NHS
Health Education England

London North West University Healthcare NHS Trust (Northwick Park Hospital)

Haematology

Risk-based Review (on-site visit)

Quality Review report

2 May 2019

Final report

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Quality Review details

Background to review	Following a Health Education England (HEE) quality review in December 2018 and a resulting immediate mandatory requirement, it was agreed that HEE would arrange to follow up in 2019. The concerns raised at the December 2018 review included clinical supervision of junior trainees, progress on improvements to the training environment, support for trainees out of hours, management of outlier patients, frequency of consultant review and access to training from the consultant team. The department has been under General Medical Council (GMC) enhanced monitoring since September 2017.
Training programme / learner group reviewed	Haematology
Number of learners and educators from each training programme	The review team met with six haematology trainees at specialty training levels three to seven (ST3-7). The review team also met with educational and clinical supervisors in the haematology department and Trust representatives including: • Director of Medical Education • Medical Education Manager • Associate Medical Director for Medical Education and Research & Development • Guardian of Safe Working Hours • Acting Clinical Director/Divisional Director • Educational Lead • Director of Strategy and Deputy Chief Executive.
Review summary and outcomes	As a result of long-standing concerns about the training environment, clinical supervision and pastoral care of trainees in the department, and further concerns during the current review that the trainees continued to feel clinically unsupported, it was decided that HEE would suspend the haematology training posts at specialty training level three (ST3) from the next rotation date on 1 August 2019. The department remains under GMC enhanced monitoring and the GMC has proposed conditions for improvements to training in the interim period, which will be agreed with the Trust prior to being finalised. If these conditions are not met, HEE and the GMC may agree to conduct a phased withdrawal of training posts from the department. HEE has written to the Trust outlining the full details of the training suspension. The review team identified some areas of good practice including the recent investment in the physical environment of the department, the appointment of a Service Manager for haematology and the reinforcement of the departmental teaching programme (see Good Practice section). Further areas for improvement were also identified: • The evening handover between haematology and the general medical ward cover was of concern, as the trainees were often unable to identify who to hand patients over to in the absence of a formal handover meeting.

	This impacted on the trainees' ability to leave the hospital on time at the end of their shift and created the potential for patients not to be handed to the specialty team in a timely manner. However, the trainees had not reported this through Datix or other formal channels. • Trainees also reported that the system of handing newly admitted haematology patients to them by the acute medicine team was ineffective, challenging their ability to pick up new patients in a timely fashion. • The trainees reported that the staff on the day unit did not always respond with appropriate urgency when contacted by sick patients. • Concerns were raised that the clinical support and supervision of junior (ST3) specialty trainees remained limited at times, relating to which consultant was providing the ward cover. The ST3 trainees reported significant anxiety about working within the clinical setting. • Trainees raised further concerns about undermining behaviour. In one case this had been highlighted and managed through the Director of Medical Education and Medical Director, however a second episode, in the setting of a recent morbidity and mortality meeting, was also raised.

Quality Review Team			
HEE Review Lead	Dr Geoff Smith Deputy Postgraduate Dean, North West London Health Education England	**Head of Specialty School**	Dr Martin Young Head of the London Specialty School of Pathology
GMC Representative	Samara Morgan Principal Education Quality Assurance Programme Manager General Medical Council	**Lay Member**	Jane Gregory Lay Representative
HEE Representative	Louise Brooker Learning Environment Quality Co-ordinator Quality, Patient Safety & Commissioning Team Health Education England, London	**HEE Representative**	Paul Smollen Deputy Head of Quality, Patient Safety & Commissioning Team Health Education England, London

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

The review lead enquired about progress since the previous quality review in December 2018. The Educational Lead (EL) advised that feedback from the trainees was positive and indicated that clinical supervision had improved and the consultants were more engaged with teaching. The postgraduate medical education (PGME) team had regular meetings with the EL and educational forums with the consultants. The EL planned to establish meetings between the trainees and supervisors.

At the previous review, Health Education England (HEE) mandated that specialty training level three (ST3) trainees undergo an induction period and competency assessment prior to going on-call overnight without direct supervision. The EL advised that in future ST3 trainees would not be on the night on-call rota for at least two

months at the start of their rotation to allow time for them to complete these competencies. One of the senior trainees had been involved in developing the competency checklist with the EL.

