QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Barts Health NHS Trust

Oral Maxillofacial Surgery and Urology

Risk-based Review (on-site visit)

Quality Review report

31 January 2018

Final report

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Quality Review details

Background to review	Based on the General Medical Council National Training Survey (GMC NTS) 2017 results, Health Education England (HEE) undertook an Educational Leads Conversation with Barts Health NHS Trust on 26 September 2017. During this meeting it was agreed that a number of on-site visits would be scheduled for 2018, including oral and maxillofacial surgery and urology at the Royal London Hospital, due to the significant number of red and pink outliers that were received. Within oral and maxillofacial surgery at the Royal London Hospital, the 2017 survey produced four red outliers for 'overall satisfaction', 'reporting systems', 'supportive environment', and 'induction'. Furthermore, oral and maxillofacial surgery produced two pink outliers for 'clinical supervision out of hours' and 'regional teaching'. Within urology at the Royal London Hospital, the 2017 survey produced six red outliers for 'overall satisfaction', 'adequate experience', curriculum coverage', 'educational governance', 'educational supervision' and 'local teaching'. Furthermore, urology produced 4 pink outliers for 'clinical supervision', 'clinical supervision out of hours', 'induction', and feedback'.
Training programme / learner group reviewed	Urology, Oral and Maxillofacial Surgery (OMFS)
Number of learners and educators from each training programme	The quality review team initially met with the Director of Medical Education, two deputy Directors of Medical Education, the Clinical Director, the Educational and Clinical Leads, Education Manager, Associate Director of Simulation The quality review team met with two oral and maxillofacial trainees from Specialty Training Level 3 (ST3+) and two urology trainees from ST3+. The review team also met with a number of educational and clinical supervisors.
Review summary and outcomes	Health Education England would like to thank the Trust for accommodating the Risk-based Review (on-site visit) as well as ensuring all the sessions were well attended. The review team was informed of a number of improvements that had been made, and areas that were working well with regard to the education and training of urology and oral and maxillofacial surgery (OMFS) at the Royal London Hospital, as outlined below: • The review panel were pleased to learn of the plan to combine the duty roster for the OMFS departments on the Royal London and Whipps Cross sites and to bring the inpatient services together on the RLH site. The new rota had been designed with the Guardian of Safe Working. • The review panel heard that that the trainers were supportive and accessible. • The review panel recognised that the urology department has undergone a period of significant transition over the previous 3 years but were pleased to hear positive comments from the specialty trainees about the trainers being supportive and accessible. In addition, areas for improvement regarding the training of doctors within OMFS and Urology were highlighted as follows:

- Regarding the OMFS department, the review panel heard that the rota had multiple gaps at a junior level and that there were occasions when the higher trainees had to step down to fill gaps. The solution of closing the department was not effective at protecting the middle grade staff. It was also reported that the higher trainees were responsible for finding locum cover for these rota gaps. This seemed to be an unsatisfactory arrangement and a poor use of training time.

- The review panel heard that cross-site working for trainees in OMFS had developed around the merger of the head and neck cancer services at Barts Health and University College London Hospital (UCLH). At the time of the visit, a trainee was working during the day at Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) but returning to the Royal London Hospital (RLH) to fill an out of hours service commitment. There seemed to be scope for improving training by reconfiguring posts into single sites, each with a specified training objective e.g, trauma and orthognathic surgery at RLH, Head and Neck oncology at UCLH etc. It was hoped that the Trust and Training Programme Director (TPD) would work together with HEE through the School of Surgery to achieve this.

- Trainees in both specialties had raised no exception reports. This matched findings in other Barts Health NHS Trust sites and suggested a culture of non-reporting. The review team suggested to the Trust executive team that exception reporting was an important tool and encouraged the Trust to work towards changing the culture to facilitate open and complete exception reporting.

- Trainees from both specialties needed on site accommodation in order to be able to perform their on-call out of hours duties, as their pan-London rotations meant that they often lived too far from the hospital to return home. The trainees gave mixed reports on the John Harrison House, specifically highlighting the issue that there had been no heating within the building, with some trainees describing broken windows and inadequate bedding. The review panel encouraged the Trust executive to consider how the quality of overnight accommodation could be improved for trainees.

