QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

London North West Healthcare NHS Trust Foundation

Risk-based Review (on-site visit)

Quality Review report

Date: 6 and 7 July 2016
Final Report

Developing people
for health and
healthcare

www.hee.nhs.uk

THE NHS
CONSTITUTION
the NHS belongs to us all

Quality Review details

Background to review	Following the merger of Ealing Hospital (EH) with the North West London NHS Trust, there had been significant service reconfigurations, which had affected the foundation programme. For example in a short space of time the community posts had risen from two per cent to forty-five per cent. The visit team wanted to investigate whether these new posts offered good quality training and education to foundation doctors as well as establishing whether the clinical leads in these posts were supportive. The General Medical Council National Training Survey (GMC NTS) 2015 presented red outliers for EH site in 'workload' and 'access to educational resources' for emergency medicine (EM). There were pink outliers for foundation year two (F2) medicine in 'clinical supervision' and 'feedback'; there were red outliers in foundation year one (F1) psychiatry in 'overall satisfaction' and 'adequate experience'. There were red outliers for F2 surgery in 'overall satisfaction'. For Northwick Park Hospital (NWP) the survey generated pink outliers in F2 medicine, for clinical supervision out of hours. The North Thames Foundation School requested this visit to review the quality of education and training at the Trust in light of all the changes.
Specialties / grades reviewed	The visit team met with the foundation year one and two doctors (F1 and F2) at EH and at Northwick Park Hospital (NWP) on two separate occasions. The foundation specialties that were reviewed included: medicine, surgery, emergency medicine (EM), obstetrics & gynaecology (O&G), paediatrics, general practice and community and psychiatry posts.
Number of trainees and trainers from each specialty	At the EH site the visit team met with three foundation training programme directors (FTPDs), followed by a meeting with the foundation doctors (FDs) consisting of: • Five F1 doctors in surgery • Seven F1 doctors in medicine • Seven F1 and F2 doctors from the community including those in general practice (GP) and on the old age psychiatry rotation • Two F2 doctors from cardiology and respiratory medicine • Five F2 trauma and orthopaedic (T&O) surgery doctors. The visit team also met with 11 educational and clinical supervisors (ES and CS) from the foundation programme. At NWP site the visit team met with one FTPD (there was an absence of the other FTPD and one was on long term leave). This was followed by a meeting with the FDs: • Nine medicine F1 doctors • Five surgery F1 doctors • Three community F1 doctors working in short-term assessment, rehabilitation and reablement service (STARRS) • Two general practice F2 doctors • Seven medicine F2 doctors • Two T&O surgery F2 doctors This was followed by a meeting with nine educational and clinical supervisors.

Review summary and outcomes	**Ealing Hospital** The visit team noted the following areas to be working well: • Both the F1s and F2s found EH to be a friendly environment with the opportunity for a great breadth of clinical experience at the Trust. • The FDs reported some highlights of consultant supervision. • The electronic patient register outcome (EPRO) prescribing system was reported to be effective. • There was a highly proactive postgraduate medical education (PGME) team and the F1s were complimentary of the team and the FTPDs. • There was excellence in teaching and FDs reported positive teaching experiences they received from the surgery consultants. However, the visit team uncovered a number of serious issues at the EH site and issued the Trust with three immediate mandatory requirements (IMRs) relating to the following areas: • Foundation doctors were being asked to carry out inappropriate duties due to inadequate provision for phlebotomy services on surgical wards, especially at weekends • There was no system in place to notify the clinical teams when urgent scans were declined, which could lead to patient safety risks. • There was inadequate and inconsistent middle grade cover for urology on the EH site at weekends. A urology middle grade doctor was meant to carry weekend ward rounds from NWP site but this frequently did not happen and posed a potential clinical safety concern. In addition, further improvements were required in the following areas: • There was a lack of local induction across the breadth of surgical specialties and an inappropriate distribution of junior doctors as well as a lack of weekend middle grade cover. • There was reporting of unprofessional feuding between parts of the consultant team in the urology firms. • The middle grade tier in cardiology was too stretched and there was an inconsistent timetabling of consultant ward rounds and a sporadic review of clinical decision making. • F2 doctors in O&G were left with inappropriate levels of clinical responsibility in antenatal clinics, on the postnatal ward round and in obstetrics triage. • Due to service reconfigurations there was a low acuity of gynaecology patients at EH site which meant that FDs were not receiving enough O&G experience. There was the further dictation of ultrasound reports by sonographers in the early pregnancy unit (EPU). • F2s in respiratory medicine were not properly inducted into the management of non-invasive ventilation (NIVs) and there was a variable provision of middle grade cover in respiratory medicine. • There was a lack of clinical experience and educational content in the paediatric firms. The visit team felt this could be improved with acute general paediatrics experience.

