Health Education England

London North West University Healthcare NHS Trust (Northwick Park Hospital and St Mark's Hospital)

Gastroenterology

Risk-based Review (on-site visit)

Quality Review report

2 April 2019

Final report

Developing people for health and healthcare

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Quality Review details

Background to review	The 2018 General Medical Council National Training Survey (GMC NTS) results for the Northwick Park Hospital site returned seven red outliers for Overall satisfaction, Clinical supervision out of hours, Teamwork, Handover, Supportive environment, Adequate experience and Local teaching. The department also returned seven pink outlier results for Clinical supervision, Reporting systems, Workload, Induction, Curriculum coverage, Educational governance and Feedback. The St Mark's Hospital site had too few trainees to return NTS data. A recent trainee survey highlighted two reports of bullying and undermining behaviour, one within specialty and one in the context of the acute medical take.
Training programme / learner group reviewed	Gastroenterology
Number of learners and educators from each training programme	The review team received feedback from three foundation trainees, two core medical trainees and seven higher trainees in gastroenterology. The review team also met with educational and clinical supervisors from the department and the following Trust representatives: • Director of Medical Education • Medical Director • Divisional General Manager for Surgery • Guardian of Safe Working Hours • Educational Lead for Hepatology • Educational Lead for Endoscopy • Medical Education Manager • Postgraduate Centre Manager.
Review summary and outcomes	The review team identified several areas of good practice including the case mix and variety of learning opportunities available, the clinic and endoscopy experience available at the Central Middlesex Hospital site and good multidisciplinary team working (see Good Practice section below). The following areas for improvement were also identified: • The outlier ward 'buddy' system increased the potential number of outlier patients under the care of the gastroenterology trainees at all levels, making workloads unpredictable and difficult to manage due to the numbers of patients spread across multiple locations. • The trainees described variable levels of consultant input on the inpatient wards at Northwick Park Hospital, which sometimes impacted on trainees' ability to plan their work and to leave the ward for learning opportunities such as clinics and endoscopy lists • Core medical trainees needed more regular access to clinic lists to meet their curricular requirements • The higher trainees noted that it was difficult to find out what teaching sessions and learning opportunities were offered by the various subspecialty teams and suggested that a centralised list should be compiled

	• Foundation and core medical trainees on the acute medical on-call rota had to communicate between the acute medical and gastroenterology rota coordinators to avoid clashes between their clinical commitments. Trainees reported being told that they could not take zero days on certain days of the week due to staffing levels • The trainees required clarification around when it was appropriate to exception report for either additional hours worked or missed educational opportunities • The trainees described variable levels of access to endoscopy lists, particularly at the start of the training year when the majority of lists had been pre-booked by trainees with earlier start dates or other staff for the first few weeks. During the acute medical rotations, trainees had no access to endoscopy training.

Quality Review Team			
HEE Review Lead	Geoff Smith, Deputy Postgraduate Dean Health Education England, North West London	**School of Medicine**	Andrew Deaner, Head of London School of Medicine and Medical Specialties Health Education England
External Clinician	Elspeth Alstead, Training Programme Director, North East London	**Lay Member**	Jane Gregory, Lay Representative
HEE Representative	Louise Brooker, Learning Environment Quality Coordinator Health Education England, London		

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

The review lead asked about the Trust's response to the 2018 General Medical Council National Training Survey (GMC NTS) results. The Director of Medical Education (DME) outlined the five main areas of improvement:

- Rotas
- Workload and patient numbers
- Access to teaching
- Access to endoscopy
- Length of ward rounds.

The review team heard that the Trust had recruited three Trust-employed doctors to help manage the workloads on the gastroenterology inpatient wards, as well as adding a second core trainee-level doctor on-call out of hours. The bed base on the main gastroenterology ward at Northwick Park Hospital (NPH) had been reduced in an effort to reduce patient numbers. The Trust also planned to review the arrangements for admitting outlier patients.

