NHS
Health Education England

London North West University Hospitals NHS Trust, Northwick Park Hospital

Emergency Surgery

Urgent Concern Review (on-site visit)

Quality Review report

22 May 2018

Final

Developing people for health and healthcare

www.hee.nhs.uk

THE NHS CONSTITUTION
the NHS belongs to us all

Quality Review details

Background to review	In April 2018, a group of postgraduate surgical trainees at Northwick Park Hospital wrote to a Training Programme Director (TPD) and raised a number of serious concerns regarding patient safety, professional behaviours and quality of training in the emergency surgery department. There had been previous reports of bullying and undermining behaviour in the department, which resulted in a trainee being moved to another Trust. In addition, there had been similar concerns in other departments within the Trust. In view of this, the General Medical Council, NHS England and NHS Improvement were informed of the situation. Prior to the review, the Head of the London Postgraduate School of Surgery held a confidential telephone clinic for trainees who wished to do so, to call in and give feedback about their experiences in the department one to one. Feedback from these calls and other sources corroborated the concerns raised in the letter to the TPD relating to the department culture and undermining and discriminatory behaviour directed towards some trainees.
Training programme / learner group reviewed	Emergency surgery
Number of learners and educators from each training programme	The review team met with five foundation trainees and six specialty trainees, as well as non-training grade doctors, clinical academic fellows and specialist nurses. No core trainees were available to attend. In addition, the review team met with eight consultants who act as clinical and educational supervisors in the emergency surgery team, including the Clinical Lead.
Review summary and outcomes	The review team noted that the department had already begun to investigate and address some of the concerns raised by the trainees. The Trust had been proactive in arranging additional training for consultants and planning to offer mentoring for female trainees by female senior colleagues. Health Education England (HEE) planned to work with the Medical Director and Director of Medical Education to continue to improve the department culture and working environment. There were also several examples of positive practice highlighted during the review: • The higher surgical trainees were able to access good numbers of operative training opportunities and workplace-based assessments appropriate to their curricular needs • The department had acted on feedback from foundation trainees and made changes to the rota, to include time shadowing on the acute team and time on the enhanced recovery unit which were felt to be educationally valuable • The trial of a ‘twilight’ specialty training grade doctor to improve flows of surgical patients through the emergency department was effective at reducing the time to decisions to admit and improved patient care and support for the junior team. Two immediate mandatory requirements were issued on the day of the review, relating to serious issues with foundation training:

- Foundation year one (F1) doctors covering the 'chronic' practice of the emergency surgery team had shifts that ended one to two hours prior to handover and were consistently staying late
- The review team heard that foundation year two (F2) trainees were taking referrals from General Practitioners and the Accident and Emergency department without appropriate induction and training and with inconsistent senior support and supervision, especially during twilight hours.

There were several further areas requiring action:

- Trainees who raised concerns to the head of the department reported not always receiving feedback on how these had been dealt with. Some trainees felt that no action had been taken when they had raised concerns and reported that their concerns about specific consultant staff were forwarded to the individuals concerned without appropriate action being taken to manage the issues raised
- Foundation trainees reported that they did not receive a departmental induction prior to commencing their emergency surgery rotation, including some trainees who had started their rotation by working night shifts
- The rota arrangements for foundation trainees were highly complex, which appeared to contribute to difficulties experienced by trainees in accessing leave, exacerbated by delays in responding to requests for leave by the rota coordinators
- The twilight specialty trainee (ST) grade shift was only filled 50% of the time and was a short-term ad hoc arrangement
- The trainees were unaware of the purpose and timing of local faculty group and surgical training meetings.

Quality Review Team			
HEE Review Lead	John Brecknell Head of School, London Postgraduate School of Surgery Health Education England	**Deputy Postgraduate Dean**	Geoff Smith Deputy Postgraduate Dean Health Education England (north west London)
External Clinician	Avril Chang Consultant General Surgeon / Training Programme Director King's College Hospital NHS Foundation Trust	**Foundation School Representative**	Anthea Parry Director of North West London Foundation School
GMC Representative	Jane MacPherson Education Quality Assurance Programme Manager	**HEE Representative**	Andrea Dewhurst Quality, Patient Safety and Commissioning Manager Quality, Patient Safety and Commissioning Team Health Education England - London and Kent, Surrey and Sussex

HEE Representative	Louise Brooker Learning Environment Quality Co-ordinator Quality, Patient Safety and Commissioning Team Health Education England - London and Kent, Surrey and Sussex		

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

The review team thanked the Trust for accommodating the review and for the efforts made in facilitating the process. The review lead outlined the concerns raised by trainees and acknowledged the response from the Chief Executive which detailed the initial steps taken by the Trust to address these concerns. The Director for Medical Education (DME) had met with some trainees and emailed others to seek feedback about their experiences of culture and behaviour within the department. The DME reported that the majority of this feedback was positive, with trainees praising the consultants' commitment to training and the range of training opportunities available. The consultants and department management had been surprised at the reports of bullying and undermining. It was suggested that changes in the department during the last autumn and winter had contributed to stress within the team. These included changes in consultant staffing, the appointment of locum consultants and uncertainty around the relationships between surgical teams and service allocations across Trust sites.