- There was a lack of consultant presence in breast surgery which impacted on the FDs and the other consultant in the department.
- There were multiple allegations of bullying and undermining behaviour by a senior emergency consultant in the emergency medicine department.

Northwick Park Hospital

On the second day of the visit the visit team reviewed the foundation programme at the NWP site. Overall the visit team found that the FDs were generally very happy and reported clinical supervision and senior support to be excellent.

However, the visit team was concerned about the impact of one particular doctor on other doctors, their work culture and how this might impact on patient safety. The visit team viewed this as a serious concern.

In addition, the following areas also required improvement:

- There needed to be a more robust phlebotomy service on the general surgical wards and T&O surgery wards, especially at weekends.
- There was an inadequate departmental induction in vascular surgery, stroke medicine and at the St Mark's Hospital posts.
- There was no continuity of junior medical handover on Friday evenings between 5pm-9pm.
- There was a potential patient safety concern when G+S samples were not processed by the haematology department as there was no feedback to clinicians.
- There was chronic understaffing in O&G, vascular surgery, and T&O which was affecting the training opportunities of FDs. It transpired that there was going to be a shortage of one FTPD due to a secondment to another Trust. The visit team felt there needed to be measures in place to replace the FTPD to ensure the training and education of FDs was not impacted.

Educational overview and progress since last visit – summary of Trust presentation

The DME gave a short presentation to the visit team at the EH site relating to the educational progress of the Trust since the last review. The areas found to be pertinent to the foundation programme were as follows:

- There was a weekly teaching programme and the department of surgery ran a weekly journal club/teaching session for FDs
- The general surgery department was strengthened with the appointment of a consultant surgeon who was also a FTPD for F1s.
- The FTPDs were diverse and represented specialties including elderly care, gastroenterology, general medicine, surgery, T&O.
- There was a keen psychiatrist leading in community psychiatry posts and with the placement of a number of FDs in such posts, this was thought to be beneficial.

On the second day of the visit, the visit team interviewed the FTPD at the NWP site. The visit team heard that the FTPD had recently come back from sabbatical and was due to be placed on secondment to another Trust in August 2016. The visit team was informed that there were meant to be three FTPDs but one was on long term leave and the other one was not present at the interview.

The FTPD provided a broad overview of the NWP site's education and training stating that:

- The creation of new community post had brought about mixed feedback but there had been no big effect at the Trust.
- Psychiatry posts were rated to be of good educational value, although FDs did not necessarily want to train as psychiatrists.

- The visit team was informed that there were a lot of in-house issues in O&G but this was not felt at the foundation level.
- The infectious diseases department was reported to have received good feedback and the lead consultant was reported to be geared towards education and training.
- The visit team heard the STARRS community posts had the potential for improvement, as currently there was more focus on hearing about patients through virtual ward rounds and there was opportunity to develop this.
- The FTPD stated generic teaching was reported to be good by the F2s.

