QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

# Royal Free London NHS Foundation Trust
## (Royal Free Hospital)
## Obstetrics and Gynaecology
## Risk-based Review (on-site visit)

## Quality Review report

**25 January 2018**

**Final**

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# Quality Review details

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| **Background to review** | The Trust received a significant number of red and pink outliers in the 2017 General Medical Council National Training Survey (GMC NTS).<br>- Obstetrics & Gynaecology (GP) received one red outlier (local teaching) and seven pink outliers (overall satisfaction, clinical supervision, work load, supportive environment, adequate experience, educational governance and educational supervision).<br>- Furthermore, Obstetrics & Gynaecology (O&G) received five red outliers (overall satisfaction, clinical supervision, adequate experience, curriculum coverage and educational governance) and three pink outliers (clinical supervision out of hours, induction and educational supervision). |
| **Training programme / learner group reviewed** | Obstetrics and Gynaecology |
| **Number of learners and educators from each training programme** | The review team met with the College Tutor, Clinical Director, Deputy Director for Medical Education, Medical Education Lead and Joint TEL.<br>The review team then met with the following grades of trainees:<br>- foundation year two (F2)<br>- specialty training year one (ST1)<br>- specialty training years three to seven (ST3 to ST7).<br>The review team met with clinical and educational supervisors from the department. |
| **Review summary and outcomes** | The review team thanked the Trust for accommodating the review and for the efforts made in facilitating the process.<br>The review team was pleased to note the following positive areas:<br>- The trainees commended the supervisors and particularly the college tutor for the work done to improve the training programme following trainee feedback.<br>- The trainees were complimentary about the departmental induction to their posts.<br>- The higher trainees particularly recommended some of the advanced training skills modules such as emergency gynaecology, benign gynaecology and hysteroscopy.<br>- The junior trainees reported that they would recommend their posts to colleagues.<br>However, the review team identified some areas for improvement, as follows:<br>- Consultant presence and supervision in clinics was variable. Sometimes if consultants were present in clinic they were not actively supervising trainees, and the review team heard of instances where trainees were left to run clinics when consultants arrived late, left early or carried out administrative tasks during clinic time.<br>- Sufficient experience in obstetric and gynaecology theatres was lacking at all levels, compounded by the presence of clinical fellows. In addition, the most junior trainees were sent to the emergency theatre meeting in the |

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| | morning to obtain places for patients on the theatre list, which the trainees found to be counterproductive and detrimental to their wellbeing.<br>- The review team heard that it was difficult for the trainees to access sufficient ultrasound training experience in both obstetrics and gynaecology.<br>- The trainees expressed concern about midwifery staffing numbers. This was felt to be contributing to delays in care and timely transfer of patients and to senior midwives bullying and undermining junior medical staff.<br>Two Immediate Mandatory Requirements were issued on the day of the review. These related to the following issues:<br>- The review team heard that trainees had been asked to cover consultant clinics at short notice.<br>- The review team heard that junior trainees were expected to take consent from patients prior to operative procedures at pre-assessment without being appropriately trained to do so. |

| **Quality Review Team** | | | |
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| **HEE Review Lead** | Dr Greg Ward,<br>Head of the London School of Obstetrics and Gynaecology | **HEE Deputy Review Lead** | Dr Sonji Clarke,<br>Deputy Head of the London School of Obstetrics and Gynaecology |
| **Trust Liaison Dean/County Dean** | Dr Gary Wares,<br>Deputy Postgraduate Dean,<br>Health Education England, North Central London | **Lead Provider Representative** | Dr Marcus Lewis,<br>Programme Director for GP Training |
| **External Clinician** | Dr Sarah Reynolds,<br>Consultant at Bedford Hospital,<br>Chair of the Advanced Training Committee | **Lay Member** | Robert Hawker,<br>Lay Representative |
| **Scribe** | Elizabeth Dailly,<br>Deputy Quality and Review Manager,<br>Quality, Patient Safety & Commissioning Team<br>(London and South East) | **Scribe** | Louise Brooker,<br>Learning Environment Quality Coordinator,<br>Quality, Patient Safety & Commissioning Team<br>(London and South East) |

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

The review team were informed that the obstetrics and gynaecology unit had 17 consultant posts including a dedicated emergency gynaecology consultant and a locum obstetric post which was awaiting recruitment. There were seven ST1 level posts, including one clinical fellow and three GP VTS trainees. There were 11 trainee posts at ST3 to ST7 level although only eight of these posts were filled. Of the 12 higher specialty trainees, 10 worked less than full-time hours. The unit also employed a physician associate (PA) on the postnatal ward, who assisted the junior trainees with some of their administrative and clerical duties. The Trust had also recruited

clinical fellows to address gaps in the junior doctor rota across the labour ward, complex ultrasound scanning and theatres.

