on ward rounds, sometimes for 2 or 3 days. The review team considered there to be a real potential for a patient to come to harm. A response from the Trust indicating how they have addressed this issue is required within four weeks. Four specific areas were noted to have been working well: • Trainees from Foundation to ST8, as well as trainers, in general surgery, praised the firm structure for making them feel integrated within a specific team, as well as the providing continuity of patient contact. • Trainees gave positive reports of the induction that they received. • General surgery ST3+ trainees benefitted from training opportunities provided which matched their individual training needs. • Trauma and Orthopaedic higher trainees had access to the recommended number of operating sessions and reported that they were ahead of schedule with the log of operative cases. There were, however, a number of areas for improvement: • It appeared that a significant proportion of the issues raised at the visit might be solved by the creation of a dedicated surgical assessment unit (SAU) at the Whipps Cross site. This would help create efficiencies and training time, and would bring opportunities for foundation trainees to clerk patients. It may also help with the issue of patient tracking within the hospital.

- Departmental local faculty group (LFG) meetings in T&O and general surgery may have detected and addressed the issues raised in the GMC NTS before the survey was taken. The LFGs in general surgery and trauma and orthopaedics are still at an early stage of development.
- While the 'firm' structure in general surgery has many benefits and is valued highly by both the trainers and trainees, it presents some issues regarding case mix, access to leave and Foundation trainee working patterns. More flexibility within the system with a shared or linked firm structure may help address these issues.
- The review team heard of FY1 trainees carrying up to six bleeps at a time whilst assigned to 'ward cover', with no clear line of escalation if the senior doctors in their firm were busy. This was an unsatisfactory and potentially unsafe arrangement.
- Experience in theatre and outpatients was not included in the rotas for Foundation doctors, and rather required the trainee to organise this themselves, often leading to ward tasks being delayed, causing the trainee to stay late at the end of the day. It was heard that the focus of trainees attending theatres was for observation, rather than a tailored learning experience.
- Foundation trainees were never the first doctors to see a new patient in A&E. If this could be set up in a supervised manner, it would be beneficial for their training.
- Trainees regularly stayed beyond their rostered hours to complete ward rounds, teaching or feedback, but this was not reflected by exception reporting. There did not seem to be a culture of recognising or acknowledging working beyond rostered hours. Although this appears to be done voluntarily by the trainees in recognition of the clinical need of the service, there is a potential for these additional hours to impact adversely on trainee well-being. It is important for the trust education team, Guardian and senior staff to encourage a culture in which exception reporting is welcomed and valued.
- The night time responsibilities of the core surgical trainees in general surgery were heard to be unmanageably busy. A structured approach to of the Hospital at Night programme with bleep filtering by an appropriate individual and a better skill-mix of professionals making up the team would improve this.
- Based on experience from other units, the trauma and orthopaedics trainees suggested that theatre time could be utilised more efficiently, particularly with reference to trauma lists. This could further increase their available case load for training, as well as having potential benefits for the Trust.

Quality Review Team			
HEE Review Lead	Mr John Brecknell, Head of the London Postgraduate School of Surgery	**Deputy Postgraduate Dean**	Dr Indranil Chakravorty, Deputy Postgraduate Dean
General Surgery Representative	Mr Sas Banerjee, Consultant General, Laparoscopic & Colorectal Surgeon	**Foundation Representative**	Dr Dan Farrar, North Central Thames Foundation School
Trainee Representative	Lucy Cooper, Trauma & Orthopaedic Specialty Registrar	**Lay Representative**	Kate Rivett
Scribe	John Forster, Quality Support Officer		

Summary of information from the leadership team

The review team heard that due to the Barts Health merger, the Whipps Cross site had undergone multiple changes in management structure which had felt quite disruptive. However, in both the management of service and education, the recent evolution from a trust-wide Clinical Academic Group structure to a site based approach had brought a more responsive and optimistic atmosphere back to Whipps.

