NHS

Health Education North Central and East London
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Developing people for health and healthcare

Pan-London Quality and Regulation Unit

Great Ormond Street Hospital for Children NHS Foundation Trust

Paediatrics

Quality Visit Report

Date of visit: 5 May 2015

Final

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Health Education
North Central and East London

SPECIALTY-FOCUSED VISIT REPORT

Visit Details	
LEP	Great Ormond Street Hospital for Children NHS Foundation Trust
Specialty	Paediatrics
Date of visit	5 May 2015
Background to visit	This visit was organised as part of the on-going process to review paediatric training at the Trust. The paediatric department had been visited in April and November 2014 which highlighted serious concerns with the educational capabilities of the departments as well as patient safety concerns. The concerns raised generated seven immediate mandatory requirements over the course of the two visits. The paediatric sub-specialty trainees in oncology had been removed from the Trust in stages in November 2014 and February 2015, as they were not meeting the curriculum requirements for their level of training. Concerns had been raised to the Trust at the previous visits with regards to the training experience in gastroenterology, endocrinology and rheumatology.
Visit summary and outcomes	The visit team met with the senior management team including the chief executive, interim medical director, interim director of medical education (DME), the director and deputy director of human resources and operational development and assistant director of medical education and leadership. The team then met with the interim director of medical education and two college tutors. The visit team requested to meet with paediatric junior doctors and although the team met with over twenty doctors unfortunately there were minimal paediatric trainees, the majority of those that attended were non-training grades. The team met with the paediatric clinical and educational supervisors from all sub-specialties but gastroenterology was not represented. Further to the decision to suspend posts in paediatric oncology, the visit team met with those involved in the management of the posts, including the interim DME, Human Resources, interim medical director and the oncology leads. Finally, the visit team provided feedback to the senior management team, which included the chief executive, interim medical director and interim DME. Since the first visit to the Trust in April 2014, there was a noticeable change from the trainees with a sense of disengagement. The visit team found that many of the issues that had been raised at previous visits continued to be a concern. There were pockets of improvement, but still areas where education did not appear to be a priority. The visit team were pleased to hear that the endocrinology trainees' experience had improved since the visit in November 2014. The consultants had taken it upon themselves to prioritise education and the experience of trainees had improved greatly because of this. There was acknowledgement that this had led to an impact on their outpatient clinic waiting times. The visit team were pleased to meet the new chief executive, and heard of his plans to attend trainee inductions to increase the educational profile of the

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	Trust. The visit team heard that the medical director will be starting in post in June 2015, and a medical education manager had been appointed and will be starting in post July 2015. The visit team were interested to hear about the Paired Learning (learning between clinicians and managers) in paediatrics intensive care unit (PICU). This had been arranged by the PICU Unit Training Director and was highly rated by the trainees. It was felt to be an innovative idea and had potential to be disseminated across other departments. The visit team were disappointed to hear that there continued to be no robust education strategy within the Trust. The visit team recommended that this should be addressed, to include a defined and mandated role for a substantive DME. The visit team heard that due to the senior staff changes, job planning had not been completed for 2015. The visit team recommended that this was reviewed as soon as possible to ensure that each department had an educational lead with adequate Supporting Professional Activities (SPA) time in job plans to support educational work and development within the sub-specialty teams. The rota management continues to be a concern to trainees. The trainees commented that Human Resources did not understand how the rota also needs to enable the trainees to meet their postgraduate education requirements, nor the curriculum requirements of a paediatrics sub-specialty trainee. The Trust was issued with one Immediate Mandatory Requirement (IMR) regarding the ease of access for clinical guidelines out of hours. This seemed to be a concern when trainees were grouped within specialties that they did not work in during day hours. Departments held their guidance in various places and this had caused delays in tracking down the clinical guidelines. Gastroenterology had previously been flagged up as having concerns because junior doctors struggled to attend the requisite number of endoscopy clinics. However, at the time of the visit there were no paediatric sub-specialty gastroenterology trainees in post, the visit team met up with one post-certificate of completion of training (CCT) fellow. There are plenty of opportunities to undertake endoscopy however poor internal organisation means the trainees struggle to attend endoscopy lists.