The Trust acknowledged that there were barriers to trainees accessing training opportunities, such as workloads and the timing of some teaching. The departmental teaching time had been moved to Thursday at lunchtime to allow more trainees to attend and additional sessions such as a journal club had been introduced. The supervisors found these sessions were also useful ways to meet regularly with trainees and receive informal feedback. The Trust planned to restructure the higher trainees' acute medicine rotations so that only one trainee was in acute medicine at one time, to minimise the effect on the rota. The Educational Lead for Hepatology (ELH) advised that the team planned to increase the Trust-employed doctors' participation in the acute medicine

rota to assist with this. The Trust ran a rotation and training programme for Trust-employed doctors which included annual reviews of competency progression (ARCPs) and teaching sessions. The aims of this were to improve recruitment and retention of staff in these posts and to standardise processes and quality of care.

The Educational Lead for Endoscopy (ELE) advised that there were historical issues with providing endoscopy training lists for all trainees and staff who required them. The review team heard that there were 37 trainees across medicine and surgery and three endoscopy fellows who all required one list per week, as well as research fellows, training nurse endoscopists and Trust-employed surgeons who also needed endoscopy training. The ELE reported that trainees had access to a minimum of 30-35 lists per year each. It was also noted that there were more endoscopy lists available at Central Middlesex Hospital (CMH) so trainees could build significant levels of experience while on rotation there. The review lead enquired whether trainees booked endoscopy lists but were unable to attend due to service pressures and whether this was monitored. The ELE advised that non-attendance was followed up but that trainees did not always provide reasons and that the Trust aimed to track this more effectively in future.

The department held local faculty group (LFG) meetings but these were not attended by trainee representatives. Instead, trainees participated in junior doctor meetings with the ELs who fed any issues through to the consultants' meetings and LFGs as appropriate. The DME reported that there was greater attendance from junior trainees than higher trainees at these meetings. The Divisional General Manager for Surgery (DGMS) explained that the Trust tried to encourage trainees to give feedback through a variety of different mechanisms, for example email, letters or meetings about specific issues rather than waiting for scheduled departmental meetings. A lack of computer access on the wards was one issue which had been raised by trainees and the Trust had invested in four more computers as well as additional workstations on wheels for use on ward rounds.

The Guardian of Safe Working Hours (GoSWH) informed the review team that all trainees were encouraged to submit exception reports for additional hours worked and missed educational opportunities and were taught how to exception report during their induction. The review team heard that trainees in gastroenterology submitted very few exception reports for missed breaks or missed teaching. The GoSWH advised that if exception reports were accepted, the Trust typically paid overtime rather than giving time off in lieu.

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

G1.1	**Patient safety** The higher trainees raised some concerns about the competence of some locum doctors. The higher trainees explained that their workloads were increased when working some locums who did not have appropriate skill levels and were not engaged with team working. Trainees felt confident that they could discuss these concerns with their supervisors and that action would be taken. The foundation and core trainees (junior trainees) were reluctant to recommend treatment at the Trust to friends and family due to the potential for tasks to be missed or delayed if ward rounds were prolonged. The supervisors agreed that reviews of new admissions could be delayed but noted that all patients were seen in the emergency department (ED) or on short stay wards before being transferred to specialty wards. Most of the higher trainees said that they would refer friends and family to the Trust for treatment.	
G1.2	**Responsibilities for patient care appropriate for stage of education and training** The junior trainees reported that their jobs were sometimes overwhelming due to the workload and numbers of patients, particularly outlier patients who could be situated on a number of different wards. Some trainees had escalated these concerns to supervisors and reported variable responses. The foundation trainees found the core and higher trainees a valuable source of support at busy times.	
G1.3	**Rotas** The junior trainees advised that the Northwick Park Hospital (NPH) gastroenterology team had been short of doctors at core and higher trainee level at the start of their rotations, but that these rota gaps had been filled for the past two months. The junior trainees described the workloads as very difficult to manage during the period of short-staffing. During this time the infectious diseases team and gastroenterology team were meant to provide cross-cover for each other but the junior trainees reported that these arrangements had been unclear and some members of the infectious diseases team were not aware of them. The trainees participated in the acute medicine on-call rota as well as the gastroenterology rota. The junior trainees reported that they had to liaise between the rota coordinators in acute medicine and gastroenterology and that they had initially been told that they could not take certain zero days from gastroenterology which had been planned on the acute medicine rota. The consultants at NPH were allocated responsibility for the inpatient wards on weekdays for three-week periods. During this time the consultants still ran clinics and endoscopy lists. The review team heard that Trust policy mandated that consultants carry out a minimum of two full inpatient ward rounds per week and that there were daily board rounds. The trainees reported that the consultants varied in the number of board rounds they attended and whether they conducted more than two full ward rounds each week, although all consultants would review new admissions and sick patients as required. It was also commented that some consultant ward rounds took place in the afternoon or lasted several hours, leaving trainees with long lists of tasks to complete after 17:00. Board rounds were multidisciplinary, including the nurse in charge, discharge coordinator and a member of the outpatient team. The junior trainees suggested that it would be useful if the consultant attended the board round as well. The higher trainees had rotations on the gastroenterology wards at NPH and St Mark's Hospital (SMH), the gastroenterology wards at Central Middlesex Hospital (CMH) and the acute medical wards at NPH. During the acute medical rotation, the higher trainees provided cover for the high dependency unit (HDU), which they described as being well-supported in terms of senior cover although there was not a dedicated HDU consultant out of hours or at weekends. The on-call gastrointestinal bleed service at SMH was led by higher trainees and middle-grade Trust-employed doctors. The	Yes, please see action G1.3