The Trust reported that they were surprised by the results of the 2017 GMC NTS, and that they did not have a full understanding of the causes. Since the NTS, it was reported that local faculty groups (LFGs) had been initiated, access to study leave had been reviewed, as well as the development of a more formal handover process in the evenings. The Trust also reported that a new induction process had been developed.

The Trust reported the historical view that surgical trainees on the whole enjoy their time at Whipps Cross, with many of them forming good links with the hospital and requesting to come back. The review team heard that the trainees appreciated the team-focused 'firm' structure that the department employed. The departments felt this situation still applied, despite the NTS results. There is a renowned and well-established exam preparation course associated with the hospital which is valued by trainees.

The Trust reported the contribution of the deteriorating fabric of the estate as a principle obstacle to training within the hospital. Training was compromised by problems with patient flow as well as the extra workload imposed by the large distances to travel in the pursuit of widely distributed trainee roles, in buildings which were old and, it was suggested, no longer fit for purpose. A redevelopment director had been appointed to the site executive and progress had been made recently with the construction of a new HDU, and the idea of a surgical assessment unit as a way of co-locating all the elements of the acute surgical service was described. The Trust clearly expressed a strong desire for this project to be escalated to the senior management.

The review team heard that the Trust had recently increased its number of educational fellows, from three to sixteen. These had roles in the delivery of both undergraduate and postgraduate training and, it was hoped, would allow the Trust to identify areas of concern earlier, as the fellows could collate feedback from learners.

The Trust suspected that trainees may be struggling with issues of workload, but stated that the Guardian of Safe Working Hours (GOSWH) had heard received remarkably few exception reports on this front.

The review team heard that non-surgical specialties had been asked if they wanted to help with the surgical on-call shifts. Historically, there had been a trainee from obstetrics and gynaecology who helped with the on-call rota. It was reported that there was an FY1 in intensive care who had been happy to help out, but that the Foundation doctors in psychiatry had declined. The trust reported that they had respected this decision. There was an ongoing project of involvement in the QM Physician Associate Programme, which it was hoped would help develop an Extended Surgical Team.

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
S1.1	**Patient safety** Foundation trainees reported that ‘losing patients’ (failing to register where the patients had moved from the emergency department (ED) on firm lists held by junior doctors) within the hospital was a fairly frequent occurrence. The review team heard that mostly these would be picked up quickly, but there had been an incident where a patient had not been reviewed by the team for two days, as the general surgery team thought they had already returned home. No robust patient tracking system appeared to be in place, and the review team felt that there was a real risk for patients to come to harm, as a result. Core and higher surgical trainees, as well as supervising consultants, also reported awareness of this problem, which seemed to affect general surgery more than the trauma and orthopaedic service. On direct questioning on this issue, the review team heard that the hospital record system was not updated in respect of patient movement in real time, and that the clinical team’s ability to follow patients depended on a list updated by the duty SHO. The visit team highlighted this as a patient safety related risk to the executive team on the day of the visit and required a rapid response. One of the perceived potential benefits of a surgical assessment unit was an improvement in patient tracking.	Yes, please see S1.1
S1.2	**Responsibilities for patient care appropriate for stage of education and training** In the general surgery department, an adherence to the traditional ‘firm’ structure was described. It was felt by all that this brought with it benefits in terms of allowing doctors in training to develop a sense of belonging to a team, a defined set of responsibilities and exposure to a stable population base. However, the consequences of this model were not all beneficial to training. In a firm-based structure, individual absence led to difficulties for team members in identifying who to contact for clinical advice and guidance. Foundation trainees in general surgery reported that it wasn’t uncommon for them to be uncertain who to contact. The review team heard descriptions of buddy systems which were well developed in the colorectal division of the general surgical service but less so elsewhere.	Yes, see S1.2a below

