QUALITY MANAGEMENT VISIT REPORT

TRUST	York Teaching Hospitals NHS Foundation Trust

SITE	**DATE**
York Hospital	29 March 2016

Sarah Kaufmann (Visit Chair)	Associate Postgraduate Dean
Jackie Tay	Head of School, Obstetrics & Gynaecology
Paul Renwick	Head of School, Surgery
Jason Waugh	SAC Representative (O&G)
Julie Platts	Quality Manager
Jane Burnett	Quality Manager
Alison Pettigrew	Head of Quality and Standards – Hull/York Medical School
Una McLeod	Deputy Dean – Hull/York Medical School

SPECIALTIES VISITED:

- Obstetrics and Gynaecology
- Surgery

The Trust Visit Report will be published on Health Education England working across Yorkshire and the Humber's Website

Conditions that are RAG rated as Amber, Red and Red* will be reported to the GMC as part of HEE YH's Reporting process, the reports are published on the GMC website.

Date of First Draft	**31/3/2016**
First Draft Submitted to Trust	**08/4/2016**
Trust comments to be submitted by	**12/4/2016**
Final Report circulated	**15/4/2016**

GENERAL COMMENTS

The visit was well organised by the Postgraduate team and the panel appreciated the detailed update provided by the DME and the relevant College Tutors.

It was noted that the 'Dr Who' campaign posters were on display on notice boards and in lifts. Whilst this has started to have an effect there were still numerous references to SHOs from both trainees and trainers during the interviews.

- **Obstetrics and Gynaecology**

At the QM visit in November an issue of undermining by an O&G consultant and from midwives was reported. However, at the revisit, undermining was no longer reported as an issue and the trainees described that the Trust dealt with the issue in a positive manner. The panel felt the Trust should be commended for their swift action in organising workshops and reiterating unit policies. All trainees felt well supported and had no hesitation about calling consultants out of hours if necessary.

Obstetrics was viewed by the trainees as providing an excellent training experience with Consultants leading ward rounds and supporting trainees' learning in outpatient clinics. All the trainees interviewed would recommend their posts based on the Obstetrics element of their placements.

The higher trainees also remarked that they feel well supported in the Gynaecology clinics and the consultants are approachable. Core trainees reported they have learned a significant amount about acute gynaecology from their StR colleagues. However, there was little opportunity for core trainees to attend Gynaecology clinics and hence unable to learn about management of non-acute gynaecology conditions. Overall, the majority of trainees would not recommend their placement based on the Gynaecology element of their roles.

It was noted that there is no dedicated gynaecology ward at present as this has been converted to an Elderly Medicine outlier ward to manage winter pressures. The panel felt this situation is likely to be impacting on the problems the trainees are currently experiencing in Gynaecology and adding to work intensity issues. It was also noted that in the Early Pregnancy Unit nurses finish their shifts at 1pm leaving core trainees to sort out any unresolved problems associated with beta-hCG results such as contacting patients by telephone with a management plan. Often core trainees spend a significant amount of time unsuccessfully trying to telephone patients. There did not appear to be any process by which the patient was given the responsibility of contacting the Early Pregnancy Unit for results, or allocating another nursing member of staff to contact the patients.

There are no problems with regards to O&G trainees taking consent inappropriately as consultants personally take consent for procedures they are undertaking.

The DME reported that Core Trainees are provided with a week where they were unallocated to service provision but this was not being properly utilised. Therefore trainees now meet with their Educational Supervisor and keep a record of what they attend in that week to map towards their educational objectives.

- **Surgery**

The trainees reported friendly staff, both medical and non-medical and they appreciate the multi-disciplinary approach which allows them to learn from others. They particularly commended the Surgical Care Practitioners. All trainees felt well supported and had no hesitation about calling consultants out of hours if necessary.

However, the panel were disappointed at the low number of surgical trainees who attended the revisit.

Proposed support for the Trust from HEE YH

The Head of School of Surgery and O&G will arrange to meet the relevant College Tutor along with the DME to assist them in addressing the outstanding concerns. This will enable the sharing of good practice and experience from other organisations in the region to support the resolution of some of these issues.

It should be noted that trainees, including foundation surgery trainees, were happy to be involved in finding solutions.

It is noted that the deadline for resolving issues for Foundation trainees in Surgery around consent, pre-operative assessment clinics and handover has passed without them being resolved (31st March 2016). This is a serious concern for the education and training of these trainees and for patient safety. These need to be resolved

immediately. There will be a re-visit to the relevant clinical areas in June 2016 and the Trust will receive 24 hours' notice of this.

Proposed support for the Trust from HEE YH

The conditions identified at the Postgraduate Medical Quality visit in November 2016 were reviewed in detail by the two panels with the following updates below.

Condition 16/0011 – excessive contribution to service (O&G and Surgery)

- **Surgery**

The issue appears to have been resolved as the trainees interviewed did not express any concerns about being able to meet their curriculum requirements. The trainees were able to attend theatre and clinic opportunities and were well supported with WBAs. All the FY1s and the core surgical trainees that attended had met their logbook requirements from this post for their forthcoming ARCPs. It should be noted however that the Surgical Care Practitioners have to attend a minimum number of theatre sessions to complete their training. They compete with the Core Surgical trainees . Whilst this did not affect this cohort of trainees, it is something that needs to be monitored. In terms of the specific reference to Urology trainees, patients are now admitted to the Surgical Admissions Unit and filtered from there which has given trainees more time to access training opportunities.