Visit team

Lead Visitor	Dr Camilla Kingdon, Head of the London Specialty School of Paediatrics	**TLD**	Dr Andrew Deaner, Trust Liaison Dean
Head of Quality	Mr Ian Bateman, Head of Pan-London Quality and Regulation	**GMC Representative**	Dr David Evans, GMC Enhanced Monitoring Associate
GMC Representative	Ms Jennifer Barron, Quality Assurance Programme Manager for London	**Lay Member**	Ms Ann Rozier, Lay Representative
Lead Provider Representative	Dr Sandhia Naik, UCLH representative for junior trainees	**Lead Provider Representative**	Dr Robert Klaber, Imperial representative for junior trainees
Trainee Representative	Dr Tatiana Hyde, Paediatric Trainee Representative	**Visit Officer**	Miss Michelle Turner, Quality and Visits Officer

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Findings				
GMC Domain	**Ref**	**Findings**	**Action and Evidence Required.** **Full details on Action Plan**	**RAG rating of action**
1	P1.1	**Patient Safety – Clinical Guidelines** The clinical director and college tutors stated that there had been a guideline committee many years before, who were responsible for updating the external website which held the clinical guidelines for every specialty. The team alerted departments when guidelines were due to expire and they would ensure all documents were kept up to date. This team had been disbanded and each individual department had taken ownership of updating and storing their guidelines. The visit team heard that there was an automatic mechanism on the website, to remove guidelines as soon as they reached the expiry date, which had been an issue if departments were unaware of impending expiries. The trainees were able to search on the internet for the guidelines they required, but it was not always immediately clear where they were stored and not all guidelines were on the website. The trainees reported that they covered sub-specialties at night that they were not familiar with. Trainees stated that it was not always clear where guidelines were saved, and they often felt out of their depth covering patients they were not familiar with. The educational supervisors commented that since each department had taken responsibility for guidelines, the documents were now not as easily accessible. Guidelines were often held in various places, whichever was easiest for the department to access, including the departmental drives, pharmacy website, the intranet etc. Unfortunately the departmental drives were not necessarily accessible to other teams.	Trainees were not always able to readily access guidelines out of hours. This was a particular concern when covering a specialty not their own. The Trust must ensure that within five working days of the visit, every junior doctor working out of hours should be given information so as to be able to easily access all guidelines for the patients under their care.	**Red** Immediate mandatory requirement
1	P1.2	**Clinical Supervision** The trainees stated that not all patients were reviewed by consultants on a daily basis. While consultants were available for telephone discussions, trainees felt that more regular consultant contact would improve learning. The junior doctors in endocrinology reported that inpatients were seen by junior doctors every day but less regularly by consultants.		