The review team heard that there had been significant investment in the department, including collocating the inpatient ward with the day care unit and laboratory, increasing the number of inpatient beds and employing a physician associate (PA). The Trust had recruited an interim Clinical Director and a haematology Service Manager and was in the process of recruiting four substantive consultants. The vacant haematology clinical nurse specialist (CNS) post had been filled and the Trust was working with the consultants and trainees to determine which tasks could be allocated to the CNS and PA. The previous CNS had performed most of the bone marrow aspirates for outpatients and the new CNS and PA were being trained to do this along with a clinical fellow who worked in the day unit three days per week. The Divisional Director (DD) reported that the consultant laboratory rota was now shared more widely so trainees were aware of who was responsible for direct clinical supervision each day. An audit showed that 88% of outlier patients were seen by a haematology consultant within 14 hours of admission. The numbers of outliers had reduced from 15 to three to five per day following the increase in the haematology bed base.

The Trust representatives acknowledged that workloads were still high and that this put pressure on the trainees and the supervisors, but it was anticipated that this would improve as staff were appointed to the vacant posts. The Director of Medical Education (DME) reported that the department had worked to accommodate trainees' regional training attendance and study leave prior to the examination period in April 2019. The Guardian of Safe Working Hours (GoSWH) advised that the department received 25 to 35 exception reports per quarter, most of which were for additional hours worked rather than missed educational opportunities. The GoSWH noted that a lot of reports related to acutely unwell patients being admitted late in the shift, leading to late handover times. The DME advised that the Trust was looking at potential solutions for this such as altering the handover time or process and that having a CNS and a PA in post should help to reduce trainee workloads. There was a thematic review of exception reports in progress and it was anticipated that this would help to measure the impact of increased staffing levels in the department and identify other areas for improvement.

The review team heard that there had been a recent allegation from a trainee of bullying and undermining by a consultant. It was suggested that the consultant had delivered feedback to the trainee in an inappropriate way. The department planned to provide training around giving feedback after the formal case investigation was complete. The DD advised that the Trust was looking into leadership and organisational development training for consultants and planned to create a forum for consultants to escalate ideas and feedback about the department. The Head of School noted that it would be important to involve the Service Manager in local faculty group and consultant meetings to ensure that training issues were considered in service plans.

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**
Hm1.1	**Patient safety** The trainees expressed concern about the quality of patient care provided by the nurses in the haematology day unit. An example was given of a patient who contacted the unit in the morning but was sent to the emergency department. The review team heard that the patient was not seen by a haematologist and admitted until late afternoon. The trainees advised that the nurses on Drake ward provided good care and worked well with the haematology team.	Yes, please see action Hm1.1
Hm1.2	**Appropriate level of clinical supervision** The trainees reported that some consultants had become more proactive about teaching, supervision and seeing patients on outlier wards, but that there had not been an overall change in consultant behaviour. This resulted in considerable variation in the quality of clinical support and supervision in the care of haematology inpatients. There was a consultant assigned to the laboratory each weekday and the trainees advised that some would come and work with the trainees but that some would leave the trainees to complete the outstanding blood film and bone marrow reviews. The trainees felt responsible for the laboratory and the workload as they did not see the consultants consistently taking accountability for it. The supervisors reported that when they covered the laboratory, they generally spent at least an hour there to ensure that urgent reports were completed and to supervise and sign out cases with the trainees. The review team heard that there were usually two or three bone marrows and around 10 blood films per day which required review, except on Mondays when there would be additional films from the weekend. The review team asked about the disparity in the trainees' and supervisors' feedback and the Educational Lead (EL) explained that due to examinations, study leave and annual leave during March and April, some trainees had borne the brunt of additional laboratory sessions and the variable consultant engagement with these duties meant that on some days there was no opportunity for a trainee and supervisor to review films together.	Yes, please see action Hm1.2
Hm1.3	**Responsibilities for patient care appropriate for stage of education and training** Following the previous quality review in December 2018, it was mandated that trainees at specialty training level three (ST3) not take part in the overnight on-call rota until they had completed the appropriate competencies. The review team heard that a competency checklist had been drafted in April 2019 and was based on the ST3 curriculum.	
Hm1.4	**Rotas** The department had recently increased the inpatient bed base from 14 to 20 but had not increased the number of nursing staff assigned to the ward. The trainees were concerned that nurses' workloads and capacity were not given sufficient consideration when the service was redesigned. The senior team have fed back that recruitment was underway, but at the time of the review this had not been successful.	
Hm1.5	**Handover** The trainees advised that there was no formal process for handing over to the acute medical on-call doctors at the beginning of the night shift or for taking handover of new admissions from the acute medical team in the morning. The trainees found it difficult to contact the medical team and find out who they should hand over to. The process	