	trainees described this as a good training experience and felt supported by the on-call consultants.	
G1.4	**Induction** All trainees had had an induction at the start of their rotations and reported that they had been allocated supervisors and assigned logins for the relevant computer systems. Both junior and higher trainees noted that no time was assigned for statutory and mandatory training during work hours, so trainees were obliged to complete this in their own time. The higher trainees worked in the HDU during their acute medicine rotations but reported that they were not given an induction for this.	Yes, please see action G1.4
G1.5	**Handover** The higher trainees noted that handover between the ED and the acute medical on-call trainee was minimal. The trainees informed the review team that the team in ED added patients to the acute medical list during the day and the on-call trainee took the list at 20:00 but was not given any further details. The review lead asked whether this system was safe and the higher trainees advised that it was because the nursing teams would alert them if a patient was sick and the ED team would discuss new admissions with them overnight. The trainees were aware of instances where patients had been 'lost' between ED and the acute medical team but stated that this was very unusual.	Yes, please see action G1.5
G1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The junior trainees informed the review team that the Trust offered a variety of learning opportunities but that it could be difficult to access these due to workloads on the inpatient wards, particularly at NPH and SMH. The foundation trainees reported that some ward rounds took several hours to complete but that there was often good teaching during rounds. Foundation trainees also had the opportunity to clerk and present patients when working in the acute medicine service. The core trainees reported that their curriculum required them to attend regular clinics but that these had not been included in their rotas and had to be booked on an ad hoc basis. Due to workload, the core trainees sometimes felt unable to leave the wards to attend clinics. The higher trainees were given their own clinic lists which were included in their rotas. The higher trainees felt well supported in clinic and reported that they could always access consultant supervision when needed. Access to endoscopy lists was raised as an issue by both trainees and trainers. The review team heard that some higher training rotations included a regular endoscopy list but that others did not. The higher trainees reported that a list of available training endoscopy lists was distributed via email six to eight weeks in advance and the trainees had to respond with their requests for lists. This was difficult at the start of the academic year as trainees in other teams who had earlier start dates or substantive staff at the Trust had pre-booked most of the lists already, so some higher trainees advised that they spent very little time in endoscopy for the first two months of the year. When trainees were able to book ad hoc lists, they sometimes felt unable to leave the wards due to workloads or changes to the timing of consultant ward rounds. The supervisors suggested that they could proactively encourage trainees to leave the wards to attend endoscopy in these cases. Trainees who had completed rotations at CMH found that there was much less competition for endoscopy training there and reported attending multiple lists each week. During the acute medicine rotation, the higher trainees were not allocated any endoscopy lists and advised that this made it difficult to build and maintain their skills. The supervisors were aware of the shortage of lists but were unsure whether there was a solution for this, given the number of trainees, Trust-employed doctors, clinical fellows and nurses who required endoscopy training.	Yes, please see action G1.6a Yes, please see action G1.6b