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1	P1.3	**Handover** The senior management team reported that consultants had been encouraged to attend all daily handovers. The trainees on the MEGGA rota (acronym used historically for the metabolic, endocrine, gastroenterology, genetic and adolescent medicine on call rota, although the rota now consisted of metabolic, endocrine, gastroenterology, renal, rheumatology and dermatology teams). stated that the evening shift had been abolished, and replaced with extended day shifts; there was now only one evening handover. The trainees had been informed that the rationale behind this was to have doctors on site for longer periods that were familiar with the department protocols, and it was indicated that this would also improve the content and quality of the handover. The trainees reported that the handover had improved in content. However, the handover was poorly organised and at times felt chaotic. The visit team heard that the handover had been better organised and with greater consultant presence during the period of the visit by the Care Quality Commission (CQC). General paediatric consultants had previously led the handover and all staff was encouraged to arrive on time, each specialty was asked to hand over separately and it generally felt better organised. Following the completion of the CQC visit, the handover had returned somewhat to the previous practices, which were poorly organised and had minimal consultant leadership if any at all. The trainees suggested that the improved leadership was important in ensuring the handover was more controlled with relevant content. The trainees indicated that there had been mention of a move towards an electronic handover system but this had not been confirmed. All departments were required to upload or email handover notes to the specialty teams following the handover. There were access restrictions with some handovers, for example the neurology team covered respiratory medicine out of hours, but were unable to review the respiratory medicine handover notes on line due to the protection levels of where it was saved. Most wards had adopted the 'nerve centre' system, which involved the junior doctors carrying an iPod with access to the handover notes. The nurse in charge held an iPad that was linked to the iPods and sent alerts to the on call doctors regarding patients. The visit team heard that the system was good, but there were small intricacies that meant some patients had triggered the alert system due to the complexities of their illness but they were not in immediate need of review. This was common with patients with a tracheostomy in the respiratory medicine wards.	The handover appeared to be disorganised, lacked consultant leadership and the content not always relevant. The Trust is required to review the handover process currently in operation and look at steps to improve the organisation, patient prioritisation and clinical relevance of the handover content. In addition, the trust is required to develop a handover toolkit that clearly outlines the leadership of handover as well as key patient parameters that are necessary for an efficient and safe handover.	**Amber** Mandatory Requirement
2	P2.1	**Educational Structure** The medical director reported that each of the divisions worked differently and it was not		

		possible to have a 'one size fits all' package with regards to the educational structure of the Trust. Each of the paediatric sub-specialties had regular meetings which the interim DME attended. The chief executive stated that he will attend all corporate inductions and this gave him an opportunity to introduce himself to the trainees, and had been attending part of the post graduate medical education meetings since starting in post. The visit team heard that the Trust had two paediatric college tutors. They were each responsible for different levels of training and this had appeared to be working well. They meet with the trainees at the induction, and confirmed their roles and responsibility with regards to trainees. The committee meetings were the main interface with the postgraduate medical education team. The interim DME reported that during the period that the 'From the Coalface' report was published, there was no DME in post, and the feedback mechanisms were lacking. Since the interim DME had been in post, there had been a focus on changing this perception and culture. The visit team heard that the interim DME and interim medical director were meeting regularly to discuss education and training. The visit team heard that there was no link directly from the interim DME to the Trust executive, feedback was via the interim medical director, who was a member of the Trust executive. The interim DME had been invited on occasions to clarify concerns and address issues which had been raised, but had never attended for strategic or proactive reasons. The interim DME confirmed that the role had an allocation of 4PAs, and the contract was not substantive. The visit team heard that the medical education manager resigned in March 2015 and the replacement would start in July 2015. At the time of the visit there was no administrative support in terms for trainers to deliver medical education. The interim DME and college tutors confirmed the setup of the postgraduate medical education (PGME) within the Trust, and the split of work streams in Human Resources. The interim DME confirmed that a meeting had been held at the Trust regarding the educational strategy and there was a discussion on producing a formal document. The meeting had been held whilst the interim DME was on planned annual leave. The interim medical director stated that since the previous visit, there had been a focus on addressing the issues raised, and making sure that training was where it should be on the Trust agenda. It had been difficult to address this fully with the pressures on staffing and changes within the Trust.	The Trust confirmed that they were producing a formal document on the Trust's educational strategy. The Trust is required to send the educational strategy Including details on the commitment to review the medical workforce over the following year.	**Amber** Mandatory Requirement