- The review panel heard that the arrangements for consultant staffing were having a detrimental effect on training. It was reported that ward rounds were due to have urological consultant presence however the consultant was scheduled to perform other tasks simultaneously which resulted in most ward rounds taking place without any consultant present, which limited their educational merit for the trainees. It was possible that patient safety was at risk from these arrangements, but the review team heard no specific examples.

- It was heard that trainees within urology were allocated their own clinic list with between 12 and 14 patients per list. The review team heard that this workload was such that there was no time available for discussion with the supervising consultant which impacted negatively on the training available.

- It was heard that the urological trainees on-site were in their early years of training with a requirement to achieve core urological competencies. The trainees reported that while high volume opportunities existed in ureteroscopy and template biopsy, there were limited opportunities for them to achieve the required numbers in other areas. Although there was a different perception of this state of affairs amongst the department's trainers, a review of the operative case mix made available to the trainees, including scheduled sessions in the Saturday morning and Newham lists, may help to rectify this. This information will be fed back to the relevant TPD to inform rotation planning.

	• It was reported that there was limited time included within consultant job plans for supervisors and the review panel asked that this be reviewed. • With regards to local faculty group meetings, there was conflicting information from faculty and trainees as to whether meetings had taken place. • The review team was informed that the departmental induction had been six weeks late in one case and booklets which had been prepared were distributed on the day of the induction, not the day of arrival to the department.

Quality Review Team			
HEE Review Lead	Mr John Brecknell, Head of the London School of Surgery,	**External Clinician**	Mr Robert Bentley, Consultant for Head and Neck Surgery and Maxillofacial Surgery, King's College Hospital NHS Foundation Trust
Trust Liaison Dean/County Dean	Dr Indranil Chakravorty, Deputy Postgraduate Dean, Health Education England North East London	**Scribe**	Andrea Dewhurst, Health Education England
Lay Member	Robert Hawker, Lay Representative	**Scribe**	James Coeur-de-Lion, Health Education England

Educational overview and progress since last visit – Information from executive team

The quality review team heard that the urology department at the Royal London Hospital had undergone a large transition within the three years preceding the review. It was reported that the entire consultant pool had changed, following resignations and opportunities elsewhere. The review team was informed that there was a time when the Trust had been going through a recruitment phase in order to stabilise the department and that a two-year plan had been implemented. Since then, the review team heard that the consultant posts had been filled and that there was a designated educational, clinical and governance lead in post, resulting in a more stable department. Due to the lack of consultants, the urological services provided had been reduced.

The clinical lead provided the review team with two emails from trainees containing positive feedback regarding the supervision that was provided. It was heard that the red outliers in the General Medical Council National Training Survey (GMC NTS) came as a surprise to the clinical leads and that the educational and clinical supervision that trainees received included one to one meetings at the beginning of their placements which highlighted who their points of contact were and what their interim meetings involved.

When discussing the GMC NTS survey and overall satisfaction in relation to oral maxillofacial surgery (OMFS), it was heard by the review team that the relocation of Head and Neck cancer in-patient services to University College London Hospital (UCLH) had had a major impact on the department due to the large proportion of work which had been transferred. It was brought to the attention of the review team that as well as reducing access to cancer related training opportunities, this had had a negative impact upon the morale in the department. It was also heard that one factor that may have contributed to the poor GMC NTS results received, was the challenging trainees who had previously been based within the department. It was reported that one trainee based within the department during the time the survey had been completed, had requested an inter deanery transfer (IDT) due to personal issues and overall unhappiness, which could possibly have been portrayed in the results.

The quality review team was informed that the agreed transition arrangement between UCLH and the Royal London Hospital (RLH) was that a higher trainee would be allocated to do their placement at UCLH to include access to operating and ward rounds. However, the higher trainee would be required to join the multidisciplinary

team (MDT) as well as carrying out clinics at the RLH site. The issues subsequently raised following the change of service were related to the team working relationship between the two sites, which then had an impact on the trainee who had been allocated to UCLH. The review team heard that this trainee had become the 'go to person' for any issue within the department, which had impacted on them negatively and resulted in significant stress and pressure being put upon them. Since then, the RLH had made links with Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) and after some negotiation, the trainee was allocated there which resulted in positive feedback. It was reported by the clinical director that conversations took place between RLH and UCLH to investigate the interpersonal issues between the sites as well as the workload which had been put upon that particular trainee. Following this, the review team heard that the UCLH department had recruited a clinical fellow as well as re-purposing a higher trainee to support the team. The quality review team were informed that the relationship between RLH and UCLH had improved.