It is recommended by the panel at the QM revisit that this portion of the condition is closed.

- **Obstetrics and Gynaecology**

In terms of education and training opportunities to meet their curriculum requirements Higher Trainees are still not receiving appropriate sessions to achieve their ATSM elective case mix. Trainees reported there are a high number of outpatient clinic lists cancelled with one ST2 telling the panel she has only attended one outpatient clinic this year.

The trainees were concerned generally that they are not getting enough exposure to theatre sessions with one ST2 trainee reported having undertaken only one diagnostic laparoscopy since commencing in post in August 2015. Trainees felt that Consultants do not have a full understanding of their capabilities, even if this is logged as WBAs and signed off as being 'competent' by another consultant from the team. Consultants are reluctant to allow them to undertake procedures if they have not previously seen the trainee perform that procedure. There is no protected ATSM theatre time and it is the responsibility of the higher trainees to organise these opportunities. Even if suitable cases are identified in advance, the trainee may not get the opportunity to operate on that case on the day. This seems to be due to a variety of reasons varying from time constraints to the Consultants being unfamiliar with the particular trainee.

Core trainees who are allocated sessions on the Early Pregnancy unit often have to contact patients with beta-hCG results (see general comments), depriving them of time for education and training opportunities.

There must be Consultant input into creating a weekly timetable for trainees that includes experiences appropriate for the trainee that is a balance between clinical service and training.

The RAG rating to remain at red.

Condition 16/0012 – consent (Surgery).

The main issue remaining is related to FY1 trainees taking consent for Interventional Radiology procedures. The consultants are prepared to offer advice and check the consent obtained by trainees but not to visit the ward to undertake this personally, or to take consent for emergency procedures in the Radiology department. It was made clear to the trainees who attended the revisit that in order to take consent they should have an in-depth knowledge of the procedure and be able to relate the risks to the individual patient. A review is needed regarding the current processes and if it is appropriate from a patient safety perspective. It was highlighted that some LEPs have a pre-assessment clinic where the Interventional Radiology consultants obtain consent. More generally, it was apparent from trainee comments that consent and who takes it seems to be dependent upon the assertiveness of the trainee. It was noted that the Trust has a consent policy (March 2015) and the practices described here seem to deviate from it.

The RAG rating to remain at red.

Condition 16/0013 – Induction (general surgery)

Trust induction was reported as being useful and trainees received their login details before they commenced in post. However, it was reported that locum doctors are not provided with login information and trainees feel pressurised to share their password/login details in order for patient records to be updated in a timely manner.

In terms of specialty induction, the Trust is developing handbooks for General Surgery and each surgical sub-specialty. The Vascular and Urology handbooks have been written but it is unlikely that the General Surgery handbook will be ready for the Foundation change over in April. The DME reported that one person from each specialty will be nominated to deliver a sub-specialty induction. However, consistent specialty/cross cover induction appears to be lacking or delayed, with one trainee who moved from Emergency Medicine to Surgery in December not receiving an induction and induction taking place on 15th December, when the rotation was 2nd December. Another trainee commenced on an out of hours shift and had no information on how to manage acute patients and the Vascular Surgery induction did not occur until the second week of the placement.

Specialty induction for the new cohort of Foundation trainees must be organised for next week
RAG Rating to remain at red.

Condition 16/0014 – pre-operative assessment clinics (Surgery and O&G)

Surgery

Pre-operative assessment - this is a nurse led clinic yet FY1 trainees are asked to complete VTE forms and drug charts from review of clinical notes without having seen the patient, and without having the opportunity do so as the patients have been allowed home. The Trust view is that this is a nursing-led process and although FY1 trainees are expected to sign off the drug chart, they are simply transcribing repeat prescriptions and therefore the history of the patient is not required. This is contrary to the prescribing training that FY1 trainees get via SCRIPT. This recommends as best practice that prescribing should involve verification of lists of medication (including GP surgery printouts or recent discharge summaries) with the patient directly to check for changes, unless the patient lacks capacity. In addition the FY1 trainee often does not know whether the test results are normal at the time of prescribing or whether the transcribed dosage is correct. There are also concerns on a FY trainee completing a VTE assessment on a patient they have not seen. The completion of drug charts and VTE assessments has stopped in O+G, so it is not clear why this continues in surgery. It transpired that sometimes a trainee has concerns about a patient who has already been allowed home and if this is the case the trainee doctor then contacts the GP. As an example, one patient was reportedly allowed to leave with severe sepsis. Datix forms are not being completed and trainees were advised to use this process as one way of effecting a change to the system. This issue continued to raise serious governance and safety concerns.