The unit had a birth rate of 3100 per year, with a level one neonatal unit and offered several specialist clinics and services including benign gynaecology, hysteroscopy, colposcopy, emergency gynaecology unit (EGU), vulval disease, menopause, advanced labour ward and some gynaecological oncology. The Trust were trying to increase the number of deliveries taking place at the Royal Free Hospital to ease pressure on Barnet Hospital and had been encouraging GP referrals to the Royal Free site. The catchment area covered a diverse and complex patient population and the hospital served as a specialist unit for the care of pregnant women with renal, hepatic and cardiac disease.

The Clinical Director and College Tutor described the working arrangements between the Royal Free and Barnet sites. The labour ward and neonatal team held a daily meeting at 11.00am where they contacted their counterparts at the Barnet site by phone to discuss activity and staffing levels on both sites and to plan transfers of patients between sites (usually from Barnet to the Royal Free) for the afternoon. Patients requiring higher level neonatal care were usually transferred to University College London Hospital. The review team heard an example of cross-site working to meet the complex needs of an obstetric patient who required urgent liver surgery and delivery at 32 weeks' gestation. The Trust was able to provide all necessary care for the mother and baby at the Royal Free site by sending neonatal specialist staff from Barnet hospital. The review team was advised that staff did not typically work across the two sites, although if necessary trainees could arrange to attend clinics at other sites to meet training needs. The Trust were planning to roll out a new IT system in June 2018 to allow the sites to share electronic notes and access pathology results and scan reports across sites.

The red outlier results for local teaching and workload from GP trainees were discussed. The College Tutor advised that at the time of the 2017 GMC NTS there had been five to six O&G (GP) trainees in post; this had since been increased to seven which addressed the rota gaps and had alleviated the heavy workload. The review team was informed that O&G (GP) trainees had protected learning time and an appropriate rota for their training including time in relevant clinics. O&G trainees had reported clinical supervision as being a red outlier, and the Trust reported that work had been done around clinical supervision in clinics and ensuring that trainees had clear pathways for escalating concerns and seeking advice. Both O&G (GP) and O&G trainees had rated the range of clinical experience as a problem, and the Trust had worked to increase the trainees' exposure to different aspects of the gynaecology service, and to increase their experience with instrumental delivery. The review team heard that due to the hospital having a level one neonatal unit, trainees needed to spend time at other hospitals in order to gain experience with delivery of premature babies.

The College Tutor explained the changes made to local teaching practices. Advanced Training Skills Module (ATSM) specific teaching was held monthly, there was weekly gynaecology teaching and MRCOG trainees received specific trainee-led teaching. Skills and drills training for junior trainees was held monthly. To help address the issues with obtaining sufficient ultrasound scanning experience, the trainees were allocated a week of study leave each to focus on scanning competencies, although to date only three trainees had booked this. The College Tutor reported that clinical supervisors were aware of trainees' needs and would call them to observe or assist with relevant cases. The Medical Education Manager informed the review team that the Trust planned to provide additional spaces for the trainees to use for educational purposes, as well as additional computers.

