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Quality and Regulation Team (London and South East)

North Middlesex University Hospital NHS Trust
Trust Wide Review

Quality Visit Report

16 March 2016

Final Report

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Visit Details	
Trust	North Middlesex University Hospital NHS Trust
Date of visit	16 March 2016
Background to visit	The Trust Wide Review was one element of a multi-specialty and multi-professional visit undertaken by the Quality and Regulation Team (London and the South East), Health Education England. Other areas that were reviewed over the two days, included nursing, midwifery, and allied health professionals, a departmental review of the emergency medicine department and specialty-focused reviews of medicine, foundation, general practice, and surgery. The findings of these visits were all recorded in separate reports. The remit of the Trust Wide Review was to assess the educational governance structure of the Trust, including: how education fitted within the Trust, the structure to support communication from trainees through to the Trust's board, how serious incidents were incorporated into learning and fed back to the trainees and, to receive a broad understanding of the issues and good practice that were experienced at the Trust. Postgraduate medical education had historically resided within the human resources department but the Trust had developed an independent education structure and was beginning to implement local education governance systems, such as local faculty groups. The extent of this implementation needed to be assessed, as did the ramifications on education and training from the large-scale service reconfigurations within the area from the Barnet, Enfield and Haringey Clinical Strategy, which the Trust had been absorbing since 2014. The Trust had a total of 213 postgraduate medical trainees and 614 undergraduate medical students who received training and education.
Visit summary and outcomes	The visit team would like to thank the Trust for accommodating the visit over the two days. The visit team for the Trust Wide Review was aware that the attendance at the sessions would be lower than normally expected at Trust Wide Reviews because of the number of other visits occurring within the two days, however there was a good scope of specialties seen and the senior management had prepared a very detailed presentation. The visit team first met with the senior management team, followed by individual sessions with the postgraduate medical education team, then the postgraduate medical trainees in obstetrics and gynaecology (O&G), core medicine, paediatrics and clinical oncology, a separate session with the undergraduate medical students from University College London and St George's University (SGU) in Grenada and finally a meeting with the education leads from paediatrics, histopathology, clinical oncology and O&G. The visit team was alerted to a few areas for patient safety concerns from the attendees at the Trust Wide Review. The most salient regarding the lack of doctors to paediatric and paediatric emergency medicine cases out of hours, combined with the high workload and large area expected to be covered; there were no concerns regarding clinical supervision for paediatrics during the daytime. Other areas for concern were the lack of radiology services across the Trust out of hours and at weekends, the slow computer systems, delaying care, acute concerns regarding the emergency medicine department, and general concerns regarding the gaps in the rota causing increased workload and inhibiting patient care and adequate training. The Trust had obviously engaged in the process of creating a clear education strategy and an education governance system with local faculty group (LFGs) and internal quality monitoring. However, the visit team found that in reality, the system was not yet embedded and departments tended to remain insular and solve issues amongst themselves instead of escalating through the education governance system. The visit team was pleased to hear, though, that the postgraduate medical education team was aware of the work that needed to be done, but was concerned that education needed more prominence and empowerment within the Trust to fully achieve its trust-wide objectives. The visit team found that although the higher echelons of management were engaged in serious incidents and monitoring them, at the grass-roots levels there was little learning from serious incidents and very limited feedback and support provided for trainees. There was, however, encouraging good practice from the O&G department and especially the paediatric department, which provided an exemplary culture of how the learning loop could be closed

	surrounding serious incidents. The college tutor for paediatrics was to be commended for the work undertaken to provide an excellent training environment with bespoke learning opportunities, a supportive environment, and excellent engagement from the consultant training body with service and training and education needs. The visit team was concerned that because of the gaps in the rota the department's excellent work could be undermined, and this was an issue not only specific to paediatrics but across other areas of the Trust too. The visit team was also concerned to hear of an apparently new Trust policy that might prevent the filling of rota gaps with locum staff because of cost-saving measures. The visit team was pleased to hear that the Trust would be investing in the physical education facilities and it was hoped that this would improve the already good library resources but also help to develop and sustain the simulation facilities and the supportive and open environment the Trust was trying to encourage. The Trust would also do well to invest in information technology, especially the computer hardware to promote the new software used to view scans, imaging and other test results. This would assist in delivering evidence based and efficient patient care. The visit team found that the requirements of the two medical student cohorts were very different and there was no awareness amongst departmental staff of the differentiation in the students' teaching and needs. The visit team felt that the two university cohorts needed to be clearly defined and more work was needed to help acclimatise the third and fourth years from St. George's University. Overall, the visit team found a Trust that was committing to implementing, improving and encouraging education and training and was aware of the majority of issues that needed development.

