Health Education
North Central and East London

TRUST-WIDE REVIEW

Visit Details	
LEP	The Whittington Hospital NHS Trust (Whittington Health)
Date of visit	20 January 2015
Background to visit	The Whittington Hospital NHS Trust was formally last visited in 2012 with Trust Wide Review (TWR), where no areas of concern were highlighted or specific mandatory actions required. The Trust generated minimal negative outliers across most programmes in the General Medical Council National Training Survey (GMC NTS) 2014. The only specialty to produce a red flag in 'feedback' was ACCS with 40% of trainees rarely receiving feedback. ACCS also produced a red flag for 'overall satisfaction', with 40% of trainees rating the clinical supervision as 'poor' or 'very poor'. Emergency medicine generated red flags in 'overall satisfaction' and 'clinical supervision' for Foundation Year Two (FY2) with 36% of trainees stating they are 'forced to cope with clinical problems beyond their competence'. emergency medicine FY2 also generated pink outliers for 'handover' with 45% of trainees stating that handover arrangements before a night duty are informal and 54% for after a night duty this is a clear decline in performance over the three years of results. The Head of Quality Performance and Programmes in Health Education North Central and East London organised a pilot visit for health care professionals. The multi-professional education quality visit to nursing and midwifery as well as health care professions were aligned as parallel sessions to the post-graduate medical TWR. The focus of the TWR was to explore how the Trust has addressed the issues highlighted in the GMC NTS results, how post-graduate medical education and training was integrated within the Trusts' vision of being an Integrated Care Organisation and their strategy was for providing unique training and learning opportunities within close proximity to large university teaching hospitals.
Visit summary and outcomes	The visit team met with the post-graduate medical education team, the senior corporate management team, core and higher trainee representatives from Paediatrics, Obstetrics and Gynaecology (O&G), Geriatric Medicine, Acute Medicine, Anaesthetics, Emergency Medicine, Trauma and Orthopaedic Surgery (T&O), General Surgery, Core Surgery, Urology as well as the educational supervisors and college tutors from T&O, O&G, Anaesthetics, ITU, Geriatric Medicine, Palliative Medicine, Core Medical Training, Radiology, Paediatrics, Emergency Medicine and a Training Programme Director (TPD) for GP trainees. The visit team would like to thank all those who actively participated in the visit. The visit team was pleased to find a trust that placed a high importance to the training and education of doctors, nurses, midwives and other health care professionals. The team was impressed with the commitment shown by the Trust to improve the quality of experience of healthcare trainees, by providing innovative, multi-disciplinary simulation and encouraging participation by both hospital and community based healthcare teams. The Trust's vision as an Integrated Care Organisation and the work being done to see this come to fruition must be commended. The visit team found that this vision was challenged with the realities of the Trust's existing structures and how specialties traditionally function, but through active engagement with the consultant body, who are committed to improving quality of training and education, many of these issues could be overcome. The visit team was also pleased to see the appointment of new permanent members of the senior corporate management team which the visit team can report had led to renewed confidence within the consultant body and optimism for the future of the Trust. The visit team met a contented cohort of trainees who emphasised the friendly and supportive environment within the Trust. Some medical trainees found the volume of cases seen at the Trust slightly lower than other trusts they had worked in and sometimes this affected their ability to fully meet their specific training goals, however they did state that there were benefits too, with greater opportunities for supervision and time to improve and focus their skills. Most

	trainees were happy with their rotas although emergency medicine trainees stated that ten consecutive shifts on nights led to fatigue and their rota did not allow time to complete work based placed assessments (WBPAs). Other areas of improvement which were highlighted at the visit were: the paper based handover in medicine which needed to be evolved quickly into an auditable electronic format, there should be recognition of educational activity as per current tariff and consistency of job plans for educational supervisors across departments, and serious incident feedback should be trust wide. There was one Immediate Mandatory Requirement (IMR) distributed at the visit for a partial power failure in one of the theatres that had appeared to be a recurrent issue and led to the monitoring equipment being disabled for several minutes. Since the visit the Trust has responded to the IMR and the issue has been resolved.