# 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.**<br>**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.** | | |
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| **Ref** | **Findings** | **Action required? Requirement Reference Number** |
| O&G 1.1 | **Patient safety**<br>The higher trainees expressed concern about staffing capacity and the effect that this had on care, citing the labour ward in particular. The review team was informed that the midwifery team were fully staffed according to the Birthright tool, but the trainees reported that patient transfers to the labour ward had been delayed on multiple occasions when there was no midwife available to take over their care. In some cases, this had resulted in women giving birth on the antenatal ward.<br>The junior trainees reported that they had not needed to raise concerns about patient safety, but were unsure of how to do this if a concern arose. One trainee informed the review team that there were no higher trainees in the neonatal team, therefore junior neonatology trainees were responsible for attending deliveries and responding to bleeps from the labour ward. The trainee was not aware of any cases where this had compromised patient safety. | |
| O&G 1.2 | **Appropriate level of clinical supervision**<br>The junior trainees related positive experiences of supervision by higher trainees and consultants, describing the senior staff as helpful and enthusiastic about teaching. The junior trainees reported that there was always senior support available in clinic, either from a consultant or a higher specialty trainee.<br>The higher trainees raised concerns about consultants cancelling their attendance at clinics at short notice; this had resulted in higher trainees being removed from their planned activities and, although clinic lists would usually be reduced, the higher trainee would be the sole clinician present in clinic. The review team heard examples of this occurring in gynaecology outpatients, rapid access and recurrent miscarriage clinics. The higher trainees reported that on some occasions they had been asked to cover unfamiliar clinics at other Trust sites. The review team heard that this has impacted upon training opportunities and the support provided to junior trainees on the wards.<br>The higher trainees reported that they had also experienced some consultants arriving late to clinics, leaving early or carrying out administrative work and phone calls relating to private patients during clinic times, leaving the higher trainee to see the patients. The review team heard that these issues had been raised at the local faculty group (LFG) meeting, but had not been resolved. | Yes, please see O&G 1.2a<br><br>Yes, please see action O&G 1.2b |
| O&G 1.3 | **Taking consent**<br>The review team heard that the junior trainees were responsible for carrying out pre-assessment and gaining written consent for operative procedures while on call. The trainees reported that although they were supervised by a more senior trainee when undertaking this initially, including the completion of a proforma document, no competency was established before the junior trainees began carrying out this task independently. The review team was concerned that this was not appropriate and questioned why written consent was not taken in clinic when the procedure was booked. | Yes, please see O&G 1.3 |

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| O&G 1.4 | **Rotas**<br>The junior trainees informed the review team that they had not needed to exception report as they rarely had to work past the end of their shifts, although there were occasions where the trainees had not taken breaks but had not exception reported.<br>The junior trainees raised the issue of missing training opportunities when allocated to morning ward rounds on the postnatal ward. The review team heard that, due to the length of time taken by the ward round and tasks such as blood tests and discharging patients, it was often not possible to leave the ward on time to attend other training opportunities such as clinics or hysteroscopy.<br>The higher trainees reported that there were often rota gaps when staff needed to take annual leave, despite the team appearing well-staffed. This presented difficulties in accessing training opportunities and study leave as service provision was prioritised. | |
| O&G 1.5 | **Induction**<br>The junior trainees reported that the departmental induction had been useful and had included practical information about on-calls and administrative duties, as well as providing the opportunity to shadow other trainees and be supernumerary in clinics before practicing more independently. | |
| O&G 1.6 | **Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience**<br>The review team discussed concerns about local teaching based on the GMC NTS 2017 data. The trainees reported that there were historical problems around a lack of experience at ST1 level; trainees at this level had been spending a disproportionate amount of time on postnatal ward and lacked clinic experience.<br>The unit had historically had a lower workload but trainees at all levels felt that the unit was becoming busier, and that the hospital's birth rate did not reflect the workload or the clinical complexity of the patient group. The higher trainees advised that patients could wait for several days for scheduled induction of labour and there was frequently a backlog of patients waiting for a space on the antenatal ward.<br>The trainees were able to gain experience in a range of clinics, for example antenatal, menopause, haemophilia, transplant, and psychosocial. The junior trainees had been contacted periodically by the rota coordinator to ascertain which clinics each trainee needed to attend and it was felt that the clinic allocation system was well-organised.<br>The trainees had experienced difficulties obtaining time in certain clinical areas and achieving some competencies. The junior trainees cited assisting with elective caesarean sections, performing episiotomy and perineal repair as areas where they required more experience. The higher trainees reported that they required more time allocated to the caesarean section and gynaecology theatre lists to achieve the required competencies, as well as more experience of instrumental delivery.<br>The Trust had hired clinical fellows to fill gaps in the rota, but this had decreased the number of theatre lists available for the trainees. The review team heard that even when there were multiple cases on a theatre list, the list would not be split between the clinical fellows and the trainees. Some of the higher trainees believed that their job did not provide adequate opportunity to learn or maintain operative skills. The issue had been raised multiple times at local faculty group (LFG) meetings but had not been resolved.<br>Lack of experience in ultrasound scanning was another area of concern for all the trainees, however the higher trainees reported that a new gynaecology consultant had recently been appointed and would be running additional clinics, creating further ultrasound scanning opportunities. The College Tutor had recently introduced a policy whereby all trainees were entitled to one week of study leave to spend in scanning clinics, but due to rota pressures few trainees had been able to participate in this. | Yes, please see O&G1.6a<br>Yes, please see O&G1.6b<br>Yes, please see action O&G 1.6c |