	It was also suggested that the on-call team provided a safety net in this regard but the perception of lack of a robust escalating structure persisted. Foundation trainees explained the system of having an FY1 each week as 'ward cover', who was expected to hold the bleeps of any doctors who were not present due to annual leave or sickness. It was reported that this was highly stressful for the FY1, as they could be required to hold up to six bleeps, on top of their regular duties. The review team heard that the bleeps were viewed as the individual responsibility of the FY1, rather than the team.	Yes, see S1.2b below
S1.3	**Rotas** Foundation trainees reported that they received their rotas just two weeks in advance, which made it difficult to book annual leave or to arrange swaps. The review team also heard that there was more than one person organising the rotas, and as a result they had previously received two different rotas, with discrepancies between them. The review team heard that there had been a move towards e-rostering, but at the time of the visit this had not yet been set up. While Foundation doctors reported being welcome when they attended clinic or theatre but that such educational opportunities were not included in their work schedules. In combination with the firm structure described in S1.2, this meant that if they chose to attend, there was no one to cover their ward work, and they would have to stay very late to finish their jobs. Though staying late was heard to be a common occurrence amongst foundation trainees, there appeared to be a culture of not 'exception' reporting within the department. The core surgical trainees from general surgery, reported that their night-time workload could be very high. The various mechanisms in place for covering the emergency workload during the day cease operating overnight and the CST becomes responsible for all referrals and the review of patients in A&E and the wards, which are separated by a considerable distance. Although the review team heard that there was a Hospital at Night scheme in operation, contribution to the provision of medical care to the general surgical patient group at night was not felt to be evident to the night time general surgical doctor. The suggested surgical assessment unit may have a role in improving this situation by collocating the various elements of the emergency role.	Yes, see S1.3a below Yes, see S1.3b below Yes, see S1.3c below
S1.4	**Handover** Foundation trainees reported that evening handover was conducted verbally and informally, with the team handing over to an FY1 who stayed until 8pm. This FY1 subsequently would hand over to the night team more formally, but this solely relied on the notes kept by the foundation trainee. While the review team heard that this provided an adequate system for clinical handover, it may not be sufficient on its own to assure accurate patient tracking.	
S1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** Foundation trainees reported that they did not 'clerk' patients and were never the first to see them. It was heard that a locum doctor was employed to do clerking. They all agreed that this was disappointing and would appreciate the educational opportunities that clerking would provide. Core surgical trainees reported good levels of access to training in the operating theatre (at least 4 sessions per working week in every case) and the outpatient clinic. Like the other groups met at the review, they seemed to value the 'firm' structure within the department. However, the lack of flexibility imposed by this system did mean only learning from one consultant and one senior trainee, which could be potentially limiting in terms of scope. This was particularly the case when a relatively junior higher surgical trainee was assigned to the same firm as a relatively senior core trainee, in which case competition for training opportunities limited access to relevant training, or where the	Yes, see S1.5a below Yes, see S1.5b below

	firm's business was that of complex surgical care in which the core trainee could take little part.	
S1.5	**Protected time for learning and organised educational sessions** Foundation trainees reported that the quality of teaching varied greatly, and that often lectures did not feel relevant to the trainees' needs. The review team heard that time in 'clinical skills' rarely included actual clinical skills, and that a substantial proportion of time was spent re-covering basics, such as cannulation. In addition, the FY1 teaching was reported to include a gap from 2pm to 3pm which was hard to fill with useful activity.	
S1.6	**Induction** Having received negative outlying returns from the GMC NTS over the last three years, both departments had worked to improve their local induction which was felt to be satisfactory by all the trainees met at the review.	

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.

S2.1	**Effective, transparent and clearly understood educational governance systems and processes** The leadership team met in the first session of the review described a sense of surprise at the results of the 2017 NTS and reported the early stages of setting up local faculty groups (LFGs) in the departments of both general surgery and T&O, partly in order to better understand the issues which had resulted in the apparent dissatisfaction. The various groups met reported different levels of awareness of these meetings. The CSTs reported that they were unaware of any local faculty group (LFG) meetings, and they had not attended any. General surgery trainees reported that while they were aware of an LFG meeting once a month, it had an informal structure, no minutes were taken, and there was no representation from the management structure. One of the trainees was not aware of the existence of the LFG. The clinical and educational supervisors for general surgery reported that the LFG was in the process of being developed and that it would be minuted in the future. The clinical and educational supervisors from trauma and orthopaedics reported that they had no formal LFG.	Yes, see S2.1 below