G1.7	**Protected time for learning and organised educational sessions** The department ran weekly gastroenterology teaching and several of the sub-specialty teams ran separate teaching sessions. The higher trainees noted that they were usually aware of the teaching available in the sub-specialty teams they worked with but did not have an overview of learning opportunities across the department. It was suggested that a centralised list of learning opportunities should be compiled and shared with all trainees in the department. The junior trainees reported that they were usually able to attend the main departmental teaching and leave their bleeps with the office staff. The higher trainees advised that they sometimes felt unable to leave the wards when workloads were high, particularly if there were less experienced junior trainees on the ward and the consultant was in clinic.	Yes, please see action G1.7

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.

G2.1	**Effective, transparent and clearly understood educational governance systems and processes** All trainees reported that they had been taught how to submit exception reports during their inductions. Some junior trainees advised that they or their colleagues had submitted exception reports and been told that their reasons for reporting were not appropriate. Most of the higher trainees felt that the job required some extra work and did not want to submit exception reports. None of the trainees had attended local faculty group meetings but both junior and higher trainees had submitted feedback to consultants for escalation. The majority of higher trainees felt that the consultants were receptive to their feedback and acted on their concerns, whereas the junior trainees were less confident of this.	Yes, please see action G2.1
G2.2	**Impact of service design on learners** The higher trainees reported some friction with middle management around clinic cancellations. The review team heard that trainees had cancelled clinics because of study days or leave but had received text messages at late notice saying that the clinics were still running or had been reduced instead of cancelled. The junior trainees described feeling under pressure to make decisions about discharging patients, despite this not being part of their remit. When asked where this pressure came from, the junior trainees advised that it came via the discharge coordinator but that it originated from the bed managers. The review team enquired about the higher trainees' experience of clinics. The higher trainees responded that there was a good range of specialty clinics available but that	

	they were booked to a standard clinic template with 10 appointment slots. The patient cases were often complex so the higher trainees advised that clinics frequently ran late. In addition, the higher trainees indicated that when they returned to the wards from clinics there were often still tasks to be done which the teams had not been able to complete in their absence. The junior trainees reported that on occasion ward rounds at NPH could last until 16:00 or later, making it difficult to find time to carry out tasks, order investigations and prescribe medications for patients being discharged. The review team heard that this was partly due to the number of outlier patients, who could be spread across multiple wards. The supervisors agreed that the high number of outliers could be difficult to manage but acknowledged that there was a balance to be struck between the size of the main ward base and the amount of outlying patients. The supervisors reported that the gastroenterology team provided medical cover for a large surgical outlier ward which further increased the workload. The number of medical patients on the ward could fluctuate if elective surgical procedures were cancelled, for example due to winter pressures. The supervisors suggested that the department would benefit from more protection against such sudden increases in patient numbers and from a cohort approach to outlier patient admissions. The trainees expressed appreciation for the increased number of computers on the wards at NPH. The junior trainees noted that patient records were still located on four different systems which did not synchronise data but agreed that it was now easier to access a computer. The higher trainees advised that it would be helpful if there were more computers equipped with microphones and dictation software and if they were located away from the main ward workstations.	Yes, please see action G2.2
G2.3	**Systems and processes to identify, support and manage learners when there are concerns** The supervisors were aware of the process for managing trainees requiring additional support (TRAS) and the Trust had appointed a TRAS lead to assist supervisors with this. The supervisors advised that they were able to access good informal support from each other and could discuss concerns about trainees at departmental meetings.	
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.**		
G3.1	**Behaviour that undermines professional confidence, performance or self-esteem** Both junior and higher trainees gave examples of inappropriate communication in the department, such as being shouted at on the phone or being spoken to in a rude way. The trainees felt that most of these instances were not personal and indicated that this type of behaviour was linked more to stress and workload levels or misunderstandings between teams than to intentional undermining or bullying. However, the trainees did not think that this behaviour was appropriate and noted that most people in the department communicated well with one another.	
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.		
G4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The supervisors advised that their job plans included time for supervision activities and that the PGME team provided good support, both informally and through the educational forum.	