Visit team

Lead Visitor	Indranil Chakravorty	**Trust Liaison Dean**	Andrew Deaner
Lay Member	Kate Rivett	**Observer**	Michelle Hagan
Trainee Representative	Imran Mannan	**Visit Officer**	Lizzie Cannon

Findings

GMC Domain	Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
1	TWR 1.1	Patient Safety Higher trainees in the emergency department (ED) stated that the Trust had engaged in discussions to close the observational ward (staffed by the emergency department), or to relocate the ward. The higher emergency medicine trainees were concerned that they would miss out on training opportunities and if the ward was relocated away from the emergency department that may compromise their ability to supervise patients in this area at night. A trainee stated that they had submitted a DATIX that day, which was due to a power failure in theatre. This had meant the monitoring machines had been unavailable for seven minutes. This had not been the first occurrence in surgery theatre four and they were aware that other trainees had submitted SI reports that had apparently not been acted upon. This constitutes a concern for patient safety and was raised at the visit as an immediate mandatory requirement.	The Trust will need to review the impact of closure or relocation of the ED Observation ward away from the ED area including standard operating procedures, criteria for admission, clinical responsibility both within and out of hours and impact on trainees. This review should be shared with Pan-London Quality Regulation Unit within three months. To ensure that the Trust reviews the continuation of electric supplies to all theatres to ensure that patient safety is not compromised.	**Amber** Mandatory Requirement **Red** Immediate Mandatory Requirement

1	TWR 1.2	**Clinical Supervision** The O&G trainees stated that the department was not very busy clinically and so they received excellent supervision. The O&G educational supervisors also agreed that due to the high number of consultants on the ward (eight to ten) the trainees received close supervision and allowed them to maximise their training opportunities, such as doing elective caesarean sections. The FY2 trainees reported that they received good clinical supervision. FY1 trainees corroborated this statement and added that the critical care outreach team was also approachable and they felt able to ask for advice and support. The core trainees for general medicine stated they felt very well supported, that all colleagues were approachable and there was excellent daily consultant supervision. Paediatric trainees were also pleased with their clinical supervision and would recommend the training post to their colleagues. The emergency medicine trainees stated the support they received at night was good with a consultant present in the Emergency Department from 8am – 8pm and often to 10pm. After 10pm but there was normally a middle grade Trust doctor on the shop floor that the trainees could go to except if the middle grade was a locum doctor, then supervision is usually found to be variable. The trainees stated that there was a dearth of regular middle grade trainee doctors within the emergency department and to compensate there were many locums, who were also expected to manage trauma calls. The senior management stated that they were aware of the staffing problems for middle grade doctors within the Emergency Department but the situation had greatly improved in the last year. They were looking at restructuring some of the posts, improving staff retention, reducing turnover from 12% annually and active recruitment from Northern Europe. The visit team heard from the surgical and emergency medicine trainees that the new ambulatory care ward was felt to be a valuable service. Staff members were reported to be approachable and were able to facilitate trainees escalating their patients to the ward if they had clinical concerns. The T&O trainees stated that the combination of the rigid rota structure and being assigned a consultant for their six months was good for their training and progress. This was due to the consultant getting to know the trainee and being able to identify areas		

		that need improvement etc. The trainees did acknowledge that this was easily done due to the steady work load of the relatively small department, and the small staff cohort, however the culture in the department of trust and openness allowed trainees far more opportunities to excel in their training. The other surgical trainees stated that they received good clinical supervision, with consultants being very approachable and available. The visit team can report that no trainees had any qualms in escalating patient care to a consultant.		
1	TWR 1.3	**Handover** The visit team heard from all the medical trainees that the medical handover was a paper-based system. The trainees stated that progress had been made to formalise the morning and night handovers. They stated that there was also a formal meeting on Friday afternoons, but that due to a paper based system, doctors were walking round with various paper lists all weekend. The O&G trainees stated that the labour ward had a formal daily handover between the day and night coordinators. There was also a MDT meeting at the beginning of every shift. The evening handover was not always attended by a consultant. The general medical trainees stated that at present there were verbal and written handover notes on each patient. They also stated that they were introducing electronic patient records in A&E and ambulatory care. The visit team heard that the ED handover is electronic with a screen in the doctor's room to review bloods etc. Handovers occurred at 8am and 8pm. There were also consultant handovers that occurred in the early evening and morning. There had been a few initial problems with the new system but no patients had been missed. There was a formal handover conducted every Friday evening for the weekends where all patients are identified.	The Trust is required to develop an electronic handover system for medicine to replace the paper-based system at present.	**Amber** Mandatory Requirement
2	TWR 2.1	**Serious Incident (SI) Reporting** The senior corporate management stated that they embedded the learning from SIs regularly and they felt it was a robust system of analysis and feedback. The visit team heard that there was a multi-professional SI panel, chaired by the Medical Director, which had a system of identifying individual trainee involvement and training needs and these were then fed back to the post-graduate medical team. Where		