Visit team			
Lead Visitor	Dr Indranil Chakravorty, Trust Liaison Dean, Health Education England North East London	**Lay Member**	Robert Hawker, Lay Representative
Health Education England Representative	Xavier Baby, Senior Project Support Officer, Quality and Commissioning Health Education England North Central and East London	**Scribe**	Elizabeth Cannon, Learning Environment Quality Coordinator, Quality and Regulation Team ((London and the South East)
Higher Education Institution Representative	Helen Lewis, Quality Assurance Manager, University College London	**Observer**	Samina Ashraf, Deputy Quality and Visits Manager, Quality and Regulation Team ((London and the South East)

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	Requirement type
GMC Theme 1) Learning environment and culture			
TWR	**Patient safety**		

1.1	The visit team was concerned to hear that there were no interventional radiology services out of hours in the Trust and so the procedures had to be done either by a higher training grade, or equivalent Trust grade doctor. If due to staff shortages they were not available, the core trainees would have to either transfer the patients or on rare occasions the radiologists would come in to perform the procedure but delays were inevitable. The medical director stated that there was an agreement whereby the clinical teams could discuss cases with the interventional radiology team at The Royal Free London NHS Foundation Trust. However, this was not mentioned by the trainees or consultants the visit team met. The visit team also heard of cases where a patient with deteriorating liver function had waited over a week for an urgent ultrasound scan.	The Trust is required to ensure that there is an adequate staffing level in all departments to ensure patient safety, clear lines of responsibility for clinical supervision and escalation. The Trust must confirm that rotas in the paediatric, O&G, clinical oncology, and medicine departments are staffed consistently and devise a robust plan to ensure a good mix of skills are available where recruitment is challenging.	Mandatory Requirement
	The visit team heard that the impact of staff shortages in paediatrics, because of maternity leave was causing gaps in the rota and the sheer volume of work at night had caused patient safety risks. The visit team heard that at night the trainees did not think it was safe because there was one higher grade and one core grade trainee or equivalent Trust training level one grade doctor to cover two wards, which amounted to 31 beds, the paediatric assessment unit and calls from the emergency department (ED). This resulted in the doctors being stretched over a large geographical area and this was felt to be unsafe, especially during winter increased attendances. The lack of paediatric trained staff being present consistently in the ED meant the higher paediatric trainees were constantly supporting the emergency medicine trainees and meant that if the higher trainee was called down to a resuscitation in the ED, there would be no higher grade cover on the wards, just a core trainee. The trainees stated that they had raised this with the consultants, but that because of the staff vacancies in the paediatric department, it was not always possible for them to come in. The visit team heard that trainees were concerned regarding the patient experience in the ED, and trainees would not recommend the Trust's ED to friends and family. The trainees were also tentative in recommending other areas of the Trust because of the staff shortages. Obstetrics and gynaecology (O&G) was recommended for elective cases but the outpatient service was described as having minimal access and very long waiting lists. However, the trainees would be content to have their own children delivered in the Trust.	The Trust is required to confirm via a written policy or SOP document, that out-of-hours access to radiology investigations and interventional radiology provision is appropriate to the needs of the patients and a clear escalation policy is available to all on call and ward teams. The Trust is required to provide a plan to support the safe management of paediatric emergency attendees between the emergency medicine and paediatric departments, which outlines the roles and responsibilities, and the patient pathway for paediatric cases.	Mandatory Requirement Mandatory Requirement
	The visit team heard that the Trust's computer system was very slow and the hardware could not support the new software for scans, imaging and other test results that had been installed. This resulted in delays to patient care because the computers would crash, and have to be restarted and the software reinstalled when staff wanted to search for patients' results. The visit team also heard that there was no access to picture archiving communication systems (PACS) so radiology images could not be viewed on many of the computers on the wards, which led to the team splitting during ward rounds and challenged the delivery of safe care and learning. This was experienced most acutely by core medical trainees on the medical wards. This was not helped by the slow and unresponsive nature of the support available from the information technology department.	The Trust is required to review the IT system and ensure that this enables an efficient and safe service. An IT infrastructure and strategy vision/ plan is required to be shared with the visit team.	Mandatory Requirement