- **Obstetrics and Gynaecology**

The StR who is allocated to the theatre list and who sees the patient pre-operatively on the day of surgery now re-writes the drug card. Prescribing and pre-operative review is now a theatre-based responsibility. It was felt there were no outstanding prescribing issues in O&G and this section of condition 14 can be closed.
The RAG rating to remain at red.

Condition 16/0015 – handover (Surgery)

The DME reported that Trust Handover starts at 4.30 pm on the acute surgical ward and the College Tutor for Surgery will build this into rotas. However, the trainees described no formal handover from sub-specialties to general surgery out of hours. There appears to be little leadership from the Trust or specialty in relation to handover with trainees handing over in silos grade to grade.
The RAG rating to remain at red.

Condition 16/0016 – Clinical Supervision – O&G

In terms of Gynaecology, Consultants do not routinely lead ward rounds and so these are not utilised as educational and training opportunities for trainees. Trainees reported that patients are occasionally missed and do not receive a

senior review especially as patients are scattered across the hospital.

The RAG rating to remain at red.

Condition 16/0017 – Handover – O&G

The gynaecology handover does take place but is complicated and it is unclear who is handing over to who. In addition, handover is not consistently consultant-led. On the other hand, Obstetric handover works well, but this takes place before the Gynaecology handover, even though the same Consultant and StR are involved in both.
The RAG rating to remain at red.

The following condition was identified from the revisit:

GMC Theme	**LEARNING ENVIRONMENT AND CULTURE**	
Requirement **(R1.12 Rotas)**	Organisations must design rotas to: • make sure learners have appropriate clinical supervision • support doctors in training to develop the professional values, knowledge, skills and behaviours (KSB) required of doctors working in UK • provide learning opportunities that allow doctors in training to meet the requirements of the curriculum and training programme • give learners access to ES • minimise the effect of fatigue and workload	
HEYH Condition Number	1	
LEP Site	York	
Specialty (Specialties)	Surgery	
Trainee Level	Foundation	
Concern	Trainees are provided with rotas, which do not provide them with sufficient opportunities for rest and recreation.	
Evidence for Concern	Foundation Surgery trainees expressed concerns about doing up to 11 consecutive days. They work 7 consecutive long days with 4 normal days. They feel that this is demoralising and could be broken up into shorter blocks	
Action 1	Work with trainees and educational supervisors to develop rotas that have an appropriate balance between the needs of the patient safety and clinical service and the trainee's legitimate expectations for teaching, training, feedback and rest and recreation.	**30 June 2016**
Action 2	Review the impact of the introduction of new rota arrangements.	**31 October 2016**
Evidence for Action 1	Copies of rotas.	**30 June 2016**
Evidence for Action 2	Summary of the impact of any changes made.	**30 November 2016**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with link APD	

RAG guidance can be found at Appendix 1.

Approval Status

Approved pending satisfactory completion of conditions set out in this report.

Signed on behalf of HEE YH	**Signed on behalf of Trust**
Name: **Miss Sarah Kaufmann**	**Name:** **Dr Alison Corlett**
Title: **Associate Postgraduate Dean**	**Title:** **Director of Medical Education**
Date: **31 March 2016**	**Date:** **14 April 2016**

RAG Rating Guidance

The RAG rating guidance is based on the GMC RAG rating to ensure a consistent approach. The model takes into account impact and likelihood.

Impact

This takes into account:

a) patient or trainee safety

b) the risk of trainees not progressing in their training

c) educational experience – eg, the educational culture, the quality of formal/informal teaching

A concern can be rated high, medium, or low impact according to the following situations:

High impact:

- patients or trainees within the training environment are being put at risk of coming to harm
- trainees are unable to achieve required outcomes due to poor quality of the training posts/ programme

Medium impact:

- trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement
- patients within the training environment are receiving safe care, but the quality of their care is recognised as requiring improvement

Low impact:

- concerns have a minimal impact on a trainee's education and training, or the quality of provision for the patient.

Likelihood

This measures the frequency at which concerns arise eg. if a rota has a gap because of one-off last minute sickness absence, the likelihood of concerns occurring as a result would be low.

High likelihood:

- the concern occurs with enough frequency that patients or trainees could be put at risk on a regular basis. What is considered to be 'enough frequency' may vary depending on the concern eg. if rotas have consistent gaps so that there is a lack of safe cover arrangements, the likelihood of concerns arising as a result would be 'high'.

Medium likelihood:

- the concern occurs with enough frequency that if left unaddressed could result in patient safety concerns or affect the quality of education and training, eg. if the rota is normally full but there are no reliable arrangements to cover for sickness absence, the likelihood of concerns arising as a result would be 'medium'.

Low likelihood:

- the concern is unlikely to occur again eg. if a rota has a gap because of several unexpected sickness absences occurring at once, the likelihood of concerns arising as a result would be 'low'.

Risk

The risk is

then determined by both the impact and likelihood, and will result in a RAG Rating, according to the below matrix:

Likelihood	**IMPACT**		
	Low	**Medium**	**High**
Low	Green	Green	Amber
Medium	Green	Amber	Red
High	Amber	Red	Red*

Please note:

* These conditions will be referred to the GMC Reponses to Concerns process and will be closely monitored

Source: GMC Guidance for Deaneries, July 2012

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