		system failures were identified and reminders were then sent to all clinicians across the Trust about the different areas that need improvement. The Trust valued the role that all trainees may have had in undertaking projects in trust wide quality improvements. The visit team heard from the senior corporate management that they viewed the SI data as a learning tool for the trainees and had plans to place them on the intranet. They stated that they already used past SIs as simulation scenarios for FY1 and 2 trainees. The trainees stated that they knew how to report SIs via DATIX and O&G trainees stated that they get an email back the next day from a midwife with feedback and stating what the process will be. Both O&G and paediatric trainees stated that the SIs are regularly discussed at the morbidity and mortality meetings and are turned into learning opportunities and areas for improvements. The visit team heard from the educational supervisors that it often depended on the directorate as to how well the feedback for SIs was. The O&G department was stated to have a well-developed feedback system with good learning opportunities from events. The surgical directorate feedback system however was less developed with 'word of mouth' feedback. All educational supervisors stated that they would like to have SI information that was transparent and disseminated to all departments, so they could learn from one another. All the surgical trainees knew how to use DATIX, however there was variable experiences with feedback. The core surgical trainees had received good feedback; but the urology trainees had received no feedback at all.	The Trust is required to develop a robust mechanism for disseminating SI's to all departments and learning opportunities.	**Amber** Mandatory Requirement
5	TWR 5.1	**Teaching** The senior corporate management stated that there were weekly grand rounds for medicine, with every fourth grand round being a morbidity and mortality meeting. However the trainees were unaware of the grand ward rounds. The trainees did state that because college tutors had good links with other members of the staff there were extensive, multi-disciplinary ward rounds. The higher trainees in geriatrics also stated that there were allied health professional ward rounds for care of the elderly which included a multi-disciplinary team. The paediatric trainees stated that they received excellent ward rounds. All medical trainees stated that they were able to attend the majority of regional and local teaching opportunities. The anaesthetic trainees agreed with this statement		

		reporting that the department was excellent at facilitating regional training days and managed the rota very well to allow trainees to attend. The urology trainees also stated that there had only been one instance when they were unable to attend, due to staffing shortages. The visit team found that the consultant body was engaged with the Trust vision of being an Integrated Care Organisation and introduced this ethos into the training and education of their trainees. However due to the reality of the work patterns of some specialties there were limitations as to the extent that some departments could apply the Trust vision. The O&G educational supervisors stated that once a month they organised teaching in simulation and clinical skills which was multi-disciplinary; it included nurses, midwives and ACAs. They also stated that they had won a tender to provide gynaecological community services; this will provide trainees with the opportunity to attend four to five clinics a week with a consultant with good learning and training opportunities, due to the higher patient numbers in these clinics in comparison to the hospital ones. The GP TPD stated that over the years the relationship with the Trust and the GP practices in the community had improved greatly, combined with the curricula mapping exercise, to assess the training needs of the GP trainees within the hospital, their training and education had enhanced. The CMT educational supervisor stated that at present the curricula for the trainees was based in house. They were looking at working with GP's and creating learning experiences together but at present it was very difficult to meet all their requirements. The endocrinology and diabetes mellitus educational supervisors also stated that there were challenges to expanding training out into the community but, as the respiratory department had shown with: an integrated registrar post, opportunities within care home settings and working with GP's through teleconferences, there were examples that could be replicated to broaden training opportunities. The palliative medicine educational supervisors however stated that it was difficult to organise multi-disciplinary training as they found it difficult to get nurses released for training. They also stated that the medical trainees often go on to the wards to receive training with the nurses. They also stated that there were no limited opportunities for community based learning within palliative medicine because North Middlesex had won the bid for the area.		