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		The chief executive stated that changes had been made, and a culture shift was happening in the Trust with regards to the delivery of education. The Trust was committed to improving the standard and commitment of educational supervisors. The visit team heard that the Trust had committed to review the medical workforce over the next year, and look at what was needed strategically to improve the shape of training including the educational culture of departments.		
2	P2.2	**Trainee Engagement/Educational Governance** The senior management team reported that they had struggled with trainee engagement and had received minimal feedback from trainees which made it difficult to act on concerns and find solutions. There were regular junior doctor forums, but despite the trainees being encouraged to attend, attendance had been poor. The chief executive stated that it was difficult for the Trust to get a sense of the majority view when there was limited engagement by trainees. The Trust was keen to take advice and recommendations to improve engagement. The visit team heard that there was a lack of a route for education into the Trust board. There was no substantive DME in post, no medical education manager or administrative support for education and training and no dedicated space for medical education. The trainees reported that only 15% of junior doctors had been involved in the updated Coal Face report, however, they stated that the issues raised were an accurate reflection of the junior doctor workforce as a whole	The Trust was in a period of change within the organisation and the educational structure was undergoing changes. The visit team requires updates on the progress being made by the Trust in regards to the educational structure, including the appointment to substantive posts (DME and MEM), confirmed job descriptions for educational roles, dedicated space for the educational department.	**Amber** Mandatory Requirement
2	P2.3	**Local Faculty Group (LFG)** The interim DME and college tutors commented that there were variances in the regularity of LFGs. Some departments had proactive trainers and had fully embedded LFGs. It was difficult as time was not factored into job plans, and the majority of staff had raised concerns that the heavy workload prohibited them from undertaking non-clinical tasks. The trainees stated that some departments had set up regular teaching and LFGs but this relied heavily on completion of the work in their own time.	All departments are required to have regular LFGs with trainee representation.	**Amber** Mandatory Requirement
5	P5.1	**Curriculum** Trainees reported that they rarely complete work place based assessments out of hours this was due to the heavy clinical workload. The consultants had often completed the		

		assessments the following day. The senior management team reported that the postgraduate education team had been reviewing the educational opportunities for trainees and junior doctors across the Trust, and had been producing weekly newsletters. The Trust was developing a mobile phone application which would inform staff of the educational opportunities available. The educational supervisors indicated that they felt trainees were in the Trust or department too briefly, and an extended period would be more beneficial to all. This was a particular issue in specialties such as rheumatology, when it was reported to be difficult for trainees to understand the subject and did not gain confidence until many months into the post. It was suggested that they would be able to provide good experience for trainees for 12 month periods. The perception of some of the educational supervisors was that the general paediatric trainees were not always interested in learning subspecialties. They reported that it was hard to maintain enthusiasm within the department and keep a focus on education when trainees were uninterested in the subject matter. It was suggested that if the junior trainees were able to access the sub-specialties earlier in their training they would understand the different specialties and this could potentially develop interests earlier on. This was contested by the trainees, who in addition felt that their access to sub-specialty learning opportunities was restricted when compared with other doctors, for example overseas fellows, with less onerous or minimal out of hours responsibilities. The visit team heard that educational supervisors considered the intensive care unit was a good experience for the general paediatric trainees.		
5	P5.2	**Educational Opportunities in Paediatric Haematology-Oncology** The visit team heard that the Trust provided the oncology clinical services for children over the age of one year in North Thames London, and provided the service for the whole of London for children under one year. The interim Medical Director reported that since the last visit the Trust had focused on ensuring that they were able to provide the clinical service with the removal of trainees. They had appointed locum consultants, which had enabled the consultant rota to be adjusted and extended day shifts introduced. The interim medical director commented that the feedback from nurses and non-training grade junior doctors had been positive. Training visits from the Royal College of Pathologists (RCPath) for their trainees had had been positive.		

