NHS
Health Education England

Bart's Health NHS Trust (Newham University Hospital)

Foundation Surgery

Risk-based Review (focus group)

Quality Review report

24 September 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	This risk-based review was proposed as a result of a number of ongoing concerns about the quality of surgical training (at foundation level) at Newham University Hospital (NUH). Health Education England had concerns about the significant deterioration of 2018 General Medical Council (GMC) National Training Survey (NTS) results which returned seven red outliers for: overall satisfaction, supportive environment and educational supervision. There were eight pink outliers for: clinical supervision, induction, adequate experience and feedback. The GMC NTS 2019 survey had two pink / red outliers for overall satisfaction and induction. No result had been published for FY2 as the number of trainees in training were less than the minimum requirement. HEE had previously undertaken risk-based reviews to the General Surgery services at NUH as detailed below: ○ General Surgery (05 February 2019) ○ Surgery (26 February 2019) ○ Foundation Surgery (25 March 2019) ○ Foundation Surgery (23 April 2019) ○ Foundation Surgery (11 June 2019) The most recent quality review on 11 June 2019 identified a number of persistent concerns including intermittent weekly supervisory meetings with the FTPD during his leave, lack of a comprehensive departmental induction programme for August entrants, absence of a detailed job description(s) for the new placements in Acute & Emergency Surgical pathway and inadequate senior clinical oversight during on-call and ward rounds from the Surgical consultants. The focus group was organised to review progress and the quality of the new interim placements.
Training programme / learner group reviewed	Foundation Surgery
Number of learners and educators from each training programme	The review team met with a range of foundation year trainees working the general surgery department.

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty Deputy Postgraduate Dean Health Education England (North East London)	**North East Thames Foundation School Representative**	Dr Keren Davis Foundation School Director
Lay Member	Ryan Jeffs Lay Representative	**Lay Member**	Roz Thornton Shadow Lay Representative
HEE Representative	Tolu Oni	**HEE Representative**	Andrea Dewhurst

	Learning Environment Quality Coordinator Health Education England (London)		Quality, Patient Safety and Commissioning Manager Health Education England (London)
Observer	Emily Patterson Learning Environment Quality Coordinator Health Education England (London)		

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive learning experience for service users.

1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.

1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence based practice (EBP) and research and innovation (R&I).

1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.

1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.

1.6 The learning environment promotes inter-professional learning opportunities.

Ref	Findings	Action required? Requirement Reference Number
FS1.1	**Patient safety** The review team heard that a new local version of early warning score (EWS) system had been implemented on the surgical wards, however concern remained around the staff training and compliance with the new system. In particular, the lack of consistency in the way surgical plans were communicated and effected, when monitoring and escalating high risk / deteriorating patients, at on-call shift handovers was felt to have a significant impact on patient safety. Trainees cited anecdotal examples of patients being discovered on morning ward rounds as having passed away during the night, with little or no regular monitoring of vital signs. The review team noted that these instances had been reported through the established (Datix) reporting systems and escalated to the FTPD. In relation to the morning handover in the Surgical department, the trainees reported that they attended the post-take handover meetings at 08:00am but it was perceived to be disorganised, held in a room with inadequate space, poor visibility of the information board and lacked clearly identifiable leadership or oversight. The morning handover list was often completed by the overnight on-call registrars who relayed concerns about critical or deteriorating patients to the post-take consultant. However, due to frequent late arrival of some members of the handover team and absence of a lead nurse at the handover meeting; the exchange of patient information was regularly delayed and incomplete.	Yes, please see FS1.1a Yes, please see FS1.1b Yes, please see FS1.1b

	Trainees reported that patients admitted during the day take were not reviewed by consultant until the following morning. This system was perceived to be contributing to delayed treatment decisions with often adverse outcomes for patients. The review team was concerned to hear anecdotally that a patient with suspected appendicitis was left in the Clinical Decision Unit (CDU) with no assessment for a period of 8 hours. It was understood by trainees, that consultant working patterns and theatre/clinic commitment had contributed to this. The trainees found it difficult to seek guidance/ review from middle/ senior grade doctors to escalate deteriorating patients using the bleep system, as they were often in theatre or clinics. Bleeps were not usually covered and frequently remained unanswered for 'hours'. The review team was concerned that this could result in a potential impact upon patient and trainee safety.	Yes, please see FS1.1c
FS1.2	**Serious incidents and professional duty of candour** The review team were aware that trainees had regularly reported instances of delayed diagnosis and treatment and inaccurate compliance with EWS escalation pathways for deteriorating patients, through the formal reporting systems. They were not aware of any learning from these instances being disseminated to all staff through departmental governance processes to date.	Yes, please see FS2.2b
FS1.3	**Appropriate level of clinical supervision** All the trainees reported that consultant supervision during specific clinics (i.e. injuries and breast) was good. The review team was informed that the department encouraged learning through presentation of surgical cases. Consultant and SpR level supervision in ED was described as responsive, proportionate and supportive. Whilst in ED, trainees reported that they clerked in surgical presentations and but were not authorised to discharge patients without clinical oversight from senior doctors. The review team noted that the current job plan arrangement (for the foundation trainees) included only a nominal presence on the wards. Inpatient management was limited to the CDU/ observation ward. Senior surgical supervision for patients clerked for admission was perceived to be inadequate and often delayed. Doctors operating at surgical SHO level were unable to make meaningful decisions, hence patients waited inordinately for senior input. Trainees described witnessing 'heated exchanges' between ED senior staff and surgical staff in relation to delayed reviews and decisions.	FS 1.1c
FS1.4	**Handover** When asked about their experience in the ED: the review team heard that foundation trainees working in ED & CDU regularly participated in the morning handover meetings, which were well organised and efficiently run. The surgical departmental handover was perceived as lacking consistent senior representation from the post-take consultant. See details above. The trainees also expressed their frustration with the rapid pace at which the ward rounds were conducted offering them little opportunity to ask questions, receive any learning or being able to make any meaningful documentation of plans. Foundation trainees working on-call were also encouraged to participate in the post-take ward rounds in the surgical department at 09:00. The evening handover lacked adequate structure, documentation, leadership and representation from the nursing staff.	Yes, please see FS1.1b
FS1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience**	