There had been one incident of bullying and gender discrimination directed at a clinical academic fellow (CAF) which had led to a consultant going through a process of management, training and ongoing support. The DME and medical education team had also been working with the educational and clinical supervisors (ESs and CSs) to establish appropriate communication styles, language and ways of giving feedback. There was further training planned around aligning staff behaviour with the Trust values, as well as integration of these values into the Trust recruitment and appraisal processes. The department planned to give female trainees the opportunity to be mentored by female consultants. There were several applications from female candidates in response to recent recruitment for consultant roles. At the time of the review there were six substantive consultants and two locum consultants, all of whom acted as CSs.

Another area of concern raised by the trainees was patient safety, particularly relating to the volume of patients and the fact that telephone referrals were taken by junior trainees. The department had introduced a 'twilight' locum shift specifically to cover Accident and Emergency (A&E) department referrals during peak time.

The review team asked what reporting mechanisms were in place for trainees to escalate concerns. There was a local faculty group (LFG) for surgery and a Surgical Board meeting, but trainee attendance was poor, particularly among specialty trainees (STs). There was no apparent knowledge of a Trust Freedom to Speak Up Guardian and the review team encouraged the Trust to ensure a Guardian was appointed and to publicise the role more widely.

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
ES1.1	**Patient safety** In the letter submitted to the Training Programme Director (TPD), trainees had reported that the consultant rota arrangements were not conducive to good continuity of care, leading to inconsistent handovers and potential delays in patient reviews. The specialty trainees (ST3+) were responsible for taking internal referrals and did not report any cases where patient safety had been compromised due to delays in accessing consultant review, but they acknowledged the potential for this to occur. The non-training grade doctors felt that this was more of a concern, particularly during the evenings and nights, which were peak time for referrals and when two changes of consultant took place. The introduction of an additional locum doctor during this time had made a positive impact, but the review team heard that only around half of these shifts were filled. It was reported that these concerns had been escalated to the department management team repeatedly but had not been adequately addressed.	Yes, please see ES1.1
ES1.2	**Responsibilities for patient care appropriate for stage of education and training** The review team heard that foundation year two (F2) trainees contributed to the tier of doctors who when on-call were responsible for taking all emergency surgery telephone referrals, which numbered up to 40 per day. The trainees reported that the high volume of calls lead to frequent interruptions when reviewing patients or carrying out other tasks. The trainees were concerned that they lacked the knowledge and experience to appropriately deal with some referrals and that at times their senior colleagues were not available to supervise them. This was a particular problem in the early evening when the senior doctors were often in theatre, the volume of referrals was typically high and there was a lack of clarity around the pathway for escalation of concerns. In addition, the F2 trainees advised that they had not undergone a departmental induction or training on managing referrals prior to starting on-call shifts, including night shifts. The clinical supervisors (CSs) reported that the F1 trainees shadowed a senior colleague for three weeks prior to starting on-call shifts and that the F2 trainee rota should not include night shifts at first. The Clinical Lead (CL) felt that F1 and F2 trainees were well-supported and that consultants were aware of the different supervision needs of trainees at each level.	Yes, please see ES1.2a Yes, please see ES1.2b
ES1.3	**Rotas** The ST3+ trainees reported that the department had good consultant cover during the day and that senior supervision was always available when required. At night the consultant on-call could be from another surgical team, but the trainees reported no issues with calling consultants for advice or to come in during the night. There was also a clinical academic fellow (CAF) and a core surgical trainee (CST), F2 trainee or Trust-grade doctor on shift overnight, which the ST3+ trainees reported was sufficient to cover the workload. If the emergency (CEPOD) theatre was opened at night, the ST3+ trainees advised that they would go into theatre while the CAF remained on-	