S2.2	**Impact of service design on learners** The trauma and orthopaedic trainees reported good access to operative trainees and that their posts allowed them to collect logbook cases at the rate of 400 per year pro rata, which is substantially ahead of the minimum requirement of the curriculum. However, they also felt that there was some inefficiency in the way the theatres were run, which meant fewer patients could be operated on per day. It was heard that this issue was multifactorial but a shortage of nurses and theatre, the scheduling of anaesthetic staff and availability of portering services were all reported in this regard. The clinical and educational supervisors reported the need for support in orthopaedics, and particularly highlighted the return of the extended surgical team, including doctor's assistants, as a potential solution.	

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.

S3.1	**Access to study leave** The higher surgical trainees in general surgery, like the other groups met at the review, seemed to value the 'firm' structure within the department. However, an undesirable consequence was that it restricted access to annual leave and the review team heard that it was essentially impossible to take leave when a trainee's firm was on-call. This had impacted on the ability of trainees to attend weddings for example.	Yes, see S3.1 below
S3.2	**Regular, constructive and meaningful feedback** Foundation trainees reported that formal feedback from consultants was rare, and that formal feedback was only given if a specific negative issue needed to be addressed. It was also heard that negative feedback had been given publicly, which could be uncomfortable for the trainees.	Yes, see S3.2 below

4. Supporting and empowering educators

HEE Quality Standards

4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.

4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.

S4.1	**Sufficient time in educators' job plans to meet educational responsibilities** Trainers from both departments included in the review reported sufficient job planned time for training. However, time spent travelling around the various locations on the site where patients were to be encountered, was felt to be time lost to training and an argument for the creation of a surgical admissions unit.	Yes, see S4.1 below
S4.2	**Access to appropriately funded resources to meet the requirements of the training programme or curriculum** In addition to the other items highlighted in this report, it was suggested that the reduction of patient numbers in outpatient clinics, perhaps in a proportion of sessions branded as teaching clinics, would create more opportunities to train. In orthopaedics it appeared likely that further development of a community-based Tier 2 musculoskeletal service, might help reduce the case load to assist in this initiative.	

5. 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.**		
S5.1	**Appropriate balance between providing services and accessing educational and training opportunities** The higher surgical trainees in Trauma and Orthopaedics reported that they were given priority over departmental fellows for training opportunities. This is unusual in London and to be commended. It appeared to contribute to the excellent rate of completion of logbook cases and progress against indicative numbers reported by this group of trainees.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The trauma and orthopaedic department have developed a strategy for continued monitoring of trainee progress against indicative number targets and adjusting the allocation of training opportunities accordingly and in iterative fashion, which appeared particularly effective.		To be shared with the TandO STC for London through its chair, Dominic Nielsen.	

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
S1.1	The Trust is required to establish a robust auditable handover and patient tracking system, to avoid the loss of patients transferred within the hospital. A response is required within four weeks.	Please submit the results of your investigation into this issue, together with an action plan describing measures to be taken to improve the ability of clinical teams to identify reliably the location of patients for whom they have responsibility.	