		The visit team heard that the senior management team had met with the consultants and produced a plan of what they would like training in paediatric haematology-oncology to consist of in the future. The Trust stated that they were keen to make the changes for an improved department to enable the trainees to return to the department. The senior management team commented that the experience of junior doctors was variable in the department. The experience by the RCPath haematology trainees had been more positive than in oncology and they had looked at the difference between the programmes. The educational leads stated that the specialty was emotionally challenging and many of the trainees had been in other specialties, and had not experienced the high level of paediatric deaths. It was a challenging role that many junior doctors struggled with. The department were looking at ways to improve the resilience of trainee doctors. The visit team heard that the interim DME had looked at creating job information guides, with information provided from the trainees in order to give new staff an idea of what to expect in such an emotionally challenging specialty. The visit team heard that a workforce planning review was required to ensure that there were sufficient consultants in the future, nationally there were 32 paediatric haematology consultant roles, and eight of these were vacant posts, furthermore six consultants were due to retire in the next four years. Paediatric haematology was a pathway through the RCPath; the educational leads indicated that discussions with the RCPath to champion an increase in paediatric haematologists could be beneficial.		
5	P5.3	**Educational Opportunities in Gastroenterology** The junior doctors reported that there were opportunities within gastroenterology but the day to day workload impacted on the abilities to experience them. The junior doctors felt that they were used solely as a service provision. The department had a heavy administrative workload and no administrative support for this; the junior doctors struggled to meet the commitments during the day, and would often stay late to write clinic letters. The junior doctors commented that by increasing the continuity of team working the experience would be improved. The specialist nurses spent a lot of time with visiting international clinical fellows (as opposed to trainees), which meant that they received a good and varied experience. The experience was different for the junior doctors. There were eight endoscopy lists per week but access to these lists was limited and trainees/clinical fellows found that they work with different clinical supervisors each time and so had to start afresh each time; there was no structure or momentum to develop their skills. There was a	Gastroenterology is a serious educational concern with junior doctors not attending the requisite number of endoscopy clinics; however, there are currently no subspecialty paediatric gastroenterology trainees in post.	**Green** Recommendation

		dedicated Consultant of the Week but they did not attend the daily ward round. The general paediatric trainees stated that there was limited teaching within gastroenterology. Teaching was ad-hoc, but the time pressures and workload on junior doctors meant that it was near on impossible to attend. A junior doctor had organised a teaching session with the help of the dieticians but it had clashed with another educational/clinical session and the teaching had been cancelled without notice.		
6	P6.1	**Rota** The senior management team stated that the rotas had been adjusted, and they planned to have four trainees covering 'medical specialties' out of hours, working in pairs to support each other. This would increase the numbers of doctors in the hospital at night from 13 to 14. Some departments had been able to implement this with the staffing levels they had, but there was recruitment underway to increase the numbers of non-training middle grade doctors for the other departments. The visit team heard that the Trust was looking at the possibility of including ST2/3 trainees on the out of hours rota. The visit team heard that a hospital at night working group had been set up, but the work was on hold until the new medical director had taken up post, as he had extensive experience in this area. The director of Human Resources (HR) reported that there was a full time rota coordinator in post. The HR department were looking at producing metrics in order to reduce the pathways and timeframes to ensure all staff were notified of the rota with adequate time. The trainees reported that there had been on-going issues with the organisation of the rota. The rota was the responsibility of HR, and it did not appear that they had a concept of how the rotas worked. There was no cooperation between HR and the clinical departments to organise the rota. In response to previous HENCEL visits HR had changed the setup of the rota. The trainees noted that they had received the new rotas with only one week notice of the change to the set-up of the rota. This had caused difficulties for the trainees and particularly those with child care arrangements. Trainees were originally informed it was a six week trial, but had since found out that the rota is now permanently implemented without their views on its efficacy being sought. Many departments did not have the required staffing and the general managers had asked junior doctors to cover the shifts as locums. The trainees on the MEGGA rota confirmed that they had completed a diary card exercise, but they had pushed HR for this as they were not sure they were European Working Time	The rota management continues to be a concern to trainees. The trainees commented that the Human Resources department does not understand postgraduate education, and furthermore the curriculum requirements of a paediatrics sub-specialty trainee. The trust is required to relook at the management of the rotas and to consult with the DocRep group to ensure the trainee voice and view is heard.	**Amber** Mandatory Requirement

