QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

University College Hospitals NHS Foundation Trust

Otolaryngology and Oral and Maxillofacial Surgery

Risk-based Review (focus group and education leads conversation)

Quality Review report

25 September 2018
Final report

Developing people for health and healthcare

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Quality Review details

Background to review	Core Surgery Training – Otolaryngology HEE wanted to meet with Core Surgery Trainees (CST) working in Otolaryngology (ENT) at the Royal National, Ear, Nose and Throat Hospital (RNTNE) based on the performance of this programme in the 2018 General Medical Council National Trainee Survey (GMC NTS). There were red outliers for: - Overall satisfaction - Clinical supervision - Supportive environment - Induction - Adequate experience - Curriculum coverage - Educational supervision - Feedback - Rota Design Oral and Maxillofacial Surgery HEE wanted to meet with higher trainees, including those from Barts Health NHS Trust carrying out work at University College Hospital, working in Oral and Maxillofacial Surgery (OMFS) based on the performance of the programme based on the 2018 GMC NTS. There were red outliers for: - Reporting Systems - Teamwork - Handover - Supportive environment - Curriculum coverage - Regional Teaching - Study Leave - Rota Design The review team also wanted to assess the impact on trainees of a previous head and neck (H&N) cancer reconfiguration that co-located services previously provided at Barts Health NHS Trust with the service at University College Hospital (UCH). Education leads conversation HEE wanted to meet the UCLH education leads to discuss the impact on training of a planned rehousing of the ENT service at RNTNE to the main UCLH campus.

Training programme / learner group reviewed	The review team met: - Three Core Surgery Training (CST) year 2 trainees working in Otolaryngology (ENT) from the Royal National Throat, Nose and Ear Hospital (RNTNE) - Four higher trainees (ST5-6) working in Oral and Maxillofacial Surgery (OMFS) at University College Hospital (UCH) - Director of Postgraduate Medical Education, UCLH - Education lead, OMFS, UCH - Education lead, ENT, RNTNE - Deputy education lead, ENT, RNTNE - CST Lead and Surgical College Tutor, UCH - OMFS lead, Barts Health NHS Trust
Quality review summary	CST in ENT at the Royal National Throat, Nose and Ear Hospital: The review team was pleased to hear that the Trust had proactively gone to great lengths to address the factors behind the red outliers in the 2018 GMC NTS results. So much so, that the trainees the review team met did not recognise the impression that the previous cohort of CST trainees had. The trainees were highly complimentary to the training opportunities and environment offered, as well as their clinical and educational supervisors. The only major concern that the review team had was around the apparent lack of a clear reporting and line of clinical responsibility that ensured a named consultant was providing oversight at all times. HEE would like to commend the Trust for the turnaround in trainee satisfaction for CST trainees in ENT. OMFS trainees from UCLH and Barts Health NHS Trust: The review team was pleased to hear that the trainees had access to a broad spectrum of OMFS sub-specialties. However, there was cause for alarm to hear how the reconfiguration of H&N services between UCH and the Royal London Hospital (RLH), that began in 2015, was still negatively impacting trainee experience and the wider clinical environment. The overall impression that the review team had of the impact of the OMFS service redesign was that the lack of collaboration between the two MDTs was a major cause of concern that had the potential to jeopardise patient safety, trainee wellbeing and education, and the effectiveness of outcomes for patients. The review team welcomed the ongoing work between the two MDTs to address the issues and it was decided that HEE would work with all stakeholders and appropriate external bodies to help the Trust adapt to offering a seamless H&N service across the two sites.

Quality Review Team			
HEE Review Lead	Mr John Brecknell, Head of the London Postgraduate School of Surgery	**External Clinician**	Mr Paul Ziprin, Consultant Surgeon, Imperial College Healthcare NHS Trust

Deputy Postgraduate Dean	Dr Indranil Chakravorty, Health Education England	**Lay Representative**	Jane Gregory
HEE Quality Representative	John Marshall, Health Education England	**Observer**	Bridget Kelly, Health Education England, Kent Surrey and Sussex

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
R1.12	**Rotas** The CST ENT trainees reported being aware of the great dissatisfaction of the cohort preceding them which had led to the poor GMC NTS return. Some of the trainees in that group had changed their career intention away from ENT as a result of their experience. The current cohort of trainees were aware that a great deal of work had been done in improving the training environment and agreed that the present position was excellent. During the education leads conversation (ELC) the review team heard of the steps that the Trust had taken to address the issues behind the red outliers in the 2018 GMC NTS for CST ENT. It was reported that the Trust had anticipated the poor results and had proactively set out to address this. The review team heard that from February 2018 onwards, the Director of Postgraduate Medical Education and surgical tutor had recognised trainee dissatisfaction and had engaged the divisional management in an internal meeting in March. The Trust installed a CST lead to oversee junior trainees working at the RNTNE, including GP and neurosurgery. One of the critical changes implemented was to unburden the trainees from carrying out clinic duties at the expense of theatre time. This was reflected in the conversation that the review team had with the CST ENT trainees.	

