Health Education England

HEE Quality Interventions Review Report

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

London – North West London
Date of Review: 10 March 2022
Date of Final Report: 9 May 2022

Review Overview

Background to the review

This review was a follow up to a series of previous visits, the most recent of which was held in June 2021. The purpose of the review in June 2021 was to ensure that the improvement in training had been maintained and to review the changes made. The review panel commended the department on the work undertaken to create a supportive training environment. The review panel felt that there had been a sustained tangible shift in culture, with trainees reporting the department to be friendly and supportive. Due to the ongoing areas requiring improvement the review panel requested for a follow-up learner review to take place.

The General Medical Council (GMC) was involved in the review as the department has been under enhanced monitoring since September 2017.

Subject of the review: Haematology

Who we met with

Seven specialty trainees working in Haematology

Evidence utilised

The review panel received the following information and documents from the Trust in advance of the review:

Summary of Exception Reports in the Department February 2021 to January 2022
Local Faculty Group Meeting Minutes, July 2021, September 2021, October 2021, and January 2022
Forward Strategy for Sickle Cell Services at London North West University Hospitals
Rota Information for Specialty Trainees in the Department
Summary of Educational Activities Since Last Deanery Review

The review panel also considered information from the GMC National Training Survey 2019 and 2021 and Health Education England's (HEE) National Education and Training Survey (NETS) 2019 to 2021.

This information was used by the review panel to formulate the key lines of enquiry for the review. The content of the review report and its conclusions are based solely on feedback received from review attendees.

Review Panel

Role	Name, Job Title
Quality Review Lead	Dr Louise Schofield, Deputy Postgraduate Dean, North East London, Health Education England

Specialty Expert	Dr Catherine Horsfield, Head of the London Specialty School of Pathology, Health Education England (London)
GMC Representatives	Lucy Llewellyn, Education QA Programme Manager, General Medical Council Dr Malcolm Gajraj, GMC Enhanced Monitoring Associate, General Medical Council
Lay Representative	Jane Chapman, Lay Representative, Health Education England
Learner Representative	Dr Sarah Bird, Specialty Trainee
HEE Quality Representatives	Paul Smollen, Deputy Head, Quality, Patient Safety & Commissioning, Health Education England (London) Rebecca Bennett, Learning Environment Quality Coordinator, Health Education England (London)
Supporting roles	Ummama Sheikh, Quality, Patient Safety and Commissioning Officer, Health Education England (London)

Executive Summary

The review panel thanked the trainees for participating in the review. The review panel was pleased that trainees reported the culture in the department had improved. Trainees also reported that they felt able to raise concerns and provide feedback, which was actively encouraged by the department and sometimes acted upon. However, whilst it was reported that the culture of feedback and raising concerns had improved, there were still some reports of bullying and undermining behaviours in the department.

The review panel noted that progress had been slow in some areas and there had not been resolution of a number of issues previously identified. The review panel was concerned to hear that the trainees would not be comfortable for their friends and family to be treated in the department. The review panel was also concerned that trainees did not have confidence in clinical advice given by one of the consultants and about the informal arrangement in place to attempt to address this. The review panel noted that it was unacceptable to have someone working beyond their clinical competence and clarified that this informal intervention was not sufficient to address the issue and the safety risks.

The review panel also noted several areas for improvement including, induction, handover, the effect of consultant workload on clinical supervision, the workload of the trainee covering the outlier patients and the quality of care for those patients. This report includes a number of requirements and recommendations for the Trust to take forward, which will be reviewed by Health Education England (HEE) as part of the three-monthly action planning timeline. Initial responses to the requirements below will be due on 1 September 2022.

Review Findings

This is the main body of the report and should relate to the quality domains and standards in HEE's Quality Framework, which are set out towards the end of this template. Specifically, mandatory requirements in the sections below should be explicitly linked to the quality standards. It is likely that not all HEE's domains and standards will be relevant to the review findings.