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| O&G 1.7 | **Protected time for learning and organised educational sessions**<br>The review team heard that each week there was a consultant-led teaching session, a higher trainee-led teaching session and a perinatal meeting which trainees were able to attend. The junior trainees praised the sessions and found them useful, but reported that teaching was often poorly attended as the time was not protected. The trainees advised that teaching was not bleep-free. | |

## 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.**

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| O&G 2.1 | **Impact of service design on learners**<br>The junior trainees informed the review team that their rota consisted of one-in-three day shifts on call. Three junior trainees were on shift each day; one was allocated to labour ward, one to postnatal ward and one to gynaecology. The junior trainees were not rostered to work night shifts. When allocated to labour ward, the trainees also participated in the antenatal ward round and were on call for the day assessment unit, triage and to conduct pre-assessment for operative procedures (see point 1.3).<br>On the postnatal ward round, trainees reported spending 15 to 20 minutes with each patient, with tasks including taking blood, following up diagnostic tests and completing discharge summaries. There had been a Physician Associate (PA) to assist with this work, but the review team were informed that the person in post had left the Trust the day before the visit, and to the trainees' knowledge no replacement had been appointed.<br>The clinical supervisors advised the review team that the PA would be replaced, and that they would consider the distribution of tasks across the multidisciplinary team to reduce the burden on the junior trainees and increase the efficiency of the ward rounds.<br>The higher trainees reported being reallocated to cover unfamiliar clinics across other sites within the Trust. The review team heard that this created logistical difficulties and the necessity for trainees to bring notes and dictation tapes back to the Royal Free Hospital site after the clinic. | |
| O&G 2.2 | **Organisation to ensure access to a named educational supervisor**<br>All the junior trainees reported having an allocated educational supervisor with whom they had regular meetings and an agreed learning plan. | |

## 3. Supporting and empowering learners

**HEE Quality Standards**

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| **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.**<br>**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.** | | |
| O&G 3.1 | **Behaviour that undermines professional confidence, performance or self-esteem**<br>The junior trainees described being sent to the emergency theatre meeting to obtain theatre time slots for gynaecology patients as an F2 trainee. This meeting took place daily during handover and involved representatives from multiple specialties. The review team heard that as other specialties sent higher level trainees or consultants, the O&G trainee would be the most junior representative and would often not have seen the patient or have the patient's full clinical details. The trainees reported feeling intimidated during this meeting, finding it difficult to effectively compete for the theatre slots with more senior staff and feeling like they had failed the team, and the patient, if a later theatre time was allocated. One trainee described this as the worst part of the job and the review team heard that all the junior trainees had 'dreaded' attending these emergency theatre meetings (see point OG 1.6).<br>The clinical supervisors advised that this issue had been raised before and that they were seeking solutions, for example by sending the senior trainee from the night shift to the meeting.<br>The higher trainees reported that some of the labour ward coordinators exhibited undermining behaviour towards them, including overriding their clinical decisions. The trainees expressed a belief that understaffing contributed to some of this behaviour, for example transferring patients off the labour ward against obstetric advice as there was no midwife available to care for them. | Yes, please see O&G3.1 |

## 4. Supporting and empowering educators

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| **HEE Quality Standards**<br>**4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.**<br>**4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.** | | |
| | N/A | |

## 5. Developing and implementing curricula and assessments

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| **HEE Quality Standards**<br>**5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.**<br>**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.**<br>**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.**<br>**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.** | | |

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| O&G 5.1 | **Appropriate balance between providing services and accessing educational and training opportunities**<br>The clinical supervisors reported that they were aware that trainees sometimes missed training opportunities due to pressures of workload and the need to cover for colleagues' sickness and absence. The clinical supervisors advised that there had recently been high levels of sickness and compassionate leave among the consultants in the department. This had exacerbated the issue of trainees covering consultant clinics.<br>The supervisors were seeking solutions to allow trainees to access more learning opportunities, for example by releasing the trainees between 9.00am and 13.00pm (when there is usually consultant cover) to attend ultrasound scanning or other clinics. | |