R1.15	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The review team was pleased to hear that the CST ENT trainees had generous access to operative training. It was reported that there were four theatres running five days a week and that the CSTs were able to attend approximately six operative sessions in each working week. All day on Tuesdays, in two theatres, cases suitable for core level training in ENT were listed and the CSTs were freed from all other duties to attend. In addition, core trainees reported being able to observe cochlear implant surgery, to visit the H&N unit at the UCLH site, to access facial plastics and to practice microsurgical technique. Although CSTs were able to access outpatient-based training at will, they were only required to attend two emergency clinics every three weeks or so. This limitation was reported as being robust and that it was maintained even in the face of rota gaps. The review team heard from the higher OMFS trainees that the RLH provided excellent exposure to trauma and UCLH had a high volume of H&N cancer cases. GOSH provided access to craniofacial and cleft training. Cross-site working and cultural issues described in detail below compromised the access to some of these training opportunities.	
R1.8	**Appropriate level of clinical supervision** The review team explored both with the ENT CSTs and in the ELC, the clinical supervision of CSTs at the RNTNE. When in clinic, there was always a consultant clinic being run 'over the corridor' and help was always available on request. The team understood that in the absence of a consultant clinic, the emergency clinic was cancelled. However, when the trainee did not seek advice, it seemed that no senior clinician was necessarily aware of the patients reviewed or of decisions made. There appeared to be no universal consultant line of control. A similar arrangement was reported for the supervision of CSTs receiving and managing emergency referrals from nearby hospitals. While all admissions were discussed with a duty registrar, declined referrals were not necessarily discussed and it was not clear that consultants were involved in the decision-making process. However, there was a daily consultant ward round, including weekends, and emergency activity was audited through the maintenance of a 'book' by a senior nurse. The CSTs in ENT at RNTNE did not feel that arrangements for supervision were inadequate, although those who had not worked in ENT before were less confident in them, and the review team were aware that they represented 'the norm' for ENT services in the UK. Conversations with both trainees and the education leaders explored these norms in the light of recent legal cases and the contemporary governance framework. CSTs were all aware of who their educational and clinical supervisors were and reported meeting them regularly. This provided a sense of mentorship despite the lack of a classical firm structure. It was felt that on balance, returning to a strict one to one relationship between CST and consultant trainer would limit the volume of clinical cases available to each trainee.	Yes, please see ENT1
R1.13	**Induction** The review team heard that the induction for CST ENT trainees had also been reviewed in light of the 2018 GMC NTS performance. The current cohort reported starting on weekend nights and that for those not familiar with ENT practice, it could be quite difficult to pick things up. A new local induction was put in place from August 2018 and included five days of shadowing senior colleagues for those new to the specialty. This had been warmly received by the trainees. The education leaders also reported a whole day procedural course and the provision of a handbook. The trainees reported that they had met with the incoming cohort to pass on their experiences and advice to the next rotation of CST ENT trainees.	

R1.4	**Serious incidents and professional duty of candour** CST trainees in ENT reported that serious incidents (SI) were used as an opportunity to learn the lessons from the SI through a debrief with a senior clinician. In contrast the OMFS trainees reported that they felt vulnerable when things went wrong and that in some cases there was a lack of support from the Trust and senior consultants.	

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.

R2.3	**Impact of service design on learners** At the ELC the review team heard that the move from the RNTNE to UCLH was planned to transfer current levels of activity and staffing, about 100,000 outpatient and 5,000 operative cases per year, together with a projected 2.5% increase in workload year on year. This meant that as staff moved to the new site staffing numbers would remain consistent with retiring consultants being replaced and the scope to expand the workforce to meet increasing patient demand. The review team heard that following the move, the RNTNE and UCLH ENT departments, which sit in different Trust divisions, would remain as distinct departments. Parallels were drawn with the situation in the H&N service, in which Barts and UCLH teams remained largely separate, with tensions between the two halves of the service. The review team heard that the CSTs had not been consulted about the plans for the move from RNTNE. The review team heard from the higher surgical trainees in OMFS about the reconfiguration of H&N cancer services in 2015, which involved moving the service from the RLH to UCLH. Ongoing cultural issues were reported which had impacted upon trainees' experience and the wider working environment. The two clinical teams still functioned separately, with Barts Health staff travelling to UCLH to deliver care, and with two separate multidisciplinary teams (MDT). Patients were referred to by the Trust that had admitted them (patients from Barts Health were referred to disparagingly as 'Barts patients'). Competition or 'one-upmanship' between the two teams reduced the number of available training cases. One trainee reported that they had been actively discouraged from becoming involved in the care of Barts Health patients and were not permitted to attend Barts Health lists, which further diminished the opportunities available to trainees. The trainees reported difficulty acquiring indicative numbers of H&N cancer cases form these posts. One specific example of the consequence of the lack of cohesion in the unit which affected the trainees was in the identification of which consultant was responsible for supervising the CEPOD list. Cases had been cancelled by trainees on occasion when no consultant would accept this responsibility. The education leads from both trusts recognised that there were unresolved issues resulting from the reconfiguration.	Yes, please see ENT2 Yes, please see ENT3