	call for inpatient wards, Accident and Emergency department (A&E) and other referrals. It was estimated that the team received 15 to 20 referrals overnight and that CEPOD theatre was opened on around half of night shifts. The educational supervisors (ESs) and CSs reported that the F1 rota had been altered following trainee feedback and now included shadowing time with the ST3+ trainee in the acute time and two weeks in the surgical intensive recovery unit (SIRU). Within general surgery, there were three foundation trainees or Trust-grade doctors on shift each day; one who held the 'acute' service phone and took referrals, one who held the phone for CEPOD and one who covered the 'chronic' (inpatient) service. There was a post-take ward round each Monday and Friday, when patients were handed over from the acute service to the chronic service if they required longer-term inpatient care. The CSs estimated that there were 25 to 35 acute referrals per day and that around two thirds of these patients were admitted. Some foundation trainees had experienced difficulty in accessing leave due to the complexity of the rota arrangements. The trainees advised that since a new rota coordinator had started, arranging study leave and changing shifts had become more difficult and rotas had been delayed.	Yes, please see ES1.3
ES1.4	**Handover** The review team heard from several sources that handovers between consultants on the day, twilight and night duties were meant to take place at 08:00, 17:00 and 21:00, but that these were not held consistently. Handover in the morning was reported to be better-organised and well-attended. The review team heard that trainees were encouraged to exception report and were paid when they worked additional hours. There were some instances around handover times where trainees felt that they were regularly expected to work extra hours. The foundation trainees reported that the F1 trainee working in the 'chronic' service was required to prepare the patient list prior to morning handover which meant that they needed to start work early. If a handover took place at 17:00 between the day and twilight consultants, the trainees advised that this was often late, resulting in the trainees working overtime. The day shift for F1 trainees working in the chronic practice was scheduled to finish at 18:00, but they were frequently required to stay until after the handover at 20:00 as there was no designated medical colleague to take over care of the patients. The foundation trainees reported that they were supposed to hand over to the fourth on-call team which included the 'red coat' specialist nurses, who were reluctant to take over care if patients were unwell and required medical input. The trainees were then unable to leave until the late shift started.	Yes, please see ES1.4
ES1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The foundation trainees reported mixed experiences when considering the learning opportunities available in their posts. When rotating through vascular surgery, F1 trainees were not rostered to work in clinic or theatre and the workload on the wards made it difficult to find time to attend different clinical areas. F1 trainees in general surgery advised that the addition of SIRU and ST3 shadowing to their rotations had enhanced their experience of the post. Foundation trainees generally felt that senior colleagues were willing to teach but at busier times of day consultants and senior trainees were often in theatre so were less available. F2 trainees were sometimes put in a difficult position if there were not sufficient senior staff present, as there was pressure from the ward teams and A&E to make clinical decisions. This often revolved around the triage of referred patients to the Surgical Assessment Unit (SAU) or A&E, with reports that significant criticism was levelled against trainees by senior nurses in some cases.	

	The ST3+ trainees were positive about the opportunities available and reported that they were easily able to achieve and exceed the operative numbers required by the curriculum. It was estimated that trainees at this level performed or assisted with 30 to 40 operative cases per month in general surgery, including both routine and more complex cases. ST3 trainees reported assisting with 15 laparotomies in a six month period.	
ES1.6	**Adequate time and resources to complete assessments required by the curriculum** The ST3+ trainees advised that they were encouraged by the consultants in carrying out workplace-based assessments and had not experienced any problems in either completing assessments or getting feedback from their supervisors.	

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.

ES2.1	**Impact of service design on learners** The review team heard that the volume of patients had increased since the urgent care centre (UCC) opened. In addition, the surgical admissions area had been closed for a month prior to the review which made it difficult and time-consuming to find space to review patients referred by A&E or the UCC. The junior doctors who met with the review team were unsure of the reason for the closure or how long this would last.	
ES2.2	**Appropriate system for raising concerns about education and training within the organisation** Some junior doctors felt that when concerns were raised within the department they were not addressed or were dealt with inappropriately. It was reported that complaints about consultant behaviour had been forwarded on to the consultant involved, which had led to worsening relations with the consultants. Some felt that this acted as a deterrent against reporting bullying and undermining behaviour and contributed to a belief that management would not act appropriately on feedback. It was noted that foundation trainees attended some of the local faculty group (LFG) and Surgical Board meetings, but ST3+ trainees did not. The ST3+ trainees reported that they were not aware of the timing and purpose of these meetings, or whether these were a useful forum to give feedback.	Yes, please see ES2.2a Yes, please see ES2.2b

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.