S1.2a	Please review the firm-based structure of the general surgery team. While it seems to have many benefits for trainees, its consequences are not all desirable. In particular, there is a need to develop a robust escalation mechanism for FY1 doctors to ensure an adequate escalation structure in the inevitable absence of individuals within the team. This item is linked to S1.2b, S1.3a, S1.5b and S3.1.	Please submit an escalation policy, to be implemented amongst the Foundation doctors in general surgery, and provide evidence of its inclusion in their induction.	
S1.2b	As part of a review of the firm structure, please examine the role of the "ward cover" FY1 in general surgery, to ensure that their bleep related workload is manageable. It might be useful to consider the development of team bleeps and more formalised co-working between Foundation doctors. This item is linked to S1.2a.	We look forward to submission of a manageable departmental system of linked / shared firms and a policy for escalation and mutual cover in general surgery	
S1.3b	The surgical community should work with the guardian of safe working and the director of medical education, to ensure that wherever appropriate, doctors in training and employed through the 2015 contract, are empowered and encouraged to raise exception reports with robust reassurance about the lack of any negative repercussions or reprisals for making such reports.	Please provide via LFG minutes a standard item for regular monitoring of workload and working excess hours and encouragement for recording this via exception reporting and a statement from the general surgery department, supported by GoSWH and DME, describing work towards this challenging cultural change.	
S1.3c	A review should be undertaken to make the intensity of work at night more manageable for the core surgical trainees in general surgery. Relatively minor modifications of the existing Hospital at Night program may be all that is required to provide this support.	Please provide a description of actions taken to address the workload, including bleep filtering and update Hospial@Night team protocol/ specification in surgery.	
S2.1	Please take steps to further develop and formalise local faculty group meetings in the training departments at Whipps Cross. The NACT model is recommended. A minuted quarterly meeting of trainees, trainers and departmental management can go a long way towards detecting and mitigating, in real time, local issues affecting training, and can therefore be a powerful tool for educational improvement.	Please submit minutes and attendance registers of local faculty group meetings from both general surgery and T&O departments, together with plans for their sustainability.	
S3.1	Please examine the flexibility of the 'firm' structure in general surgery in order to find ways to ensure that it does not restrict access to leave for trainees. This item is linked to S1.2a.	We look forward to learning how the firm structure can be adapted to improve access to leave for trainees.	

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
S1.3a	As part of a review of the firm structure in general surgery, please consider how Foundation doctors might have access to planned sessions in the operating theatre and outpatient clinic without needing to work late in compensation as they complete 'their' jobs for the day. This item is linked to S1.2a.	We look forward to a job schedule and rota confirming access to rostered theatre and clinic sessions for FY1 doctors. Please refer to the Best practice standards for Foundation Doctors in Surgical Placement document.	
S1.5a	Please consider ways of adjusting the work schedule of Foundation doctors working in general surgery to allow them access to opportunities to assess, or 'clerk', acute admissions to Whipps Cross, with appropriate levels of supervision. This would improve the educational content of their post.	We look forward to hearing about arrangements for the facilitation of supervised acute patient clerking for Foundation doctors within their work schedules.	
S1.5b	Please consider adjusting the allocation of trainees to firms in general surgery such that ST3 and CT2 trainees are not competing for similar training opportunities. In addition, please consider ways of adjusting the rigidity of the firm structure to allow core trainees the freedom to migrate to those learning opportunities within the hospital which best suit their training needs. This item is linked to S1.2a.	We look forward to document describing the new arrangements for the allocation of trainees to, and increased flexing of, the firms in general surgery in order to optimise the case mix of core surgical trainees.	
S3.2	While no evidence of overt bullying was encountered on this review, some public and quite aggressive feedback was reported to the review team. The current high-profile campaigns by trainee organisations (cut it out/hammer it out) and the Edinburgh college (lets remove it) make this a topical and important issue. Please consider how the material available in these two campaigns might be used to improve the training environment in the surgical departments of Whipps Cross.	We look forward to learning whether the material on challenging bullying and harassment from ASiT, BOTA and RCSEd was felt to be useful and would also appreciate learning more about the local approach to this behaviour.	

S4.1	The challenge to effective training posed by the deteriorating fabric of the estate was described in the opening session. At many points subsequently, the idea of a surgical assessment unit as a way of improving, among other aspects of training, time for training, the night time workload of the core trainees (S1.3c), educational opportunities for Foundation doctors (S1.5a) and the reliable tracking of inpatients (S1.1). The review team would enthusiastically support the Trust, in plans to establish such a facility at Whipps Cross.	A response to this recommendation from the Trust's executive team would be useful.	

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:	
Date:	

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.