	It was reported that the situation had improved since 2015 but was still far from acceptable. The trainees felt that what improvement there had been was down to individual consultants recognising the importance of their roles as educators rather than any overarching action taken by the Trust, and three such individual consultant trainers were identified as being committed to the delivery of training. The environment was reported as having a negative effect on trainee morale and wellbeing. The overall impression that the review team had of the impact of OMFS service design on the trainees was that the lack of collaboration between the two clinical teams was a major cause of concern with regard to the training environment but also had the potential to jeopardise patient safety. When meeting the education leads the review team heard of the steps that the Trust had taken relating to the leadership of the H&N service. The Trust had appointed a new clinical governance lead and a new MDT lead, with a newly created deputy post reporting to the MDT lead. The Trust had also appointed an MDT unification lead to bridge the gap between the UCH and RLH MDTs with the chief aim of standardising clinical practice across both groups. It was reported that at present, NHSE and NHSI were not involved in this service improvement work. The review team welcomed these developments, along with the appointment to a number of other roles to support the drive to improve clinical governance and the cohesiveness of the H&N service, and that regular meetings to address the issues between the two MDTs were taking place. The trainees reported issues around split site working, and in some cases working across two Trusts. The trainees that the review team met with between them undertook duties at UCLH, Barts Health and Great Ormond Street Hospital (GOSH) and all had experienced some degree of a lack of cohesion in their workloads and work patterns. With particular reference to the reconfigured H&N and cancer services, the trainees reported that there were issues around the continuity of care of patients once discharged from UCH due to the cultural split between the two MDTs. This meant that the trainees were spending increasing amounts of their own time following up cases and catching up with emails across separate Trusts. The review team heard that for the cancer service there were plans to implement a single MDT but that they were unsure when this would happen.	Yes, please see OMFS1
R2.6	**Appropriate system for raising concerns about education and training within the organisation** The CST ENT trainees reported that there was a Local Faculty Group (LFG) to raise concerns about their training and factors beyond the training environment that impacted upon their training. However, the trainees reported that they had not been consulted directly regarding the move of ENT from the RNTNE to UCH. The review team heard that the Director of Postgraduate Medical Education operated an open-door policy, with weekly drop-in sessions as a forum for trainees to raise any concerns about their training, and that this approach was publicised to all trainees at the Trust-level induction. The OMFS trainees reported that there was an LFG but trainees were not always able to attend because of cross-site responsibilities.	

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.

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.

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.

6.2	**Learner retention** One of the CST ENT trainees reported that their rotation had been the best training experience so far in their career, and all of this group of trainees the review team met with were impressed with the variety of training opportunities available in a supportive environment.	

Good Practice and Requirements

Good Practice
The education leadership of UCLH should be complemented on the turnaround evident in the learning environment for core surgical trainees in ENT at RNTNE since the GMC 2018 NTS collected its data. Action was proactive and importantly involved appointment of a local lead for CST, freeing trainees from an overwhelming commitment to outpatient activity of limited educational value, the concentration of appropriate operative cases into specific lists accessible by the CTSs, and the improvement of local induction.

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.**
ENT1	Please work towards designing and implementing a framework to ensure a clear line of consultant responsibility around the clinical activity of CSTs in ENT, with a view to supervising the trainees. A consultant should have oversight of all clinical activity such that clinical supervision is available on-site to all CST ENT trainees, whether or not they ask for help.	Please provide HEE with a copy of the agreed framework and evidence of its implementation.	R1.8

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
ENT2	HEE recommends that the Trust takes steps to fully integrate the two ENT departments following the move of the department from the RNTNE to the UCLH site.	We look forward to learning of your plans for co-working between the two departments.	R2.3
ENT3	Involving trainees in the planning of the move from RNTNE may pre-empt inevitable problems with the training environment and make the process smoother for all.	We look forward to hearing about the contributions of doctors in training to the arrangements for the move of clinical services in ENT from RNTNE to the main UCLH site.	R2.3

OMFS1	While split-site working for trainees between UCLH and BH persists, cross-site IT access would greatly facilitate both clinical delivery and effective training.	Please explore the possibility of arranging cross-site IT access for trainees engaged in cross-site working.	R2.3

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
HEE to raise the impact of the cultural divide between UCH and RLH H&N clinical teams on the delivery of patient care with NHS Improvement and discuss how this should be resolved	Dr Indranil Chakravorty
HEE to work with the OMFS training programme director to limit split-site working whilst maintaining curriculum coverage and training opportunities	Mr John Brecknell

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Mr John Brecknell, Head of the London Postgraduate School of Surgery
Date:	6 November 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.