	for handover between the medical team and the red cell haematology team in the morning had recently changed and the trainees were unsure of who to contact. The trainees did not have access to the acute take list so were unable to check for new admissions if they had difficulty contacting the acute medical team. The trainees had not formally reported these concerns. The review lead asked whether this process was safe and the trainees advised that there had been cases where patients were 'lost' between acute medicine and haematology for up to 24 hours. The trainees noted that the nurses on Caroll ward, where sickle cell anaemia patients were admitted, were proactive in contacting the haematology team to request reviews.	Yes, please see action Hm1.5
Hm1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** At the previous quality review, the trainees had reported that much of the task-based teaching in the department was done by the trainees themselves, rather than by consultants. The review team heard that this was still frequently the case. There was a weekly training slot run by a locum consultant for trainees to practice taking bone marrow aspirates and the trainees who had attended found this useful, however there was only support for one case per week. There was a physician associate in the department who was undergoing training to take bone marrow aspirates. The trainees advised that the ST3 roles in the department were very busy due to the high service provision demand and that it was difficult to meet the requirements of the training curriculum. The trainees reported that they could take 10 to 12 bone marrow aspirates per day on the day unit and four to five on the ward but that they were not usually able to follow up and see the morphology of the aspirates they took. This made it challenging for more junior trainees to become competent in reporting. The new ward rotas included a core medical training (CMT) level doctor, who was usually a Trust-employed doctor rather than a trainee. The trainees found some of the Trust-employed doctors variable in terms of their skill level and were reluctant to leave them on the ward without direct supervision. This impacted on the trainees' ability to access other learning opportunities or do other work when covering the ward. In particular, the ST3 and ST4 trainees advised that they often picked up tasks which should have been done by the Trust-employed doctors, such as completing blood forms and drug charts. The supervisors reported that the department was working to move tasks from the higher trainees to the CMT-level doctors to reduce the trainees' workloads and allow them more time to access learning opportunities. At weekends, the CMT-level shift finished at 17:00 and the higher trainee shift finished at 21:00, which the trainees advised increased their workloads and made it difficult to leave on time. It was reported that the workforce transformation approach to managing workload was limited to one Physicians Associate post and one replacement Clinical Nurse Specialist, both of who were being trained.	
Hm1.7	**Protected time for learning and organised educational sessions** The department had started running weekly morphology teaching sessions which the trainees had found useful, but these had stopped in February 2018. The supervisors indicated that this was partly due to the period of study leave and examinations in April and partly due to an allegation of bullying and undermining against the consultant who ran the teaching, which was under investigation at the time of the review. The trainees reported that on occasion they had been told that this teaching would not take place as there were too few of them to train. The supervisors reported that the Trust had bought licenses for digital morphology software and that trainees were encouraged to login and practice reviewing cases.	
Hm1.8	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis**	

	The supervisors reported that they were able to meet regularly with trainees and discuss any concerns about their training. The supervisors acknowledged that workloads were high and that there had been a difficult period where a number of staffing changes coincided with the inpatient ward being moved and redesigned. The review team heard that recruitment for four consultant posts was underway and that workloads and supervision should improve when these posts were filled.	

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.

Hm2.1	**Effective, transparent and clearly understood educational governance systems and processes** The trainees were all aware of how to exception report and advised that they were encouraged to submit reports when appropriate. The trainees noted that if films were reviewed towards the end of shift, or if patients were admitted during the evening it was sometimes preferable to stay late to complete the review or investigations rather than hand over partially done work to the on-call doctor. The trainees agreed that it was appropriate to exception report in cases where they stayed late due to high workloads, but advised that they did not submit reports if they were required to stay late because of a medical emergency.	
Hm2.2	**Impact of service design on learners** The supervisors reported that there had been a number of improvements made in a number of areas in recent years, including supervision, facilities and the training environment. The inpatient ward had been redesigned and moved so that it was collocated with the day unit and was closer to the laboratory and doctors' offices. The supervisors advised that this had improved the environment for patient care and for training, as well as reducing the number of outlier patients. The responsibility of preparing and facilitating multidisciplinary team (MDT) meetings had been reallocated from the trainees to the consultants and the MDT coordinator. The review lead enquired whether the trainees had been involved in planning the changes to the service and was informed that they had not. The trainees had participated in the Edward Jenner supported leadership programme but had not been able to attend all the sessions and had not progressed to carrying out meaningful leadership and quality improvement projects. The trainees reported that some of the biomedical scientists (BMSs) were not sufficiently trained, so a large proportion of the referrals made to the haematologists for review were inappropriate. The trainees did not feel that this presented a safety risk, as the BMSs referred all cases which required action.	