	The visit team was pleased to hear from the O&G college tutor that unlike on previous visits where the emergency medicine gynaecology pathway had been ill established and a concern to patient safety, it was, at the time of the visit, well established, implemented, and understood by all. This had been improved by the increases in midwife recruitment after the increased caseload from Chase Farm Hospital.		
TWR 1.2	**Serious incidents and professional duty of candour** The visit team heard that the senior management team (SMT) were making a concerted effort to encourage trainees to report serious incidents, as they acknowledged that this was an area that needed much improvement. The SMT acknowledged that one of the ways they would be able to encourage serious incident reporting would be to provide accurate and timely feedback after trainees submitted a Datix. The SMT stated they had worked with local faculty groups (LFGs) to provide local communication via the trainee representatives to provide generic feedback and learning from serious incidents and it was a standard item of the LFG agenda to ensure trainees were happy with feedback. The SMT stated that there was a robust system, which was integrated into education governance for tracking serious incidents, complaints and analysing the risk register. The visit team heard that these were used to plan work and identify where trainees were experiencing difficulties and areas where trainees would be put at risk. The Trust stated that this work would be bolstered with responsive feedback, which they were trying to collate, through different fora and conduits. The Trust stated that once a trainee submitted a Datix they would receive an immediate acknowledgement email and then a report of the serious incident later on. The SMT stated that if it was a medical issue the Datix would be escalated to the clinical director, or nursing it would go through to the matron. It was reported that the director of nursing chaired a daily meeting where all incidents were reviewed and forwarded to the medical director and other relevant senior management personnel. The SMT ensured the visit team that to provide objectivity and externality the serious incident report was undertaken by an investigative officer, external from the department the incident took place in, which was appointed by the clinical director. The postgraduate medical education team confirmed this practice but stated that more work needed to be done to provide timely feedback. The SMT stated that they had received three Dr Foster mortality alerts in 2015 and had received one in 2016, at the time of the visit in March 2016. The visit team heard that they were looking at this but did not believe this to be a particular problem, as the Trust was beginning to return to normal standards for mortality figures. The SMT stated that there had been a strengthening in the mortality framework with monthly mortality meetings and there was a real time death pilot, which was underway, which was developing a more reactive review to mortality figures. The visit team heard that there was enhanced governance around the emergency medicine department a daily 12:00 meeting in the ED, attended by management and ED staff, called silver meeting. This was to discuss daily feedback on serious incidents, breach analysis, and complaints	The Trust is required to review and report on the entire system and mechanism for serious incidents across the Trust. There must be a robust system, which provides timely and constructive feedback and support, links serious incidents to learning and is monitored and scrutinised internally. This will provide the basis for greater training engagement in serious incidents.	Mandatory Requirement

	to allow for an overall picture of where the main areas of pressure were for each day. This was also followed up once a week with a meeting with the ED consultants and the executive team, which provided a forum for discussion around complaints and serious incidents. The postgraduate medical education team stated that learning from serious incidents was created through an action plan which is produced through cross referencing serious incidents via the dashboard used in the ED and this is signed off by the director of nursing. However, the visit team was concerned that this was only for the ED and the incorporation of serious incidents into leaning of all staff, not just trainees, was not widespread. The trainees the visit team met stated they were informed how to record and serious incident via Datix, but the core trainees in medicine stated that they had not received the feedback they would have wanted. O&G and paediatrics both gave examples of serious incidents being incorporated into learning, ether via the morbidity and mortality monthly meetings in paediatrics and a departmental email to everyone with learning points from the serious incident or the hot topic board in O&G that was updated every month.		
TWR 1.3	**Appropriate level of clinical supervision** The higher trainees stated that clinical supervision in clinical oncology, and O&G was very good, with trainees experiencing close working relationships with supportive and accessible consultants, which they appreciated. The visit team heard that higher trainees in paediatrics also received good levels of clinical supervision but there was an issue of support out of hours across paediatrics and the ED. This was also the case for core trainees in medicine who stated that because of the large area, they covered out of hours, including the wards and ambulatory care unit it was difficult to locate and access the higher trainee for support and supervision. However, the core trainees did state that the consultants were supportive and approachable, with consultants present for post take ward rounds.		
TWR 1.4	**Rotas** The postgraduate medical education team stated that there was the potential for issues regarding workload and supervision to arise because of gaps in rotas in various areas of the hospital. Trainees and educational leads, the visit team met confirmed this. There were concerns raised regarding the clinical oncology rota and the paediatric rota, because of the lack of staff. The gaps in the clinical oncology rota were because of trainees either being out of programme or on maternity leave, but the visit team was told that the clinical oncology department had already started to advertise for the gaps and that locums were used to cover gaps in the on call. The college tutor for clinical oncology stated that there was a national shortage of specialty training grades three (ST3) trainees, which would inevitably mean gaps in the rotas. The visit team heard that although the department had already advertised for the posts it was unlikely that the post would be filled because of the national demand for the same, limited group of people.	The Trust is required to confirm that robust and timely arrangements are available from HR department to advertise and fill predictable and unpredictable gaps. The Trust is required to confirm that no policies are being implemented which may prevent departments from filling gaps to provide safe patient care.	Mandatory Requirement