In relation to cross-site working, the quality team were made aware of a governance issue relating to MDTs taking place at the RLH without the UCLH reconstructive surgeons being present, which raised concerns with regards to operating. It was explained that there were conversations taking place in unifying these MDTs as a solution. There remained a cross site issue for the trainee allocated to elective training at GOSH during the day but to out of hours duties at RLH.

Previous quality intelligence had included an issue with the incomplete follow up of patients with ureteric stents. It was heard that this was part of a national change in practice. It was reported that an audit had been presented at the Royal Congress of Endourology, which showed that the necessary follow up was now in place. The review team heard that these results would be shared with them in due course.

In reference to out of hours provision of urological services and transfers between Whipps Cross University Hospital and the RLH, the quality review team heard that Whipps Cross was self-sufficient, except for and interventional radiology service. It was reported that the protocol for interventional radiology emergencies across the patch was initiated by making contact with the on call interventional radiology consultant on site after which the patient in question would be accepted and transferred to the Royal London Hospital.

When discussing the induction provided, there were issues relating to the two-day IT based induction which trainees were asked to carry out before they started their placements. It was reported by the DME that this was an urgent concern which was being resolved; he stated a trust position that it was unacceptable for trainees to be required to complete the mandatory training in their own time. It was heard that a possible resolution was to pay the trainees in lieu to complete the tasks prior to them starting, or to not schedule trainees for clinical duties when they started their posts. It was reported that trainees in urology had been relieved from the first two days of duties in order to complete their Trust induction. It was also heard that trainees were provided with a thirty-page induction booklet at their departmental induction, although not until some time into their placement.

The DME highlighted that both departments had been using local faculty groups (LFGs) to drive forward the improvements whilst co-earning the problems with their trainees. It was reported that the meetings had been formalised, were regular and well supported. It should be noted that this perception was not necessarily shared by the trainees.

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
OMFS &U1.1	**Appropriate level of clinical supervision** When meeting with the oral and maxillofacial surgery (OMFS) trainees, it was heard from that the job provided good exposure to trauma and orthognathic surgery. It was heard that senior support was always available. The trainees reported that the consultants had been approachable and specifically expressed that theatre sessions provided good educational opportunities, with good support and teaching provided. It was reported that urology supervisors were always approachable and accessible despite their requirements to cross cover sites during on-calls. However, there was a limited consultant presence on ward rounds due to multiple competing responsibilities. However, the review team was informed that the issue was being addressed.	Yes, see OMFS&U1.1 below
OMFS &U1.2	**Rotas** The quality review team heard that there were multiple gaps in the OMFS junior trainee rota, which had resulted in several occasions when the higher surgical trainees had to cover the junior trainee role, as well as carrying out their own responsibilities. It was heard that this increased the intensity of the out of hours work. Although trainees were released for compensatory rest the day after such shifts, this had an impact on their operative training. The trainees reported that when the on-call service had been 'closed' in response to rota gaps, this had had only a limited effect on their work load. It was noted that trainees were left with the responsibility to find locum cover for any gaps in the rota, which was a task made more difficult by a rate of pay reported to be below the market rate. This administrative task detracted from training opportunities and did not appear to the review team to represent a good use of trainee time. A plan was described, starting in February 2018,,to collocate the OMFS emergency and in patient work, currently being carried out at Whipps Cross, with the RLH service and to move the junior medical team with the work. The review te3am agreed that this was likely to improve the rota situation but there were doubts expressed by some that it would be enough.	Yes, see OMFS&U1.2 below
OMFS &U1.3	**Induction** Induction was described as a complex affair, with separate trust, site and departmental components. The issue of an extensive e-learning based component of the trust induction, completed prior to starting in post in a trainee's own time has been addressed in the opening section above. When discussing the departmental induction provided for OMFS trainees, there were mixed feelings amongst the trainees regarding its quality. One trainee indicated that the induction was poor, haphazard and delivered after the trainee had already started working within the department. However, another stated that they had completed their induction one month prior to starting. Despite this, the trainee reported that there had been issues regarding the computer based system training provided, as the trainee indicated that they had received no explanation as to how the various IT systems worked, specifically how to order bloods and complete a discharge letter.	Yes, see OMFS&U1.3a below Yes, see OMFS&U1.3b below