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.

Hm3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The trainees were concerned that there was a disconnect between the Trust management and clinical staff. The trainees felt that senior managers mainly engaged with the department when the Trust was under scrutiny from HEE or a regulatory body. The review lead asked whether pastoral support for trainees had improved since the previous review and the trainees advised that they relied on the EL and on each other for most of their pastoral and educational support. The supervisors reported that the trainees fed back that they were generally satisfied with their training and were aware of the work being done by the consultants to improve the training environment. The supervisors felt that the consultant body had become more engaged with training and that the trainees needed to be more proactive in working with the consultants to make improvements in the department.	
Hm3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The review lead asked whether any trainees had experienced or witnessed bullying or undermining behaviour since the previous review. The trainees reported that there had been one incident which was under formal investigation by the Trust. The trainees did not raise any other cases of bullying but described the environment in the department as often inflammatory and felt that both they and the consultants were at risk of burnout. The trainees gave examples of times in departmental meetings when they felt blamed and criticised while presenting cases or discussing complaint investigations. The supervisors were aware that there had been some contentious discussions at recent meetings and suggested that these were isolated incidents relating to workloads and stress levels among the consultants.	Yes, please see action Hm3.2

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.

	N/A	

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.**		
	N/A	

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.**		
Hm6.1	**Learner retention** The trainees reported that the Trust offered an excellent range of learning opportunities but that there was a lack of sufficient supervision and leadership from the consultant body and Trust management. None of the trainees wanted to take up consultant posts in the department, describing a lack of cohesion and support among the consultants. The trainees felt that some consultants were engaged with training and with improving the department but that they were not adequately supported to make changes.	

Good Practice and Requirements

Good Practice
The Trust has appointed a senior-level Service Manager for haematology.
The Trust has invested significantly in redevelopment of the department and the service as well as workforce diversification.
The review team noted the work done to reinforce the planned teaching programmes.

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.**
Hm1.1	The Trust should provide a clear escalation policy for day unit patients and demonstrate effective training and development of the Day Care staff to improve the quality of triage of patients.	Please provide a copy of this policy and an outline development programme for the Day Care staff by the end of July 2019. The Trust should consider the available skill mix and rostering in the unit in order to ensure safe, supported clinical decision making and escalation of cases where the team feel advice is needed.	R1.5
Hm1.2	The Trust should establish a robust clinical support and supervision process that does not depend on the senior trainees providing this for junior trainees.	Please provide: 1. an update on the progress of recruitment of the four haematology consultant posts and the plan that will be implemented should that recruitment not be successful 2. evidence of the senior management team interventions to ensure that high quality clinical support is in place in the inpatient setting across the entire consultant cohort.	R1.8
Hm1.5	The Trust should establish a formal process for handover between the haematology team and the acute medical on-call team, both at the end of the twilight shift and at the start of each day.	Please provide details of the handover process as well as feedback from the trainees confirming that the process is followed and is fit for purpose by the end of July 2019. The Trust should consider how best to manage this process, either as a formal handover as part of pre-existing medical handover or as a specific haematology – medicine arrangement. For morning handover of patients from acute medicine to haematology, access to the acute admissions list and a system to ensure timely handover of patients should be put in place.	R1.14

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
Hm3.2	The department is advised to carry out further cultural improvement work and to include the consultants and the trainees.	The Trust is advised to seek feedback from the consultants and from the trainees about how to improve working relationships within the department. This could usefully focus on behaviours and values that provide the foundation for effective training and patient care.	R3.3

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

Requirement	Responsibility
HEE plans to conduct a follow-up review in October 2019 to determine whether further phased withdrawal of trainees is necessary.	HEE

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Geoff Smith
Date:	4 June 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.