		The consensus across the educational supervisors was that there were opportunities for multi-disciplinary training, however in reality it was very difficult to get all professions together at the same time, such as pharmacy trainees who had a different pattern of working and so training did not coincide with medical training particularly well.		
5	TWR 5.2	**Training Opportunities** The paediatric core trainees stated that overall the balance between workload and training was good. The workload could vary and there were weeks where they were very busy with less training opportunities. An example given was when the trainees from NICU and ITU, where they receive a lot of training opportunities, were moved to general paediatrics unit to ease workload. Some of the trainees stated that due to the quiet nature of the clinical activity in the Trust sometimes it was challenging to get all of their competencies signed off; but it did make it very easy to receive in depth, high quality training. The O&G trainees stated that the small workload and the small size of the department meant that they also struggled to complete all of their competency sign offs. They did state that the department was working to improve this. The O&G educational supervisor stated that the Trust had committed to build a £20million labour ward in April 2015 and this would increase the number of maternity cases and increase the training opportunities. The visit team heard that the T&O 24hr on call system allowed the trainees to operate on the same patients they had seen in the clinic. They stated that the patients appreciated the continuity in their care. The T&O trainees stated they got adequate sleep and were not fatigued for work the next day. The core surgical trainees stated that they had good training opportunities with two operating lists per week with a consultant; and they were able to go to the Royal College for regional teaching too. They stated that with the support from the FY1 trainee with ward work they were able to maximise their theatre time and optimise their training opportunities. The FY1 trainees stated that although there was a lot of ward work involved, it was not impeding their training opportunities and would recommend the post to their colleagues. The core surgical trainees also stated that they followed the general surgery ST3 trainee round and attended their theatre time. The ST3 general surgery trainees told the	Higher trainees in all specialties should be encouraged to access opportunities to shadow/ work with managers and participate in management committees. This should also be through Quality Improvement Projects where working with management is part of the learning experience.	**Green** Recommendation

		visit team they had one whole day operating per week. They are also allocated to emergency surgical consultants and had half days for a COD list where they assisted the consultant. The trainees averaged 10 – 12 cases a week which varied in size. The surgical trainees stated that the volume of cases was slow and steady, with constant and basic surgeries. The trainees stated that the consultants encouraged the trainees to take on more complex surgeries under their supervision. Due to the steady work load, consultants had the time and were proactive in supporting and teaching trainees. The trainees did state that mid-level trainees' would quite like to have more complex cases'. The higher emergency medicine trainees felt that as senior trainees there were not many management opportunities at the Trust for preparing trainees to become consultants.		
6	TWR 6.1	**Induction** The majority of the medical trainees the visit team met stated that if they started at the common rotation dates the inductions, both departmental and Trust were good. However if trainees were to rotate outside of the normal times the trainees agreed that the departmental inductions were inadequate across the Trust, with trainees not being given access to the online prescribing system. The FY1 trainees stated that they had a week long induction and all the basics were covered and as a result felt prepared to start work in the Trust. However the departmental induction for ITU for Foundation doctors was reported to be inadequate. There was no induction on how the machines worked and the trainees had taught themselves and asked colleagues. The FY2 trainees stated that their induction was not as long as FY1 trainees however it was good. The O&G higher trainees stated that their induction was one of the best they had ever had and they were not placed on the on call rota to start with. The other higher medical trainees stated that the inductions were good with lots of eLearning prior to starting and then a standard induction. The paediatric ST1 trainees reported they had a one week long induction which was very well timetabled and thoroughly prepared them for working within the paediatric department.	The Trust is required to provide trainees with an adequate induction when they start working at the Trust. The Trust is required to review their departmental inductions for all trainees, especially those rotating outside of normal rotation dates with attention focusing on foundation doctors in ICU.	**Amber** Mandatory Requirement