Requirements

Mandatory Requirements

Requirement Reference Number	Review Findings	Required Action, Timeline and Evidence
H1.3	Trainees noted an improvement in the culture since August 2021 and confirmed it was more supportive, where previously it had been accusatory. However, some trainees reported that they had witnessed episodes of undermining behaviour between staff which had made them feel uncomfortable.	Please provide evidence of how bullying and undermining behaviour in the department has been addressed and the action plan for ongoing improvement to reduce the recurrence of these behaviours. Please also provide feedback from trainees on this topic,

		via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
H1.5a	Trainees discussed the outlier role and reported that the role was extremely variable. Trainees advised the review panel that they did not feel it was feasible for one trainee to carry out this role safely. The trainees advised that the role was very challenging, particularly when the consultant was busy too. Trainees informed the review panel that there was overwhelming recognition that the workload was high but reported that they did not feel anything was being done to address this, despite the supportive environment.	The Trust should review the workload of the outlier trainee role and make support available to help manage the workload. Please provide evidence of how this issue is being addressed and how the improvements will be sustained long term. Please also provide feedback from trainees on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
H1.5b	Trainees reported that generally there was not sufficient clarity in who was responsible for the care of the outlier patients. Trainees informed the review panel that the service was not clearly defined and that they had been informed different things by different consultants. The review panel was also informed that there was also a lack of clarity over the responsibility of haematology patients that arrived via A&E. It was noted that the medical and A&E departments had different opinions on which patients should be admitted to haematology and it was not clear whether the trainees were	The Trust should ensure that the outlier patients and A&E care pathways are well established and clearly defined. Please provide evidence that this issue has been addressed. Please also provide feedback from trainees on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.

	supposed to review the patients in A&E.	
H1.5c	The trainees advised that they did not believe there had been an improvement in the handover arrangements. Trainees noted that there was an effort from the trainees to ensure there was a clear handover between them, but there was no formal structure in place. Trainees also noted that there was not a robust system in place for handover of patients, particularly at night.	The Trust should ensure there are formalised and robust systems in place for handover. Please provide evidence that these systems have been implemented. Please also provide feedback from trainees on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
H1.5d	Trainees advised that they were not routinely involved with sickle cell patients and therefore did not attend sickle cell meetings often. Trainees reported that they were unfamiliar with these patients and felt this exacerbated issues at night or at weekends when they were responsible for those patients. It was noted that sometimes there was a short handover for these patients, but it was not a formalised process. Trainees reported that they felt able to handle the clinical situations but were unfamiliar with the patient cohort and therefore there was a lack of continuity.	Please provide evidence of how trainees are educated and supported to ensure they are confident and capable of providing care for sickle cell patients. Please also provide feedback from trainees on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
H1.7	The trainees informed the review panel that they had recently discovered a discrepancy with their pay for on-calls. It was reported that the rota that was being worked was different to the work schedule provided at the start of the post and trainees were not being paid sufficiently for the duration of the on-call shift.	The Trust should ensure that all pay issues are resolved promptly. Please provide evidence that these issues have been resolved. Please also provide feedback from trainees on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence.

	It was noted that the trainees had approached the British Medical Association (BMA) for advice and support regarding these issues and some, but not all the trainees affected had received remuneration.	Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
H3.5a	The review panel was informed that the consultant workload was very high and therefore trainees sometimes struggled to get the consultant to review outlier patients.	The Trust should review consultant job plans to ensure consultants have the appropriate time protected to provide clinical supervision to trainees. Please also provide feedback from trainees on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
H3.5b	The review panel was concerned that trainees did not have confidence in clinical advice given by one of the consultants and about the informal supervision arrangement in place to attempt to address this. It was advised that trainees felt they had to double check the clinical advice with other consultants or with a different hospital.	The Trust must conduct an urgent review of the supervision arrangements for trainees in and out of hours and ensure that all consultants providing supervision to trainees are clinically competent and appropriately trained. Please provide evidence that this action has taken place. Please also provide feedback from trainees on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
H3.9	Trainees reported that the induction could be improved. Trainees noted that the staff had been very friendly and welcoming but felt that the induction had been very disorganised and that they had not been provided with all of the	Please provide evidence that all new starters to the department receive a thorough induction prior to starting clinical activity. The Trust should include input from trainees in designing the induction and induction materials. Please provide

	information and appropriate IT systems logins and remote access that they needed.	evidence that improvements have been made to the induction. Trainees must have access to the relevant IT systems to carry out their work and access resources for training. Please provide evidence that the access to IT has improved and information about how this is being addressed. Please also provide feedback from trainees on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
H5.6	Trainees reported that there was a weekly complex coagulation meeting with Hammersmith Hospital to discuss cases, however trainees noted that they had not been able to attend due to their workload. Trainees informed the review panel that this had improved recently, and they had been able to attend.	The Trust must support trainees to attend relevant educational opportunities as necessary and this time should be adequately covered and protected. Please provide evidence that trainees can attend these meetings regularly. Please also provide feedback from trainees on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.