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.**		
G5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The trainees reported no difficulties in completing workplace-based assessments and portfolios or arranging meetings with their supervisors.	
G5.2	**Opportunities for interprofessional multidisciplinary working** There were specialist nurses and advanced nurse practitioners in some of the teams at NPH and SMH and the trainees praised these colleagues' skills and contribution to the teams. The junior trainees suggested that having a physician associate on the NPH inpatient wards would be beneficial as it was common for them to spend an hour or more ordering routine blood tests and investigations. The higher trainees felt that there were good working relationships between the different professional groups.	Yes, please see action G5.2

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.**		

	N/A	

Good Practice and Requirements

Good Practice
The department offered a good mix of training experience across general and specialist gastroenterology, hepatology and general internal medicine.
Increased staffing levels on the luminal and hepatology wards at Northwick Park Hospital had significantly improved the trainees' experience.
The higher trainees reported that the Trust offered excellent training opportunities, particularly in the inflammatory bowel disease team and the intestinal failure unit.
The trainees felt that the consultants were receptive to feedback about the quality of training and potential service improvements.
Trainees who had been on rotation at Central Middlesex Hospital described good access to a range of clinics and to endoscopy training lists.
The trainees noted the contribution of advanced nurse practitioners and clinical nurse specialists to the department and valued the opportunity to work in a skilled and effective multidisciplinary team.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	None		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
G1.3	An improved system of rota management is required for foundation and core trainees who work between the gastroenterology and acute medicine teams.	Please provide evidence that the rota coordinators between the two teams liaise with one another and that trainees are no longer responsible for booking their acute medicine commitments into the gastroenterology rota. Please provide this by the end of May 2019.	R1.12
G1.4	Higher trainees should have a HDU induction at the start of their acute medicine rotation.	Please provide and induction programme for the acute medicine rotation which includes induction to the HDU. Please also provide trainee feedback following the induction. Please provide this evidence by the end of June 2019.	R1.13
G1.6a	Core medical trainees need more regular access to clinic lists to meet their curricular requirements.	Please provide a timetable of clinics allocated to core trainees which is mapped to the core medical training curriculum by the end of June 2019.	R1.19

G1.6b	Trainees require regular access to endoscopy training lists and should be released from other clinical commitments in order to attend these.	Please provide trainee feedback demonstrating that trainees at all levels are able to access endoscopy training as required for their curricula. Please provide this by the end of June 2019.	R1.19
G2.1	The trainees require clarification around when it is appropriate to exception report for either additional hours worked or missed educational opportunities.	Please provide copies of communication to trainees outlining the situations in which it is appropriate to exception report. Please provide this by the end of May 2019.	R2.2

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
G1.5	The Trust should consider developing a more robust handover system between ED and the acute medical on-call.	The Trust is advised to seek trainee feedback around how this handover could be improved.	R1.14
G1.7	The higher trainees suggested that a centralised list of teaching sessions and learning opportunities available across the department should be compiled.	This information could be compiled via the LFG or a trainee or group of trainees with an interest in postgraduate medical education could undertake this as a quality improvement project.	R3.7
G2.2	The Trust is encouraged to involve trainees in plans to improve the outlier patient arrangements and ward 'buddy' system.	The Trust is advised to seek trainee feedback and suggestions for improvements to the management of outlier patients.	R2.3
G5.2	The Trust is advised to consider including a physician associate role on the inpatient gastroenterology wards at NPH.	The Trust is welcome to seek advice from HEE on this issue. The gastroenterology department could also seek advice from other medical specialties which have introduced similar roles.	R5.9

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

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Geoff Smith
Date:	29 April 2019

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.