		The anaesthetic trainees agreed that both the Trust and departmental inductions were thorough and well organised with theatres and labour ward covered. There was a separate induction for trainees who started in ICU. The core surgery trainees stated that their inductions were fairly good and that they received short inductions with their consultants too. The urology trainees stated that their inductions were similarly adequate.		
6	TWR 6.2	**Rota** The general medical trainees' stated that the on call was similar in workload to other Trusts. The visit team heard that the core medical trainees found it difficult to get to clinics because they were not built into their rota and there was a high volume of ward work which restricted their ability to attend clinics. The T&O trainees stated that the rota allowed for a good balance of clinics and theatre time. The visit team heard that the trainees felt they benefited from the fixed rota structure. They were able to have a good work life balance because they knew that they had a set day every week where they would be on call for 24hours and the rest of the week was a normal set time. The core surgical trainees stated that that the rota was very good, with trainees working a weekend one week in seven. The general surgical trainees stated that they always had Sundays off and the rota minimises the amount of clinical time missed. The emergency medicine trainees stated that although they expected to do a lot of nights and weekends, the rota did not allow for a reasonable work life balance with ten consecutive days and nights. The rota did not allow for trainees to complete their assessments and often the priority was felt to be service provision with trainees having to do portfolio work from home. The core surgical trainees stated that they were a trainee in A&E as a FY2 trainee and corroborated these points, stating it was difficult to even reach the minimum requirement. The senior emergency trainee stated that it was like any other emergency department and the trainees just had to be more proactive in getting consultants to sign off WBPAs. The educational supervisors for emergency medicine stated that there were lots of opportunities to do WBPAs and the trainees just needed to ask and the	A review of the core medicine trainees' access to clinics should be carried out to assess the possibility of including clinic time into their rotas to meet current ARCP requirements. The rota coordinator and Education lead in ED should review the rota with the local faculty group input to explore (1) impact of consecutive long days followed by nights on performance and work-life balance and (2) if trainees in ED were unable to complete their WPBAs while at work with consultants. This review / minutes and action plan should be shared with Pan- London Quality regulation Unit within 3 months.	**Amber** Mandatory Requirement **Amber** Mandatory Requirement

		consultants were willing to do them in situ.		
6	TWR 6.3	**Educational Supervisors and Clinical Supervisors** The visit team heard from the senior corporate management that the Trust used the e-Portfolio system to appraise college tutors and TPDs. The college tutors and TPDs undertook appraisals for the rest of the departments. The management stated that some appraisals were still done under the 'grandfather clause' but this was being phased out. The CEO stated that the appraisal approach was a two year plan which they were committed to and they aimed to have 90% of appraisals completed by the end of 2015. All educational supervisors stated that they had received an appraisal. The senior corporate management stated that, although it varied throughout the Trust, there were one to four trainees per educational supervisor. The CEO stated that the Trust was committed to education and gave all educational supervisors 0.25 PAs per trainee. The educational supervisors and college tutors for O&G, geriatric medicine, palliative medicine, surgery and radiology all agreed that they were given enough PAs to allow them enough time to fulfill their educational roles and it was protected within their job plans. The paediatric college tutor was allocated one PA for their work in November 2014 but due to there being numerous flexible trainees, the one PA was not sufficient to cover their responsibilities. The paediatric consultants stated that although the 0.25 PA was written within their job plans the reality was that they felt that this was not adequate to provide the level of engagement required for their trainees. The emergency medicine consultants mirrored this issue. The ITU educational supervisors however did not get any PAs per trainee but adequately found time to fulfill their educational responsibilities. The anaesthetics college tutor also led the simulation and had only one PA to cover these responsibilities. None of the educational supervisors in anaesthetics are allocated 0.25 PA per trainee. They found that this not a problem because the Trust was small enough that they were able to see and meet the trainees informally in the corridors. The senior corporate management stated that they allowed all educational supervisors to take professional leave for educational activities. The visit team heard from the consultant radiologist that this was true; however the O&G and anaesthetic consultants stated that the Trust or their department discouraged taking professional leave. They were moving to an annualised job plan and the issue of professional leave was a "thorny issue".	The Trust is required to review the job plans for all consultants with educational responsibilities and adhere to the recommended tariff (0.25 SPA per trainee as educational supervisor).	**Amber** Mandatory Requirement