Immediate Mandatory Requirements

Requirement Reference Number	Review Findings	Required Action, Timeline and Evidence
	N/A	
Requirement Reference Number	**Progress on Immediate Actions**	**Required Action, Timeline and Evidence**
	N/A	

Recommendations

Recommendations are not mandatory but intended to be helpful, and they would not be expected to be included within any requirements for the placement provider in terms of action plans or timeframe. It may however be useful to raise them at any future reviews or conversations with the placement provider in terms of evaluating whether they have resulted in any beneficial outcome.

Reference Number	Related HEE Quality Framework Domain(s) and Standard(s)	Recommendation
	N/A	

Good Practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that, in the view of the Quality Review Team, enable the standards within the Quality Framework to be more effectively delivered or help make a difference or improvement to the learning environment being reviewed. Examples of good practice may be worthy of wider dissemination.

Learning Environment/Professional Group/Department/Team	Good Practice	Related HEE Quality Framework Domain(s) and Standard(s)
	N/A	

HEE Quality Domains and Standards for Quality Reviews

HEE Standard	HEE Quality Domain 1 Learning Environment and Culture	Requirement Reference Number
1.1	**The learning environment is one in which education and training is valued and championed.** Trainees reported that there was a lot of potential for learning at the Trust with plenty of educational opportunities. Trainees advised that if issues with workload and staffing were addressed it would be an excellent place to work as when the department was well staffed the trainee experience was good. The trainees spoke highly of the College Tutor (CT) and noted that their experience with them had been positive. Trainees noted that the CT was supportive and receptive to trainee feedback and trainees felt that the CT genuinely listened to what they had to say.	
1.3	**The organisational culture is one in which all staff are treated fairly, with equity, consistency, dignity and respect.** Trainees reported that overall, the culture was good, and trainees felt able to raise concerns. The review panel heard that there was a desire to make improvements and trainees felt the changes made were moving in a positive direction. Trainees noted that there was a number of supportive consultants. However, it was reported that trainees found some of the consultants were not very supportive or reliable. Trainees reported a good experience with all colleagues and noted that they felt the trainee cohort worked well together. Trainees noted an improvement in the culture since August 2021 and confirmed it was more supportive, where previously it had been accusatory. However, some trainees reported that they had witnessed episodes of undermining behaviour between staff which had made them feel uncomfortable. Trainees informed the review panel that they did not feel as comfortable to report these instances as they were not directly involved. Some trainees reported that they had experienced bullying and undermining behaviours but confirmed that this was no longer an issue.	Yes, please see H1.3
1.5	**Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.** The majority of trainees reported that they would not be comfortable for their friends and family to be treated by the	

	service and would actively recommend treatment at other Trusts. Some trainees reported that they would be happy for their friends and family to be treated under very specific conditions, for example on the ward with specific consultants or where the case was not complex. Trainees noted they would not be happy for their friends and family to be treated if they were admitted via Accident and Emergency (A&E), if they were a sickle cell patient or an outlier patient. Some trainees reported that staffing levels had been inconsistent when they had started their post. It was also noted that there had also been some staff sickness and maternity leave which had compounded the issue. The review panel was informed that there had been efforts to account for the low staffing levels, but it was reported that the levels were still low. Trainees also reported that the workload had increased considerably in the last few months. Some trainees reported that the bleep was relentless and was felt that this should be covered by two trainees, but the staffing levels were too low to accommodate this. However, trainees advised that there had been minor improvement since the new trainees started. It was noted that the high workload was difficult for new trainees who were not as experienced. Trainees discussed the outlier role and reported that the role was extremely variable. Trainees advised the review panel that they did not feel it was feasible for one trainee to carry out this role without a risk to patient safety. The review panel was informed that the outlier trainee role was responsible for the outlier list, outlier bleep, Integrated Clinical Environment (ICE) referrals and for ensuring admissions were organised appropriately. The trainees advised that the role was very challenging, particularly when the consultant was busy. Trainees informed the review panel that previously there had been a trust grade doctor to support the outlier service, but the role had not been replaced following long term sick leave. It was noted that this had significantly increased the trainee workload. Trainees informed the review panel that they had raised these concerns, but no changes had been made. It was noted that there had been a slight improvement since the new trainees had started. Trainees informed the review panel that there was overwhelming recognition that the workload was high but reported that they did not feel anything was being done to address this, despite the supportive environment. Trainees reported that the outlier patients were often only seen by the consultant once a week and that trainees had to push for this. Trainees informed the review panel that they felt the general care	Yes, please see H1.5a