ES3.1	**Behaviour that undermines professional confidence, performance or self-esteem** All trainees were aware of the letter that had been sent to the TPD and the concerns raised within it. The review team heard several reports of consultants reprimanding or criticising trainees in a way which was felt to be overly harsh and not constructive, but these were not described as frequent occurrences. Sometimes these instances were described as undermining or inappropriate communication and sometimes they were dismissed as personality clashes or isolated incidents arising from stressful situations. It was suggested that the rota arrangements within emergency surgery contributed to this as trainees did not tend to work consistently with consultants and therefore had fewer opportunities to develop working relationships. The specialist nurses reported that, on occasion, they had witnessed consultant staff criticising juniors in public or in a way that was unprofessional. In these situations, nurses had privately approached the individuals involved to challenge this behaviour. The nursing team felt that their role in the department was valued and that they were not subject to undermining behaviour because of this. Of note, it was reported that as nurses they were used to seeing and being the subjects of such behaviours by doctors. A substantial number of trainees at the review reported having no concerns about inappropriate behaviour. However, these same trainees were quite dismissive of reporting mechanisms and of the importance of fora such as LFGs. These trainees tended to rationalise the concerns reported by their colleagues as representing frustration in those individuals and a failure to adapt to a uniquely busy clinical environment. The Trust should consider and mitigate against a possible negative role-modelling effect on trainees from witnessed and normalised inappropriate behaviours. The CL advised that the department was aware of two instances where named consultants had been involved in cases of bullying or undermining. The process for addressing these behaviours had been managed by the department in conjunction with the Human Resources team. The recent training sessions for consultants around appropriate communication and supervision of trainees in difficulty had been well-received. The CL stated that bullying, undermining and discriminatory behaviour was unacceptable within the department. The consultants felt they had good relationships with the trainees and that there was an open and friendly culture within the department. The review team was informed that the letter sent by the trainees came as a surprise to the consultants and to the department managers. The CL expressed regret that the trainees had not felt able to raise concerns within the department rather than contacting the TPD.	Please see Other Actions section Yes, please see ES3.1

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.

	Not applicable	

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.

	Not applicable	

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.

	Not applicable	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date

Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
ES1.2a	The review team heard that foundation year two (F2) trainees were taking referrals from General Practitioners and the Accident and Emergency department without appropriate induction and training, and with inconsistent senior support and supervision, especially during twilight hours.	This practice should cease and these referrals should be diverted to a more senior practitioner.	R1.14
ES1.4	Foundation year one (F1) doctors covering the 'chronic' practice of the emergency surgery team have shifts that end one to two hours prior to handover and are consistently staying late.	Please describe a clear policy for clinical supervision during these shifts and for the handover of responsibility at the end of these F1 shifts.	R1.8

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
ES1.1	The department should make a sustainable, long-term plan to ensure that the twilight specialty trainee (ST) grade shift is consistently covered.	Please provide a long-term plan for this post to ensure adequate staff cover for A&E referrals during the twilight period.	R1.7
ES1.2b	The Trust is to ensure that all trainees receive a departmental induction prior to commencing their emergency surgery rotation and that trainees do not undertake on-call shifts until they have received their induction.	Please provide copies of the departmental induction programme, induction attendance lists and initial rotas for the next group of foundation trainees rotating into emergency surgery.	R1.13
ES1.3	The Trust should clarify the rota arrangements for foundation trainees to ensure leave requests are processed in a timely way and approved as often as possible. This may involve simplifying the rota arrangements, or clarifying how they are explained and possibly reviewing the arrangements for workforce management.	Please provide a copy of the rota policy and the process for trainees to apply for leave, including the deadlines for confirming approval or denial of leave requests.	R1.12
ES2.2a	The department is to ensure that trainees raising concerns or submitting complaints receive feedback and are offered support. The Trust should have a process for managing these cases.	Please provide evidence of a clear pathway for addressing trainees' concerns which includes providing feedback and appropriate support to the trainees.	R2.7
ES2.2b	The trainees should be made aware of the purpose and schedule of the local faculty group (LFG) and surgical training meetings, and encouraged to attend. The further development of these fora as early warning systems for training issues as they come up can be a powerful tool for quality improvement.	Please provide evidence that information about the LFG and surgical training meetings is circulated to trainees and copies of the attendance lists for the next two meetings.	R1.6

ES3.1	HEE has received reports from multiple sources describing incidences of bullying, undermining and discriminatory behaviour in the department. It is noted that the department are already taking steps to address this behaviour. The Trust should provide evidence that the planned training is carried out and these cases are being managed appropriately.	Please provide • confirmation that all consultants in the department have completed Equality and Diversity training and the planned HEART values training • a copy of the Trust policy for addressing bullying and undermining behaviour • details of the management process for any open bullying and undermining cases within the department.	R3.3

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

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
HEE will work with the Medical Director and Director of Medical Education to continue to improve and monitor the department culture and working environment, with particular reference to bullying and undermining behaviour and gender-based discrimination.	HEE, MD, DME
According to the website of the national guardian's office, the Trust's Freedom to Speak up Guardian (FtSuG) is Joyce Inoniyegha but none of the Trust representatives at the review seemed aware of the role or appointment. Please consider signposting the availability of the FtSuG at Northwick Park Hospital to all trainees. The FtSuG has great potential utility in the confidential reporting of concerns, including those about patient safety and bullying and undermining behaviour. The web site is accessible at: http://www.cqc.org.uk/national-guardians-office/content/freedom-speak-guardians-directory	MD, DME, CL

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	John Brecknell
Date:	18 June 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.