	The department was now trying to ensure that training and patient safety was not adversely affected by these gaps. The gaps in the paediatric rota were caused by maternity leave too. The visit team was concerned to hear that there was a new Trust policy, which delayed and in some cases inhibited departments from filling gaps in the rota caused by maternity or other preempted leave. The policy entailed departments finding cost saving internally to fund the posts whereas before maternity cover would have been automatically provided. The visit team was unimpressed that the paediatric department, as a last resort, had had to take money from the nursing budget to ensure the gaps were filled and a safe, adequate level of staffing maintained. The visit team heard that the college tutor for paediatrics was exceptionally worried about the gaps in the rota because of the Trust apparently had 'the largest and busiest paediatrics department in the country' even one gap could be detrimental on training and education. The visit team heard that rotas were received in advance of trainees' inception at the Trust and the higher trainees stated that annual leave and study leave were organised well and in a timely manner. However, the core trainees in medicine had a different experience, because although the rota was generally distributed in a timely fashion, the on call element meant that trainees did one month of on call and then one month of ward work. It was reported that this set-up limited trainees' ability to take annual leave and study leave. This was compounded by the gaps in the rota, which meant that core trainees were unpaired and so could only receive annual leave if someone cross-covered. This resulted in core trainees taking annual leave sporadically and in short bursts.		
TWR 1.5	**Induction** The SMT conceded that there were issues with Trust and local inductions that needed to be improved. The visit team heard that one method of improvement was collating feedback from trainees after the inductions, which included collecting information to make sure trainees did not have to repeat modules. The SMT stated that this would ensure that the induction was smart and efficient. The SMT stated that there was a pack in the site office, which was provided for locums, which explained how to use the computers systems, gave them an ID badge and relevant logins. The SMT stated that the locums' mandatory training was provided externally from the Trust. The visit team heard that at the time of the visit the Trust used the national system for e-learning modules. However the SMT stated that this was not particularly efficient as staff could only proceed with the modules once in employment and instead the Trust would like to look at programmes which could be started beforehand and which did not need to be duplicated by staff. The visit team heard that the postgraduate medical team provided an induction of the governance structure and the associate director for medical education gave a short presentation and introduced members of the team. The visit team heard that this was to ensure that trainees knew who the key people were and who to turn to for support. The trainees confirmed that this had occurred at their induction, but admitted that they could not recall names. No trainees, who the	The Trust is required to provide a review of the Trust and local inductions, content and feedback and an implementation plan for improvements.	Mandatory Requirement

	visit team met, knew where the DME's office was. The higher and core trainees stated that the Trust inductions had been rescheduled due to the junior doctors' strikes but that those who had received a Trust induction felt it was very good and appropriate to their needs. The local inductions for clinical oncology, O&G and paediatrics were all reported to be of a high standard. The college tutor for histopathology stated that histopathology trainees received good inductions for Trust, local and laboratories. However, the core medical trainees stated that the quality of local induction varied in the different medical departments.		
TWR 1.6	**Protected time for learning and organised educational sessions** The SMT stated that because of the restructure of the education faculty and the resulting high turnover, there had been issues relating to the quality of teaching experienced by the trainees. The above statement was confirmed by the core trainees who stated that the teaching they received was sporadic, with less than half the local teaching provided. The visit team did hear however that the teaching had improved and now included more clinical content and covered aspects of the curriculum. The core trainees stated that they had worked with the academic center and now had core trainee-led practical assessment of clinical examination skills (PACES) teaching, which had resulted in a high pass rate. The visit team heard that local and regional teaching for trainees in O&G was very good and trainees confirmed that there was access for study leave for the exams, Friday afternoon journal club and Friday morning there was an academic clinical training group meeting. The visit team was informed that although clinical oncology trainees did not have to receive simulation training as part of their curriculum requirements they did attend multi-disciplinary team meetings, regarding radiotherapy planning. There was also a communication skills course that they attended. The college tutor stated that radiologists undertook teaching for the higher trainees and although there were no plans for multi-professional learning, the college tutor wanted to replicate some of the radiology training practices and adapt them for clinical oncology training purposes.	The Trust is required to review and support the access to opportunities for 'multi-professional' training in all clinical areas.	Recommendation
TWR 1.7	**Adequate time and resources to complete assessments required by the curriculum** The visit team heard that the simulation facilities at the Trust had been limited to only one trolley. However, the Trust now had a dedicated room with cameras, although this was temporary, and the lead for simulation was working to improve facilities. The new education center, it was reported, would have a high fidelity simulation suite. The postgraduate medical education team stated that multi-professional simulation learning was encouraged but it had been difficult to ensure nurses were released, however a solution which was working well to this, was ward-based simulation and learning. The trainees stated that it had been difficult to access simulation training as the facilities had been broken. The trainees stated	The Trust is required to confirm that access to ward-based and high fidelity (laboratory) multi-professional simulation based training is available for all learner groups and incorporates 'human factors training'. The release of all healthcare professionals to attend these sessions must be established. The Trust should either set up a simulation working group or embed this in the Trust education committee activity on a regular basis and publish a multi-	Mandatory Requirement