	The review team wanted to explore in greater detail, the job plan arrangement for both cohorts of trainees. The FY1 trainees reported working in a structured weekly rota arrangement with an on-call commitment of 1 in 4 weekends. In terms of day to day jobs, the review team heard that the trainees spent 2-3 days of their working week in the ED unit where they reviewed general surgical presentations, undertook clerking for patients that required admission and referred patients to the surgical team. FY1 trainees were aware that the current job plan precluded the potential learning from managing surgical in-patients. This missed opportunity was being balanced by working in the Clinical Decision Unit (CDU) which functioned as a short stay observation ward. In addition, there was an arrangement for each trainee to work in theatres and (breast) clinics. For the FY2 trainees: the review team was advised that clinical responsibilities were outpatient-focused with the expectation of 3 weekly clinics (including breast clinics). At the clinics, the trainee attended to new patients, examined all scans and worked closely with senior colleagues/consultants in coordinating care plans for these patients. The FY2 trainees also had access to the theatre surgical lists on Thursdays and assisted with the discharge of patients following the consultant-led ward rounds on Fridays. The review team noted that the bulk of the FY2 responsibilities were administrative (i.e. prepping, attending and presenting at MDT meetings as well as making sure all jobs following the meeting were completed). In terms of on-call shifts, the FY2 trainees participated in the ED out of hours working, reviewed surgical patients, presented them to EM registrars and initiated referrals to surgical team where necessary. The current FY2 job plan included management of in-patients, particularly in non-elective surgical cases. Overall, the review team was encouraged to hear that both cohorts of trainees were very well supported in the ED and described their educational opportunities as being satisfactory. The trainees also indicated that they had regular scheduled feedback meetings with their FTPD.	
FS1.6	**Protected time for learning and organised educational sessions** The trainees reported that the Foundation teaching sessions were being held regularly. The trainees confirmed to the review team that they were able to attend the local ED teaching programmes (Tuesday and Wednesday) as well as the Monday morning Surgical teaching.	
FS1.7	**Access to simulation-based training opportunities** The trainees reported that surgical simulation teaching was incorporated into their weekly rota.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.

2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.

2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.

2.4 Education and training opportunities are based on principles of equality and diversity.

2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.		
FS2.1	**Impact of service design on learners** The trainees were concerned abouot the impact of potential reduced staffing on the new cohorts of FY1 arriving in December 2019. The review team understand that all Trust appointed middle grade doctors were scheduled to leave at the end to their temporary contracts, which was imminent. The review team noted that the Trust was yet to initiate recruitment plans for the non-training grade workforce. The review team perceived an overt environment of '*strained professional relationships'* between the surgical locally employed doctors and trainees. Trainees reported that the rota coordinator had placed undue pressure on trainees to cover shifts on the wards, despite the restrictions (from HEE) set in the current job plan arrangement. The review team heard that the foundation trainees recognised several training opportunities during their on-call shifts. Some trainees were allocated to the breast and theatre clinics during these times but noted that the theatre was often overcrowded due to a variety of learners (undergraduate students) which reduced their learning opportunities.	
FS2.2	**Appropriate system for raising concerns about education and training within the organisation** The foundation trainees were unaware of a mechanism of regular learning from incidents within the Surgical department. The current structure or focus of the M&M meeting was not perceived to be 'useful for learning'. In reporting Serious Incidents (SIs): the foundation year trainees were familiar with the process of completing Datix reports but were not aware of how learning was being optimised through feedback from these incidents. The review team heard of several examples where a Datix report had been completed but did not receive any timely feedback. • Eg. a Datix report was raised following a consultant-led ward round that had missed off a patient, whose fluid prescription had been missed left for approx.. 36 hours. • The review team heard of a further two DATIX reports raised by two separate trainees related to issues with mismatched laboratory blood test results (in one case) with the potential to leading to serious patient harm.	Yes, please see FS2.2 Yes, please see FS2.2
FS2.3	**Systems and processes to make sure learners have appropriate supervision** The trainees indicated that they often felt 'unsafe' whilst being asked to work in the surgical wards, particularly out of hours. The trainees highlighted the lack of engagement and support as being major factors for this and cited instances where the middle grade doctors (i.e. registrars) had not responded to an emergency bleep for a deteriorating patient, leaving the trainee feeling unduly vulnerable.	Yes, please see FS2.3
FS2.4	**Organisation to ensure access to a named clinical supervisor** The review team noted that all trainees had access to a named clinical supervisor and were satisfied with the level of supervision provided. The review team heard that the ED consultants, were supportive and available at all times.	