## 6. Developing a sustainable workforce

**HEE Quality Standards**

**6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.**

**6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.**

**6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.**

**6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.**

**6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.**

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| O&G 6.1 | **Learner retention**<br>When asked by the review team whether they would recommend their posts to others, the junior trainees replied that they would, with the caveat that trainees needed to be proactive to achieve sufficient experience in some competencies.<br>The higher trainees likewise said that they would recommend their posts to others depending on which ATSMs the trainees planned to pursue: maternal medicine, urogynaecology and outpatient hysteroscopy were all commended. The higher trainees added that it was advisable to rotate through other hospitals with higher birth rates and more opportunity to complete labour ward competencies before coming to the Royal Free Hospital. | |

# Good Practice and Requirements

| Good Practice | Contact | Brief for Sharing | Date |
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| The trainees commended the educational supervisors and particularly the college tutor for the work undertaken to improve the training programme following trainee feedback. | | | |

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| The trainees were complimentary about the departmental induction to their training posts. | | | |
| The higher trainees particularly recommended some of the advanced training skills modules to colleagues, such as emergency gynaecology, benign gynaecology and hysteroscopy. | | | |
| The junior trainees reported that they would recommend their posts to colleagues. | | | |

| Immediate Mandatory Requirements | | | |
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| **Req. Ref No.** | **Requirement** | **Required Actions / Evidence** | **GMC Req. No.** |
| O&G 1.2a | The review team heard that trainees had been asked to cover consultant clinics at short notice. | When trainees are asked to cover clinics at short notice there must be clear guidance as to who the clinical supervisor will be at consultant level. This should be determined in advance, and the person should be readily available. | R1.1 |
| O&G 1.3 | The review team heard that junior trainees were expected to take consent from patients prior to operative procedures at pre-assessment without prior training. | The process for the taking of patient consent for operative procedures must be urgently reviewed, and processes be put in place. Non-career trainees and inexperienced specialty trainees should not be taking consent without prior training. This would require them to be signed off at consultant level. Consideration should be given for taking consent when the procedure is booked in the clinic. | R1.1 |

| Mandatory Requirements | | | |
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| **Req. Ref No.** | **Requirement** | **Required Actions / Evidence** | **GMC Req. No.** |
| OG 1.2b | The Trust to ensure that adequate clinical supervision is provided and that there is a named consultant that trainees can contact for advice during clinics, who is available throughout the clinic | The Trust to confirm that this takes place and provide trainee feedback, through the form of Local Faculty Group (LFG) minutes that demonstrate that trainees can access clinical supervision during clinics | R1.1 |
| O&G1.6 a | The Trust to ensure that junior trainees receive adequate access to elective caesarean sections, performing episiotomy and perineal repair | The Trust to submit rotas for the junior trainees demonstrating that they can access such training and provide trainee feedback confirming this | R1.15 |
| O&G1.6 b | The Trust to ensure that higher trainees receive adequate exposure to caesarean section and gynaecology theatre lists to achieve the required competencies, as well as more experience of instrumental delivery | The Trust to submit rotas for the higher trainees demonstrating that they can access such training and provide trainee feedback confirming this | R1.15 |

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| OG 1.6c | The Trust to ensure that all trainees can access adequate scanning opportunities in both obstetrics and gynaecology, in order to meet their annual review of competence progression (ARCP) requirements | The Trust to outline what plans have been made to ensure trainees can access both obstetric and gynaecology scanning opportunities. The Trust to provide trainee feedback demonstrating that this issue has been adequately resolved and that trainees can meet the scanning requirements for their ARCP | R1.15 |
| O&G3.1 | The Trust to ensure that junior trainees are not expected to attend the emergency theatre meeting to obtain theatre time slots for gynaecology patients and that this task is undertaken by higher trainees or consultants | The Trust to confirm that the emergency theatre meeting is now attended by a higher trainee or consultant and provide trainee feedback confirming this | R3.3 |

| **Recommendations** | | | |
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| **Rec. Ref No.** | **Recommendation** | **Recommended Actions / Evidence** | **GMC Req. No.** |
| | N/A | | |

| **Other Actions (including actions to be taken by Health Education England)** | |
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| **Requirement** | **Responsibility** |
| N/A | |

| **Signed** | |
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| **By the HEE Review Lead on behalf of the Quality Review Team:** | Dr Greg Ward |
| **Date:** | 15 February 2018 |

**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.