		The medical trainees stated that they all knew who their educational supervisor was and they had meetings with them and felt able to arrange meetings with them. The visit team heard from all the surgical and anaesthetics trainees that their educational supervisors were proactive in organising meetings and as a result had all met their educational supervisors. They found their educational supervisors supportive, approachable and easy to track down. This was corroborated by the emergency department trainees that stated that even while their educational supervisor was on leave they were in contact. The paediatric higher trainees stated that they had one person who was both their clinical and educational supervisor for an entire year. This did not work particularly well, the trainee stated, as the supervisor did not see them clinically. This was not the case in O&G where the senior trainee stated they had one educational supervisor and one clinical supervisor, the latter they changed every six months. The O&G trainees stated that within the department there was no formal system for clinical supervisors. The visit team heard from the paediatric trainees that the supervisor system was very structured. There was a weekly consultant meeting to discuss trainees' progress and then a monthly trainee and consultant meeting where concerns were discussed but where praise was given also. The trainees stated that this was a very open method of feedback and sometimes this amount of support felt like over supervision, because they were not use to it. The paediatric trainees also stated that when they were sent on community paediatric placements they were given extra supervision. The T&O educational supervisor felt supported as the consultant numbers had expanded within the Trust which had solidified the job plans. They met a member of the management team, one to one, and they then spread this process across the department. The Surgical tutor received one SPA to fulfill their educational role. The Trust had a permanent CEO in place since the beginning of January 2015 and there was also a permanent Director of Finance in position. The visit team heard that this stability in the senior leadership of the Trust had permeated throughout the Trust and the consultants felt more secure. The senior corporate management was aware that instability at the top was having an effect, especially financially; with a £7.4 million deficit and that a stable senior leadership would mean a better quality of patient care and safety. The educational supervisors also stated this stability was now allowing the departments to plan ahead and expand learning opportunities which would in turn benefit the training and education of trainees.		

6	TWR 6.4	**Bullying and Undermining** The senior corporate management stated that the Trust had a policy but they do not want a separate policy for medical trainees as this would split the trainees up and everyone needed to be viewed as equals and part of a community. The medical trainees stated that they had not been the victim of, or witnessed any bullying and undermining behaviour while at the Trust. The O&G trainees stated that sometimes they may receive a snappy comment from one of the midwives but this was due to the amount of stress they were under. The O&G trainees stated that the department was very friendly and supportive. The O&G trainees stated that the department at present was anxious and unsettled regarding the on-going court case (at the date of the visit 20.01.2015), however the trainees had received lots of support and all trainees had received emails on the matter and what to tell any patients if they asked about the case. All trainees stated they felt well supported in regards to the court case. The surgical, anaesthetic and emergency medicine trainees stated that they had witnessed no bullying and undermining behaviour and had not been the victim of any either. They stated that the Trust was a small, supportive and friendly environment to work in. All the educational supervisors agreed that they had bullying and undermining issues in the Trust before, however they were committed to being vigilant to make sure they were approachable people for trainees to go to and had created internal systems that were confidential and able to monitor whether behaviour of this kind is occurring. The visit team found a consultant body appeared to have a zero tolerance to bullying and undermining and a commitment to preventing this type of behaviour.		
6	TWR 6.5	**Simulation** The senior corporate management reported that except for FY1 all simulation was integrated with medical and nursing trainees. They were trying to incorporate the multi-disciplinary approach with the FY1 trainees too, but it was challenging to get nurses released to go and train with the FY1 trainees. The paediatric trainees stated that the department was very proactive in setting simulation dates and the simulation itself was very good. They ran through mock crash		

		calls. The general medicine core trainee stated that the simulation is multi-disciplinary and the feedback from the training was very good. All medical trainees stated that the simulation training was accessible and multidisciplinary. The anaesthesia trainees reported that they had a prompt course with O&G trainees and midwives, which was a little basic in content for the anaesthetic trainees but it was a valuable opportunity to meet other professionals in a multi-disciplinary setting. The emergency medicine trainees also stated that there was domestic training occurring and this was all multi-disciplinary. The surgical trainees stated that the Trust was very supportive with education and it was very accessible to trainees. The emergency medicine trainees stated that the higher trainees ran the simulation courses for the core trainees, which they found a valuable opportunity for both sets of trainees.		
8	TWR 8.1	**Educational Resources** The Head of Library services stated that the library was a short stroll from the hospital and combined with a broad catalogue of eBooks and journals the trainees had good access to educational resources. The library services also included a document delivery service across the Trust. They stated that there was a policy for learners but this was regarding the expectations of trainees and their expected conduct.		

Good Practice	**Contact**	**Brief for Sharing**	**Date**
N/A			

Other Actions (including actions to be taken by Health Education North Central and East London)

Requirement	**Responsibility**
N/A	

Information and reports provided to the team prior to the visit

DME Annual Report	no	Regulator Reports/Data	no	LFG Reports	yes	MEM minutes	yes
GMC Survey - trainees	yes	GMC Survey - trainers	no	Previous visit reports & action plans	yes		

TRUST-WIDE REVIEW

Signed	
By the Lead Visitor on behalf of the Visiting Team:	Indranil Chakravorty
Date:	26 March 2015