	that the simulation lead had been amenable but there had been little done to rectify the malfunctioning dummy. However, there were dates booked for simulation for April to June 2016, however the core trainees stated that if the dates fell within the on call block it would be very difficult to attend. The DME stated that the Trust hosted regional paediatric simulation. The visits team heard that simulation in paediatrics was well established with their own high fidelity simulation sessions on Wednesdays, and Fridays, and low fidelity simulation on Thursdays. Nurses also attended the high fidelity simulation. The O&G department also took part in once a year multi-professional teaching with the updates to the PROMPT training, and included labour ward drills.	professional simulation learning strategy.	
GMC Theme 2) Educational governance and leadership			
TWR 2.1	**Effective, transparent and clearly understood educational governance systems and processes** The visit team heard from in the presentation by the senior management team that the strategic objectives for the Trust were akin to most Trusts within the NHS. The Trust aimed to provide excellent clinical outcomes, through excellent patient care and so provide a positive patient experience. This was alongside the provision of cost effective services, allowing for site development, which would include improved facilities for patients and staff. The visit team heard that the executive responsibility of medical education had moved from the human resources department to the medical director in 2014 and with this, a new, enhanced education governance structure had been developed. It should be noted that at the time of the visit in March 2016, the Trust's medical director had been in post for just over three weeks. The Trust's workforce and education and training committee, met every six to eight weeks and was directly accountable to the board. The visit team heard that this committee provided a two pronged approach to assess the Trust's progress against set targets and then also react to feedback from internal and external surveys direct feedback and quality visits. The SMT stated that this committee allowed for internal quality management and scrutiny of the medical education department. The workforce and education and training committee directly received reports from three distinct groups, the education strategy delivery group, the postgraduate medical education team and the undergraduate medical education team. The education strategy delivery group was stated to provide a multi-professional oversight over the five work stream groups within the Trust. These were the nursing, medical education, midwifery, allied health professionals and organisation development work streams which all had their own leads as associate directors. There were also task and finish groups which were set up to provide independent work groups on immediate issues, such as the education facilities, statutory mandatory training and developing learning pathways for bands fives and sixes. The SMT stated that the efficiency of this group was scrutinised by the workforce and education and	The Trust is required to provide a plan of the development of the education facilities, how this will impact on learners during transition and how this will benefit learners as a result. This should include provision of library resources, a social space, simulation, and multi-professional learning.	Recommendation

	training committee. The visit team heard that the postgraduate medical education team received information from two other sections, the library committee and the local faculty groups (LFGs). The SMT stated that the library committee had been reinstated as the Trust had decided not to go into partnership with the University of London, but because of the delay in this decision, there had been a hiatus in the committee's activity until early 2016. The visit team heard that multi-professional educational working was in its infancy within the Trust, but that there would be further work to identify joint training needs and how the different professions could learn and work cohesively together. The associate director stated that this would be bolstered by the up skilling of nurses and clinicians who had attended the aspiring clinician project, provided by the Kings Fund. It was hoped that these people would bring back innovative ideas for the department. The visit team was pleased to hear that the paediatrics department had not only worked hard to develop a bespoke training programme for medical trainees, but was also moving towards a multi-disciplinary approach to training. This would include active working and learning of all members of the paediatric department from doctors and nurses, but also dieticians and speech language therapists.		
TWR 2.2	**Impact of service design on learners** The Trust informed the visit team that the local community presented a clinical challenge because not only was the population very diverse, presenting with a plethora of pathologies but because the population was peripatetic, they rarely attended primary health care centres, such as general practice surgeries. This meant that patients would present at a late disease stage, which provided complexities with diagnostics and the emergency medicine department was under pressure because there was a tendency to use it to access health care, which could have been alternatively accessed in primary care. The visit team heard that the complexities in patient cases was seen as excellent training opportunities but the increased workload was inhibiting access to training opportunities, especially within the emergency department. The senior management team stated that the Trust was committed to engaging with the local population, with nearly 60 per cent of its staff living in the local area. The SMT went on to state that they were committed to recruiting from the local area and developing staff internally. The Trust had nearly doubled the number of apprenticeship places in one year and there were anecdotes of nursing staff being trained up, from porters to become nurses and eventually progressing to leadership roles. The SMT stated that there was an integrated performance report, which analysed financial and safety measures to monitor the performance of the Trust against the standards set out in 2014 after the Barnet, Enfield, and Haringey integration of services. This report occurred monthly and was fed up through the various committees to provide tight monitoring on performance. The SMT stated that they had escalated their concerns to NHS England regarding how the service had		