	for outlier patients was affected by reduced review by the consultant. Trainees also noted that there had been occasions where outlier patients had been lost in the system and the trainees had not been made aware of them. Trainees reported that generally there was not sufficient clarity in who was responsible for the care of the outlier patients. It was noted that there had been disagreements about whether the outlier service was strictly for advice or whether the outlier service was responsible to the outlier patients. Trainees informed the review panel that the service was not clearly defined and that they had been informed different things by different consultants. The review panel was also informed that there was also a lack of clarity over the responsibility of haematology patients that arrived via A&E. It was noted that the medical and A&E departments had different opinions on which patients should be admitted to haematology and it was not clear whether the trainees were supposed to review the patients in A&E. Trainees advised that they had raised these issues and acknowledged that there might have been some action to make improvements, but they were not clear what these actions were and confirmed the issue had not been resolved. The trainees advised that they did not believe there had been an improvement in the handover arrangements. Trainees noted that there was an effort from the trainees to ensure there was a clear handover between them, but there was no formal structure in place. Trainees also noted that there was not a robust system in place for handover of patients, particularly at night. It was noted that there was no on-site haematology cover for patients at night and that this was covered by the acute on-call team. Trainees also noted that the handover of patients from other teams or via ICE referral relied heavily on the junior trainees passing on the information or the teams getting in touch, there was no system in place to ensure these patients were not missed. Trainees advised that they were not routinely involved with sickle cell patients and therefore did not attend sickle cell meetings often. Trainees reported that they were unfamiliar with these patients and felt this exacerbated issues at night or at weekends when they were responsible for those patients. It was noted that sometimes there was a short handover for these patients, but it was not a formalised process. Trainees reported that they felt able to handle the clinical situations but were unfamiliar with the patient cohort and therefore there was a lack of continuity. Trainees expressed an interest in being part of the red cell team but acknowledged this was not possible due to the workload.	Yes, please see H1.5b Yes, please see H1.5b Yes, please see H1.5c Yes, please see H1.5d

1.7	**All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.** The trainees informed the review panel that they had recently discovered a discrepancy with their pay for on-calls. It was reported that the rota that was being worked was different to the work schedule provided at the start of the post and trainees were not being paid sufficiently for the duration of the on-call shift. Trainees felt that there had not been informed that only two hours of the on-call shift was accounted for and believed that this figure was inaccurate with trainees averaging four-six hours of work per shift. The review panel was informed that there had not been an adequate explanation of the work schedule and therefore trainees were not aware of the pay associated with on-call shifts. It was noted that the trainees had approached the British Medical Association (BMA) for advice and support regarding these issues and some, but not all the trainees affected had received remuneration. The trainees advised that they had raised this issue and that it had been amended for future shifts, however noted that these issues had significantly impacted morale amongst the trainees. The review panel was informed that trainees had regular meetings with the CT and felt able to raise concerns in this forum as well as other governance meetings. The review panel was pleased to hear trainees had been actively encouraged to raise concerns and that trainees felt there were ample opportunities for trainees to raise issues and provide feedback. Trainees felt that their concerns had been taken seriously and that whilst issues might not be resolved immediately, it was felt that action had been taken to make improvements.	Yes, please see H1.7
1.12	**The learning environment promotes multi-professional learning opportunities.** The trainees were very complimentary of the nursing staff on the ward and noted that the nursing care was fantastic.	