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 to achieve the learning outcomes required.

3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.

3.3 Learners feel they are valued members of the healthcare team within which they are placed.

3.4 Learners receive an appropriate and timely induction into the learning environment.

3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.

	Behaviour that undermines professional confidence, performance or self-esteem No issues were reported.	

4. Supporting and empowering educators

HEE Quality Standards

4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.

4.2 Educators are familiar with the curricula of the learners they are educating.

4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.

4.4 Formally recognised educators are appropriate supported to undertake their roles.

	Access to appropriately funded professional development, training and an appraisal for educators No issues were reported.	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.

5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.

5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

	Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum No issues were reported.	

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.**

	Appropriate recruitment processes No issues were reported.	

Good Practice and Requirements

Good Practice
• The Review team were pleased to note that the ED consultants and SpRs were offering good supervision and scheduled learning opportunities for the FY1/FY2 doctors placed in the Acute & Emergency Surgical Pathway • The review team were pleased with the opportunity for regular attendance at scheduled Theatre and clinics for all foundation doctors • The review team were pleased to see the commitment from the ED and FTPDs to implement a new Acute & Emergency surgical pathway in record time for foundation doctors and the investment in its success.

Mandatory Requirements

The most common outcome from a quality intervention. The risk rating must fall within the range of 8 to 12 or have an Intensive Support Framework rating of 2.

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
FS1.1a	The Trust is required to ensure that all staff and learners are trained and signed off as competent in the use of the early warning systems and escalation pathways for deteriorating patients within the surgical wards.	The Trust is required to confirm by training schedule and competency checks that all staff have received training in early warning systems including escalation pathways which should be easily available in ward areas at all times. Please provide an initial update by 01 December 2019.	R1.2
FS1.1b 1.4a	The Trust is required to ensure that there is a robust post-take handover (8am/4pm/8PM) in the surgical department chaired by a consultant with sign in sheets for all members required to attend. As a minimum this should take place twice a day (written and auditable).	The Trust is required to submit a 'Handover Best Practice/ SoP' document describing the expected standard, ensure timely attendance is documented and checked by Clinical Lead. Please provide an initial update by 01 December 2019.	R1.14

FS1.1c	The Trust is required to ensure that there is a timely consultant review of all new admissions and a daily review of all in-patients as per current NHS England standards.	The Trust is required to confirm implementation by Clinical Lead and discussed in LFGs. Please provide an initial update by 01 December 2019.	R1.8
FS2.1d	The Surgical department to ensure that the teaching sessions are consultant-led, arranged at times that most trainees can attend.	The Trust to provide evidence by 01 December 2019	R1.16
FS2.2	The department is to demonstrate a structured learning from regular analyses and dissemination of all serious untoward incidents through a monthly clinical governance meeting.	The Trust to submit evidence of the implementation of learning from incidents within the surgical department to the Quality team by 01 December 2019	R1.2
FS2.3	The department should ensure that no FY1/FY2 trainee in a surgical placement is expected to or required to work in surgical inpatients at any time without being accompanied by a consultant. They should not be working out-of-hours or on their own.	The Trust to confirm this from Clinical Lead by 01 December 2019.	R1.8
FS2.4	The department should implement a specialty specific induction programme (bleep-free and competency mapped) so that new trainees can achieve the necessary clinical competencies to undertake their duties safely.	The Trust to provide evidence by 01 December 2019	R1.13

Minor Concerns

Low level actions which the Trust need to be notified about and investigate, providing HEE with evidence of the investigation and outcome. Given the low level nature of this category, the risk rating must fall within the range of 3 to 6 or have an Intensive Support Framework rating of 1.

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
	n/a	none	

Recommendations

These are not recorded as 'open' on the Trust action plan so no evidence will be actively sought from the Trust; as a result, there is no requirement to assign a risk rating.

Rec. Ref No.	Recommendation	GMC Req. No.
	The review team were concerned to hear of the tensions in professional interactions between the locally employed doctors and trainees in relation to workload on the wards. The imminent changeover of staff may pose a new challenge for trainees arriving in Dec'19. The team would recommend that a robust joint induction is undertaken and through regular discussions in faculty groups, the new roles of trainees in surgical department is clarified and improved professionals' interactions are fostered.	

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 Indranil Chakravorty, Deputy Postgraduate Dean (North East London)
Date:	19 December 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.