	changed in reality to the expectations set out in the integration in 2014. The Trust stated that the increase in workload, the number of electives, the length of stay, and the pressure on the ED had been large and the Trust had employed an addition 600 members of staff to combat this increased workload and combat vacancy rates. The SMT stated that this had had a detrimental impact on education and training, and staff experience but that vacancy rates were beginning stabilised at manageable levels. The Trust stated that the endpoint of the integration was very different to what had been envisioned in 2014.		
TWR 2.3	**Appropriate system for raising concerns about education and training within the organisation** The SMT stated that there had been considerable work undertaken to develop and implement LFGs across the Trust and that now all LFGs were set up. However, the postgraduate medical education team stated that the LFGs were variable across departments and that as a base unit for governance, further implementation was crucial. The visit team heard that trainee attendance, robust minutes and agendas all needed further work. The core and higher trainees confirmed that there was variability within the Trust in the prominence of LFGs. The core trainees in medicine stated that there were no LFGs established and that the trainees were not included in the academic meeting. The trainee reps liaise directly with the training programme director and the simulation lead to work on specific issues. On the other hand, paediatrics was stated to have a highly effective LFG, which occurred every two months, chaired by the paediatric college tutor. All trainees were invited to attend along with all consultants, senior nurses, paediatric psychologist and general managers and the clinical business unit managing director. This was confirmed by the clinical lead who stated that the meeting was held on the third Tuesday in the middle of the afternoon and the LFG abutted the consultant meeting. This meeting was closed to trainees attended by the consultants, senior nurses and psychologist where each trainee was discussed along with any concerns or particular requirement for their training. The trainees did state that there could be increased trainee attendance if the meeting could be placed in the morning when more trainees were available. O&G was reported to have infrequent LFGs in comparison to paediatrics but there had been at least three from October 2015 to March 2016 and if the trainees had concerns, they escalated this to the college tutor, who was responsive. The college tutor for O&G stated that there was work to be done on the LFGs, but that they should be fully established by April 2016. The visit team heard that the clinical oncology trainees used the lead provider's quarterly meetings to raise training issues and they had good trainee representation and relations with the training programme director to effect change. The visit team found that there was an automatic reliance on the college tutors and training programme directors to enact change in the departments. This was instead of local faculty groups or reporting through the education governance system. This was reported to be especially so in paediatrics as the department was historically independent from the rest of the Trust and proceeded to govern independently. The paediatric trainees stated that this was effective.	The Trust is required to fully embed LFGs into all departments and ensure that the LFGs are a fully integrated and functional vehicle for interaction with trainees within the education governance system.	Mandatory Requirement

	The visit team heard from the SMT that they were trying to collate as much feedback as possible from trainees to provide internal quality governance. In addition to the junior doctors and student for a, there was the education leads meeting too. The DME stated that with the introduction of a deputy DME there would now be the resources to attend more meetings and be more visible to trainees and the faculty. The visit team heard that trainees were aware of the junior doctor fora where rota issues had been discussed, however it was stated that these had less focus on education and more to do with clinical and services issues. It was also stated that over the winter pressures these meetings had not occurred. The trainees did however identify a robust mechanism of feedback from the junior doctors' fora, with minutes being disseminated via email to all trainees and people taking responsibility for the actions formed from this meeting. The SMT stated that there needed to be further development of the Trust's faculty with increased numbers and training for college tutors, educational and clinical supervisors. The DME stated that there was good engagement from the faculty and there was a faculty meeting held, which included college tutors and educational supervisors. The function of this meeting was to identify and discuss issues, such as clinical supervision in departments. The visit team heard that the DME and clinical directors had forged strong working relationships which provided a foundation for education to be placed within the Trust but the DME was unaware whether education was discussed at the clinical directors' meetings. The visit team heard that the Trust Liaison Dean for Health Education England North Central London had been of great support to the DME to provide guidance on matters of education and training and provide clarity over areas, which overlapped with service issues.		
TWR 2.4	**Systems and processes to identify, support and manage learners when there are concerns** The SMT stated that when trainees reported serious incidents there was a support mechanism in place for the trainees involved. The visit team heard that the DME was informed when trainees were involved in serious incidents, could track all of them and see which incidents were still live and the DME would try to seek the trainees out to talk to them. The visit team heard that there would then be someone external to provide pastoral support. The SMT stated that they also tried to provide debriefing sessions and the educational supervisor was expected to provide support to the trainee. Other visit teams found multiple cases that provide evidence that the system for providing pastoral support or any type of support to trainees was below adequate.	The Trust via DME is required to establish a policy for managing 'trainees in difficulty' within each LFG and ensure that appropriate training is provided for all LFG chairs, TPDs and educational supervisors. All LFGs must discuss and document the support provided to trainees in difficulty confidentially. The DME must have oversight on all trainees in difficulty within the Trust.	Mandatory Requirement
GMC Theme 3) Supporting learners			
TWR 3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The Trust acknowledged that there was bullying and undermining behaviour within the Trust and to combat this they had created a set of Trust values with staff participation, to encourage a	The Trust is required to invest in a 'trust-wide' approach to 'zero tolerance policy' to bullying	Mandatory Requirement