		Directive (EWTD) Working Time Regulations (WTR) compliant. At the time of the visit the diary card results had not been published. The educational supervisors reported that the junior doctors were issued with the rota by HR with only one weeks' notice. There had been no recognition of night shifts, days off following night shifts and the compliance of the new deal and WTR. There had been a lot of back and forth with Human Resources to address the rota concerns and ensure it was fit for purpose.		
6	P6.2	**Out of Hours** The chief executive commented that the Trust found it disappointing that trainees felt out of their depth overnight. It was reported that it was completely unacceptable for trainees to not feel supported to contact the consultant on call. It was a high priority of the Trust to ensure all consultants were aware of what was expected of them, i.e. to provide a warm, receptive and timely response to all junior doctors out of hours. Trainees had been reminded of keeping in contact with the consultants out of hours, and were encouraged to feed back to the management teams when the communication had made them feel uncomfortable. The interim medical director indicated that, apart from one case that was being investigated, there had been no evidence to suggest that consultants had been less than appropriate or non-responsive out of hours. However, it was possible that interactions were not happening as regularly as should have been. The trainees stated that the helpfulness of on call consultants was variable. The consultants did not actively call the junior doctors out of hours, but the trainees had called the consultant if there were serious concerns over night. The trainees in neurology indicated that the consultants were all approachable, and the specialist nurses were extremely supportive. The trainees in respiratory medicine commented that they regularly spoke to the consultants out of hours for advice on responses to the telephone service for the local paediatric departments. The trainees in renal medicine stated that the consultants were much more visible in the department and would always stay in the hospital overnight if there was a renal transplant. The trainees in palliative care stated that they felt well supported. They were non-resident and they had remote access to patient records. The palliative trainees commented that the on call system worked well and there was flexibility with time off the following day if required. The educational supervisors stated that consultants were readily contactable out of hours, and trainees and sufficient clinical supervision. If a patient deteriorated out of hours, the		

		onsite paediatric intensive care outreach (ICON) team would assist. The trainees in respiratory medicine stated that they were unhappy with the out of hour's rota taking them away from the sub-specialty in the daytime for four months of the year. The respiratory medicine educational supervisors were reviewing the on call system implemented by Royal Brompton Hospital, which had 24 hour junior doctor cover. The visit team heard that many of the trainees were in favour of this, as it would increase the training opportunities over the course of their post duration.		
6	P6.3	**Staffing** The interim DME and college tutors commented that there were often delays with the recruitment of doctors which lead to gaps on the rota. Some of the issues were because of limited numbers of available suitable candidates, but they had also experienced delays with appointed staff starting in post due to immigration and visa checks. The educational supervisors reported that since March 2015 the on call rota had been five doctors short which had affected the cover arrangements. There were weekly meetings with HR, consultant leads, junior doctors and managers to discuss the rota. There were efforts in place to plan in advance and address rota gaps but there were always last minute recruitment gaps. The visit team heard that the recruitment gaps were not necessarily the fault of HR, it was often also due to immigration regulations. The trainees in neurology stated that the consultants were supportive but there were gaps on the rota, as three fellows were unable to start when needed and this had affected the ability of the consultants to provide educational opportunities.		
6	P6.6	**Workload** The interim medical director stated that much of the clinical work, particularly from other hospitals in London was beyond the control of Great Ormond Street Hospital. The Trust had an external telephone service for 32 shared care units in London in haematology and oncology. This was a pan-London initiative, and had to be fulfilled. The trainees indicated that they found the external telephone service difficult. The visit team heard of examples when the trainees had answered a call but had minimal knowledge of the specialty and had to spend time reviewing patient notes or finding out about the illness. The trainees indicated that they were a messenger between the hospitals; they did not know which questions to ask when answering external calls and had often felt they had done a	The Trust is required to continue its review of Hospital at Night and to consider different approaches and structures. In particular a review of the handling of external phone calls and requests for advice from local hospitals out of hours is worthy of special attention.	**Amber** Mandatory Requirement