	Within urology, the trainees reported that they had received an induction on their first day which involved how things worked at the site. It was heard that before they started their placement, the trainees received an e-mail requesting them to complete an attached slide show training session on the CRS system which the hospital site used. The quality review team heard that the formal urological departmental induction and providing of urological handbook was delayed by over a month due to the difficulties in bringing everyone together at one time for it to take place. However, trainees had been informed of their supervisors when they initially started and managed to gain insight into how things generally worked through colleagues already based within the department.	
OMFS &U1.4	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** When asked about the OMFS red and pink outliers received in the General Medical Council National Training Survey (GMC NTS), the review team heard from the supervisors that the survey had been completed by trainees at an early stage of their training, when they were still adapting to the environment. It was heard that this might have been a factor which led to the results. In fact, the survey was conducted more than 6 months after trainees started their placements, at a nationally consistent time, advertised well in advance by the GMC. The supervisors informed the review team that trainees were supported and encouraged from the beginning and offered opportunities to have training exposure in areas of their interest. Urological trainees reported that there was good exposure to endourological procedures and template biopsies. It was heard that trainees had access to robotic cases although currently the case volume is low and oncology cases are performed elsewhere. It was reported that trainees received 3-4 sessions of theatre experience per week. Access to core urology training for the relatively junior trainees in the department, including procedures such as transurethral resection of the prostate (TURP), was reported to be limited however and trainees were concerned about their rate of progress towards achieving indicative numbers. The trainees reported that they had the opportunity to go to Newham University Hospital to access core urological training but that case volume was low and the sessions clashed with departmental teaching. A Saturday list at RLH was made available to trainees but in their own time. The quality review team heard that there was a urology weekly departmental Monday meeting where consultants and trainees met to discuss cases. The review team was informed that there were plans to ensure that in the future, the meetings included opportunities for the trainees to teach and present clinical cases.	Yes, see OMFS&U1.4 below
OMFS &U1.5	**Protected time for learning and organised educational sessions** Trainees gave credit to the regional teaching programme. It was reported that the teaching was very good and that it also gave trainees an opportunity to discuss other issues such as workload and where best to maximise training opportunities with peers.	

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.**		
OMFS &U2.1	**Effective, transparent and clearly understood educational governance systems and processes** It was reported by the educational leadership team that both departments had well-functioning local faculty groups (LFGs); this perception did not appear to be shared by the trainees. While the OMFS trainees reported attended one meeting in December 2017 where the rota had been discussed, the urology trainees indicated that they had not received notification of any taking place. Despite reports of unscheduled working and rota gaps interfering with education, the review team were led to believe that no exception reports had been received from these trainee groups, either by the GoSW or the DME. This matched similar recent findings from another Barts Health site and suggested to the team a culture of non-reporting.	Yes, see OMFS&U2.1a below Yes, see OMFS&U2.1b below
OMFS &U2.2	**Impact of service design on learners** The review team heard about the reconfiguration of head and neck oncology services in NCEL as described above. This had resulted in cross site working for trainees and consultant staff and eventually the cessation of access to oncology training for OMFS trainees at RLH. There remained a cross site arrangement between GOSH and RLH. It seemed to the review team that in most cases trainees were best placed in LEPs in which the service relevant to their current training needs was delivered but recognised that optimising training in this regard required a system wide approach.	Yes, see OMFS&U2.2 below
OMFS &U2.3	**Organisation to ensure time in trainers' job plans** The review team heard that there was limited time included within the consultants' job plans for educational and clinical supervision.	Yes, see OMFS&U2.3 below

3. Supporting and empowering learners

HEE Quality Standards

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.

3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.