	supportive and open environment. The SMT also hoped that this open culture would encourage staff to feel comfortable to speak to the SMT and other management levels. They stated that management visibility had also increased in areas with concentrated issues, like the ED, with management present at all meetings and the DME being visible on the service floor. The postgraduate medical education team acknowledged that they took bullying and undermining very seriously and investigate immediately, but that there was still a problem for the Trust internally to identify this. The DME stated that the only identifier that was used was the General Medical Council National Training Survey. This had identified some consultants' unprofessional behaviour in the past and these had been addressed by sending them on courses and monitoring their performance.	and undermining behaviour, increase opportunities for open discussion of such behaviours and confidential reporting. Support from the HEE support unit (John Launer) should be sought where appropriate. Progress in this area must be discussed and documented in the education committee meetings.	
TWR 3.2	**Undergraduate Medical Students** The visit team heard that there was a good induction for the UCL medical students but that the inductions received by the SGU students could be variable as they arrived at different times during the year. However, the undergraduate administrator was reported to be very supportive and responsive to the medical students' needs. The visit team was concerned to hear that there was no acclimatisation period for the SGU students who had no previous experience of the UK or the NHS, but also had no practical clinical skills training when they first arrived. The SGU students stated that there was limited clinical skills learning at the Trust and they went to Watford General Hospital instead, there had also been one clinical skills training day set up by the undergraduate clinical fellow in the undergraduate team as part of the teaching schedule, which had been useful for the SGU students. The students were keen to receive increased clinical skills training. The visit team found that teaching was not differentiated between the two student cohorts and there were substantial differences between the knowledge levels and curriculum requirements of the different medical schools. Hence, the teaching provided in clinical placements was largely irrelevant and out of the competency levels of the SGU students. The undifferentiated teaching was also detrimental to the quality of teaching the UCL students received too. The visit team heard that the teaching on wards was variable; however, there was exemplary teaching provided by the paediatrics, O&G, and anaesthetic departments. The visit team was concerned that the SGU students had minimal contact with the relevant supervisory / tutors/ mentors within SGU to raise concerns relating to their course and their experience within the Trust.	It is recommended that the Trust Undergraduate education leads set up dedicated and curriculum relevant access for the SGU students to access teaching, clinical skills training and a comprehensive induction, which acclimatises the students to the NHS. This must be distinct to UCL students.	Recommendation
GMC Theme 4) Supporting educators			
TWR 4.1	**Education supervisors** The visit team heard that within the O&G department all consultants had historically been accredited as education supervisors however the college tutor stated that with the introduction of	The Trust is required to ensure that all educational supervisors are trained and	Mandatory Requirement

	the LFGs it was becoming apparent that education supervision roles needed to be undertaken by consultants who had an active interest in education. The visit team heard from the consultants that there was support from the postgraduate medical education team, but that from their perspective the Trust did not prioritise education or support the postgraduate medical education team in the manner it should.	accredited according to GMC guidance. Refresher training should be provided to all educational supervisors regularly. Educational appraisals should be conducted by the TPDs or DME at least every 3 years.	
TWR 4.2	**Access to appropriately funded resources to meet the requirements of the training programme or curriculum** The visit team heard from the senior management team that the education facilities were underdeveloped in the Trust and needed improvement. The SMT stated that all the committees had analysed the education facilities and that there was a plan to redevelop the entire education center, with a review of the library services, increase of clinical skills training and a dedicated simulation area. The time scale for this redevelopment had not been finalised but the Trust stated that there would be confirmation by April 2016. The postgraduate medical education team stated that it was important that within the new facilities there would be a social side and area to the department. This, it was hoped, would encourage trainees to look for support and for the department to provide increased levels of pastoral care. The visit team heard from the postgraduate medical education team that there was access to e-resources on the wards and the library had a good selection of resources. The trainees confirmed this stating there was an excellent selection of reference texts and resources. The library was described as very good and the trainees stated that although they had a reading room for out of hours study, they would appreciate if the library was open for longer than 09:00 – 17:00 every day.	See Ref TWR 2.1 above.	
GMC Theme 5) Developing and implementing curricula and assessments			
TWR 5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The visit team heard that there were five separate consultants reviewing patients on the post take ward round for medicine, which although ensured consultants were always available for trainees, it meant that trainees would present patients to all consultants but would not receive feedback on their overall performance (ACATs require a minimum of 5 patients in each encounter). This was because the consultant had not seen the trainee present consistently to provide constructive feedback. The trainees were also concerned that this meant that they did not know if they were making the same mistakes, consistently. The O&G, clinical oncology and paediatric trainees stated that they received very good and consistent informal and formal feedback. The core trainees were also dissatisfied by the limited amount of time they had for clinics due to the lack of staff, which meant that they could not leave the foundation trainee unsupported on the	The Trust is required through the relevant TPDs/ LFGs to confirm that access to clinics is as per curriculum requirements. This is particularly relevant for paediatrics and core medicine.	Mandatory Requirement