		disservice to the patient. The subspecialty trainees were keen to take their own subspecialty referrals, and working in other sub specialties was not seen as a good learning opportunity. The trainees commented that the on call teams were meant to meet at 2am to discuss workload, and reallocate as per the intensity of the teams. This rarely happened, as the teams were too busy to stop. The trainees stated that the workload out of hours was heavy and not always manageable. There were particular issues within the hospital with regards to the inappropriate and often heavy workload of junior doctors. They were particularly stretched overnight, when they were bleeped to attend to patients requiring cannulation or pain medication. Trainees also reflected that the relatively well patient would be given a lower priority while they attended to the very unwell and gave an example relating to cannulation of a patient at midnight which could have been done several hours earlier had there been sufficient staffing. There was minimal phlebotomy service within the Trust which meant that the junior doctors were relied upon to do this, and there had been times when a request had been put onto the system in the afternoon and the patient had not been seen until midnight. The visit team heard that the MEGGA rota includes rheumatology, dermatology, renal medicine, metabolic, endocrinology and gastroenterology. It was an historical grouping and did not always appear to be a good or relevant grouping. The trainees that participate on the MEGGA rota stated that an extra pair of hands would be welcomed as the workload was particularly heavy. The on call rota was responsible for up to 60 patients per trainee. The trainees suggested that they did not specifically require a senior trainee but a junior trainee would be a great help with the workload out of hours. The trainees on the MEGGA rota commented that there were delays out of hours in reviewing patients, as the majority of the time the junior doctor had not seen the complex illness or the patient and so can spend up to 45 minutes reading through the patient notes and looking for clinical guidelines before being able to make clinical decisions. The trainees in the MEGGA rota commented that the workload out of hours was particularly heavy, and many trainees experienced difficulties as the specialties were different and many had no experience in that specialty. Trainees indicated that there was often times when more than one patient required urgent review, and they would have to decide who to prioritise without fully understanding the conditions. There had been times when patient safety had been compromised, due to the time delays in reviewing patients. The visit team heard that possible consequences to these delays could be that patients were left in pain.		

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		The educational supervisors stated that there was no reason for patients to be left in pain, and they were unaware that this had happened. Trainees should always discuss incidents over the phone with the consultant if they were not there directly in the hospital. The visit team heard that educational supervisors considered there was enough staff in the Trust overnight that patients were not at risk overnight and should not be left in pain. The educational supervisors reported that they were reviewing the set-up of the MEGGA rota, with a possible expansion to four doctors at night to assist with the heavy workload.		
6	P6.7	**Teaching** The senior management team stated that there had been an increase in teaching across paediatrics which had been well received, and was well attended. The educational supervisors indicated that the Trust did not give the same kudos to teaching as it did to research. Teaching had not been a priority within the Trust, and historically provisions had not been in place to allow for trainees to be released for teaching. The trainees in respiratory medicine stated that teaching was a great opportunity. There was a 'sit down' ward round which was a good experience and the consultants were approachable. The trainees in neurology stated that the consultants were supportive and bedside teaching was good. There was a willingness from the department to improve the educational opportunities for trainees but it was difficult with the shortages in staff.		
7	P7.1	**Educational Facilities** The interim DME and college tutor reported that there was no specific space allocated for education within the Trust. Many years ago there had been a lecture theatre available but this was no longer the case, although Weston House had space set aside for education		

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**

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The Head of School of Paediatrics and Child Health to meet with the medical director, director of medical education and leads of haematology oncology to discuss the training opportunities and requirements regarding the return of trainees to the department.	Head of School of Paediatrics and Child Health
The Head of School of Paediatrics and Child Health to meet with the Head of School of Pathology to discuss training in opportunities in haematology.	Head of School of Paediatrics and Child Health

Information and reports provided to the team prior to the visit

DME Annual Report	*No*	Regulator Reports/Data	*Yes*	LFG Reports	*No*	MEM minutes	*No*
GMC Survey - trainees	*Yes*	GMC Survey - trainers	*No*	Previous visit reports & action plans	*Yes*		
PVQs - trainees	*Yes*	PVQs - trainers	*No*	Result of school survey	*No*		

Signed

By the Lead Visitor on behalf of the Visiting Team:	Dr Camilla Kingdon
Date:	8 July 2015