OMFS &U3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** With regards to John Harrison House accommodation, there were differing opinions from the trainees regarding its quality. Some trainees reported that it had been unacceptable, with no lighting, heating and broken windows. It was heard that electric heaters had been banned and that trainees had chosen to stay in a hotel or in a car rather than the accommodation provided services. However, the quality review team was informed by some trainees that the accommodation was adequate, clean and similar to student accommodation. It was heard that it was easy to book with little improvement required apart from the no heating issue which was on-going.	

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.

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.

OMFS &U5.1	**Appropriate balance between providing services and accessing educational and training opportunities** The review team was informed that trainees within urology were allocated their own clinic list with between 12 and 14 patients per list. However, the review team heard that the workload was such that there was no time available for discussion with the supervising consultant, which impacted negatively on the training. In response to this, the supervisors informed the review panel that although the trainees may not have had the opportunity to discuss a patient during the clinic, they were always able to do so following the clinic. It was explained to the review team that every trainee or trainer ran their clinic in their own preferred way and that trainees were left to approach the supervisors who had an open door to provide educational teaching when they were not with a patient themselves. Trainees reported undertaking between 2 and 3 sessions in clinic in a working week.	Yes, see OMFS&U5.1 below

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date

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

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
OMFS& U1.1	Please review the urology consultant job planning for the daily ward rounds to avoid multiple completing calls on consultant time and allow them to attend and provide supervision for the doctors in training.	Please describe the measures taken and provide minutes from an LFG at which this issue has been discussed.	
OMFS& U1.2	Please ensure that higher surgical trainees in OMFS are not asked to cover down due to rota gaps in any other than truly exceptional circumstances. Plans should be made to relieve this trainee group of the responsibility for the engagement of medical locum staff.	Please make staffing a standing item at the LFG and provide minutes to share actions taken and to demonstrate their efficacy as the move from Whipps Cross matures.	
OMFS& U1.3a	An extensive e-learning package as part of trust induction should be able to be completed during employment rather than in trainees' own time.	Please provide a position statement form the DME's team regarding this issue.	
OMFS& U1.3b	The departmental induction must be provided at point of entry for any trainee starting any post at any time of year.	Please provide copies of induction handbooks together with evidence of complete departmental inductions for all trainees at the next major rotation in October 2018, for both OMFS and Urology.	
OMFS& U1.4	Please commence a programme of work to optimise access to core urological training opportunities for trainees at RLH. The scope of this work should encompass all sites in the trust and potentially also the linked work at Homerton, and training should be achieved within the work schedule. Please feel free to draw the TPD and HoS into this project.	We look forward to receiving a report on this work. Access to operative training should be added as a standing item to the LFG; please submit minutes to demonstrate success.	

OMFS& U2.1a	At a time when a disappointing GMC NTS return has come as a surprise, a well developed regular forum for the discussion of issues between trainers, trainees and managers in a department can be a very useful tool for the sharing and management of concerns. Please review the membership and communications around the urology and OMFS LFGs at RLH.	Please provide minutes and attendance registers for LFG meetings over the next 6 months.	
OMFS& U2.3	Please review the job plans of clinical and educational supervisors to ensure that those involved in training and education are remunerated appropriately.	A list of supervisors showing the allocation of EPAs or equivalent would be an excellent way of sharing the result of this work.	
OMFS& U5.1	Please review the allocation of tasks to doctors in training in the urology outpatient clinic. An arrangement which ensures that real time discussion of cases is always possible in order to assure patient safety and that the sessions represent a valuable learning event. The review should consider whether it is appropriate for a 'registrar list' to be specified.	Please submit indicative clinic templates together with a description of arrangements for real time supervision of urology trainees in clinic.	

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
OMFS& U2.1b	The new mechanisms of exception reporting represent potentially valuable tools for improving PGM training, lost in situations where a culture of silence develops.	Please consider ways of encouraging doctors in training throughout Barts Health to, wherever appropriate, utilise the mechanisms for hours of work and educational exception reporting and share your thoughts and plans with HEE.	
OMFS& U2.2	HEE will consider how best to approach the optimisation of head and neck oncology training in NCEL.	We hope the OMFS training group at RLH will join whatever workstream is initiated.	

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
HEE will communicate the approach to be taken regarding a review of training in head and neck oncology across NCEL.	HEE

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.