HEE Standard	HEE Quality Domain 2 Educational Governance and Commitment to Quality	Requirement Reference Number
	Domain not discussed at this review.	

HEE Standard	HEE Quality Domain 3 Developing and Supporting Learners	Requirement Reference Number

3.1	**Learners are encouraged to access resources to support their physical and mental health and wellbeing as a critical foundation for effective learning.** The trainees advised that there had been no issues with booking and taking annual leave.	
3.5	**Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.** Trainees informed the review panel that the majority of the time they had been able to access a consultant. Trainees advised there had been a few instances where they were unable to contact their supervising consultant. It was reported that trainees had been able to escalate accordingly when this had occurred. The review panel was informed that the consultant workload was very high and therefore trainees sometimes struggled to get the consultant to review outlier patients. Trainees felt that the consultant workload was too high for the consultants to be able to manage the ward, outliers and make senior decisions. Trainees reported that some consultants were more supportive than others. It was noted that some consultants did not always respond positively when contacted by trainees, particularly if the trainees needed to contact them frequently. The review panel was concerned to hear that trainees were not confident in the clinical advice given by one of the consultants in the department. It was advised that trainees felt they had to double check the clinical advice with other consultants or with the team at Hammersmith Hospital. The review panel was informed that there was an unofficial arrangement in place whereby a backup consultant was available to check the advice given if necessary. However, it was confirmed that this alternative consultant was only available during the day and did not support trainees at night. Trainees reported that this arrangement was communicated to them via email.	Yes, please see H3.5a Yes, please see H3.5b
3.9	**Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.** Trainees reported that the induction could be improved. Trainees noted that the staff had been very friendly and welcoming but felt that the induction had been very unorganised and that they had not been provided with all of the information they needed. Some trainees reported that they had also not been given a tour of the building. The trainees noted that the existing trainees had been very helpful and that the new trainees relied heavily on them during the transition time given the insufficient induction.	

	Trainees informed the review panel that there was a variety of systems and interfaces which they needed to access to carry out their role, it was noted that trainees had not been given access to all of the relevant systems when they first started. Trainees reported that they had to chase for access to the systems and it was noted that this process had been difficult as many of the people they approached were not aware of how to help them. Trainees noted that obtaining remote access for laptops had been particularly difficult, with some trainees reporting that they still did not have access. Trainees informed the review panel that remote access to the system was needed for off-site night shifts.	Yes, please see H3.9

HEE Standard	HEE Quality Domain 4 Developing and Supporting Supervisors	Requirement Reference Number
	Domain not discussed at this review.	

HEE Standard	HEE Quality Domain 5 Delivering Programmes and Curricula	Requirement Reference Number
5.1	**Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.** The trainees confirmed that there was weekly morphology teaching which they had found very helpful. The review panel was informed that consultants were allocated to the laboratory to assist trainees and discuss issues. Trainees reported that this was variable and dependant on the individual consultant. It was noted that some consultants were good, but others did not attend or did not involve the trainees in the resolution of issues. Trainees found this difficult as there was a lack of feedback for them to learn from with the consultants dealing with issues themselves.	
5.6	**Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.** The trainees confirmed that there had been no issues with booking or taking study leave. Trainees reported that there was a weekly complex coagulation meeting with Hammersmith Hospital to discuss cases, however trainees noted that they had not been able to attend due to their workload. Trainees informed the review panel that this had improved recently, and they had been able to attend.	Yes, please see H5.6

HEE Standard	HEE Quality Domain 6 Developing a sustainable workforce	Requirement Reference Number
	Domain not discussed at this review.	

Report Approval

Quality Review Report completed by	
Name	Rebecca Bennett
Role	Learning Environment Quality Coordinator, Health Education England

Review Lead	
Name	Dr Louise Schofield
Role	Deputy Postgraduate Dean, North East London, Health Education England
Signature	Louise Schofield
Date signed	25 April 2022

HEE Authorised Signatory	
Name	Dr Gary Wares
Role	Postgraduate Dean, North London, Health Education England
Signature	Gary Wares
Date signed	5 May 2022

Final Report submitted to organisation	9 May 2022