	wards. The trainees stated that the ambulatory care unit had been provided as a clinic but this was not a sufficient training opportunity in comparison to proper clinics. The O&G and clinical oncology higher trainees stated that they had good access to clinics with consultant presence and the visit team heard that if a consultant was not present for a clinic in clinical oncology the consultant would run through the clinic with the higher trainee beforehand. Core trainees also stated that it could be difficult to access practical procedures because emergency medicine procedures were undertaken within the ED and then during the daytime other procedures were undertaken through interventional radiology. Out of hours, there were no interventional radiology services but the supervision levels on the wards were low, which inhibited the number of safe opportunities to perform procedures. The paediatric trainees would recommend the post for training because of the range of cases and complex pathologies. However trainees did state that 60 to 70 per cent of cases the Trust saw was primary care related (and therefore less relevant for higher training) because patients did not have access to primary care and would rather wait for six hours to be seen in the ED. There was also an issue with the access to clinics for higher trainees. This was because of the availability of consultants to support a higher trainee-led clinic and the core trainees found it difficult to attend because of the gaps in the rota and the workload this created. The London Specialty School of Paediatrics had removed the quota of 20 clinics per year for each trainee, and followed the advice of the Royal College of Paediatrics, which required as many clinics as possible. The college tutor for paediatrics stated that there was a large variety of specialty clinics for trainees to attend, but that because of the gaps in the rotas the trainees had not been able to access clinics over the winter pressures. The trainees confirmed this stating that because of the workload and that there was no allotted time in the rotas they attended the clinics in their own time. The trainees did state that the college tutor and paediatric lead were both aware and trying to amend the situation. The visit team heard that the O&G post would be recommended for training, because of the learning opportunities from different pathologies and the well-controlled yet high-risk labour ward which provided a good balance of learning opportunities. The visit team did hear that there was a problem experienced by all O&G trainees nationally that there was a shortage of acute gynaecological surgery opportunities. The college tutor stated that if there were trainees taking the advanced training specialist modules (ATSM) it limited the access of acute gynaecology theatre opportunities, however at the time of the visit there were no such trainees and as a result the theatres could be accessed by all trainees. The surgery Specialty Focused Visit report stated that the urgent gynaecology slot within the emergency operating list was impeding access to surgical training. The O&G college tutor stated that the slot could be moved but that in the interests of patient care and training a slot must remain on the emergency theatre list. This was because the slot was used to perform non-urgent elective ERPC (evacuation of retained products of conception) this could be used as excellent training opportunities for specialty training grade one trainees but it also enabled better patient care. This was because patients requiring ERCP would be very distressed and by enabling a set slot on the emergency theatre list they could be nil by mouth for theatre for only the set time and	The Trust should review the caseload in Paediatric ED especially the apparent majority of 'primary care appropriate' cases. This should form part of a QIP which can set up access to paediatric pathways with collaboration from local primary care physicians even supported by paediatricians (out-reaching).	Recommendation

	the patients knew when this would occur. The college tutor stated that previously these patients had been fasted for over 48 hours, which did not lend to good patient experience. The visit team heard that the theatre committee had met and discussed how the list could be made more efficient, with one result being that the entre theatre staff needed to be ready, with the patient on the table to improve efficiency. The visit team heard that the clinical oncology department utilised its resources well to provide a good training however, the lack of pathology made it less interesting for a higher trainee but very good experience for a core trainee. The college tutor acknowledged that there was a lack of specialist cases, such as paediatric sarcomas, however the trainees provided positive feedback on the training posts and the college tutor attributed this to trainee attendance at multi-disciplinary team meetings. The visit team unfortunately did not meet the histopathology trainee and as a result, the visit team could not triangulate the statements made by the college tutor for histopathology, nevertheless the statements were very encouraging. The visit team heard that the histopathology department, because there was only one trainee, provided one to one training between consultants and trainee. It was stated that there were good training opportunities but the Trust lacked autopsies and therefore the trainee had placements organised at other trusts to ensure there was adequate exposure. It was also stated that the trainee presented at multi-disciplinary team meetings and received good feedback.	The Trust is required to ensure that there is an allocated slot for gynaecology in the emergency theatre list.	Mandatory Requirement
TWR 5.2	**Regular, useful meetings with clinical and educational supervisors** The higher trainees stated that they met with their educational supervisors regularly and found them to be supportive approachable and meetings useful. The college tutors confirmed that they ensured there were regular meetings between trainees and education supervisors.		

Good Practice	**Contact**	**Brief for Sharing**	**Date**
The paediatric department is an exemplar for education and training and the Trust would do well to implement its good practice throughout the Trust.	DME and College Tutor for Paediatrics	Complete the good practice case study pro forma.	June 2016

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
Signed	

By the Lead Visitor on behalf of the Visiting Team:	Dr Indranil Chakravorty
Date:	13 April 2016