Quality Review Team 6 July 2016			
Lead Visitor	Dr Caroline Smith Director North West Thames Foundation School	**Deputy Lead Visitor**	Dr Anthea Parry Deputy Director North West Thames Foundation School
Quality and Commissioning Representative (AM only)	Silvio Giannotta Head of Quality & Commissioning, Health Education England North West London	**Quality and Commissioning Representative (PM only)**	Lucy Wylde-Wise Quality & Performance Manager North West London
Lay Member	Ryan Jeffs Lay Member	**Scribe**	Nimo Jama Quality Support Officer.
Quality Review Team 7 July 2016			
Lead Visitor	Dr Caroline Smith Director North West Thames Foundation School	**External Clinician**	Dr Adrian Fogarty Foundation Training Programme Director, The Royal Free London NHS Foundation Trust
Quality and Commissioning Representative	Lucy Wylde-Wise Quality & Performance Manager North West London	**Scribe**	Nimo Jama Quality Support Officer.

Findings

GMC Theme 1) Learning environment and culture

Standards

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Ref	Findings	Action required? Requirement Reference Number

F1.1	**Patient safety** The visit team heard that the EH site had recently adopted an electronic-based system for the requesting of scans, which had made scan requests speedier. However, a number of FDs from the medicine and surgical rotations reported that when scans were declined by the radiology department they were not informed. The FDs reported that they would often have to spend large amount of time during their shifts checking the system to confirm whether a scan had been accepted or declined, but when they were very busy caring for patients, they did not have the time to keep re-checking the system which could mean that some urgent scans could be missed. The FDs stated that this could be improved by the radiology department informing them via a telephone call. The FDs at the NWP reported incidences of scans being declined, and at times the radiology department being obstructive when the FDs requested scans. The visit team heard that it was often a struggle to have a scan done, as the department was uncooperative and unwilling to speak with F1s especially. The visit team heard that the consultant at home was unresponsive unless a higher trainee or another consultant requested the scan. The surgical F1 doctors reported that there were times they would find out that a scan was declined when the patient had already been discharged home and they then had to call them to let them know. **Ealing Hospital** The cardiology F1 doctors reported that they found the cardiology department to be busy and stressful. There was no F2 doctor on the ward and the higher trainee was often overstretched with covering the ward and dealing with take, and therefore they felt they had to be very selective about the referrals that they made to them. The F1 doctors commented that as a result of this, they found that a lot of the work often fell on them even though they were the most junior on the wards. The visit team heard that the critical care unit, which often operated as a mini high dependency unit, (HDU) was often staffed just one F1 doctor. The visit team heard that there were consultant-led ward rounds but the consultant could arrive at any time during the day. The visit team found that the F2 doctors in the O&G rotation and on a six weeks induction attachment to NWP were left with inappropriate levels of clinical responsibility. The visit team was informed that the FDs worked with a senior person for the first two days of their attachment but due to a lack of cover, they were placed in antenatal clinics, on the postnatal ward and subsequently in the emergency gynaecology triage unit, despite being supernumerary to the service. The visit team was made aware that they were used as competent F2s within days of starting their induction. The FDs reported that they found themselves dealing with medical and obstetric problems, as well as treating patients who had presented with problems for which they had no previous experience of treating. The visit team heard the FDs had to cancel the antenatal clinic and send the patients home on the second occasion of being placed in this clinic as they did not feel confident seeing the type of patients that presented at the clinic. The visit team was informed about the absence of both a consultant and a higher trainee during this period. The visit team heard that the urology cover at the Trust was split across multiple sites and on a normal day it was covered by three consultants. On weekends the EH site was meant to be covered by a higher trainee from NWP, but the visit team heard the cover was often inconsistent. The higher trainees covering the weekend rota was good when they were available, but there were difficulties when they were not as the FDs did not know who to refer patients to. When FDs called NWP from EH site they did not receive a response, or the doctor on call did not arrive. The visit team was informed that there was a time when the rota was being covered by a locum higher trainee, but it was reported by the FDs that they found this doctor to be	Yes, see Ref. F1.1a below Yes see ref. Ref F1.1b below

	incompetent and potentially dangerous to patient safety. **Northwick Park Hospital** The visit team heard that there was no system in place to inform the clinical teams when blood samples were not processed. The visit team found that although blood samples were valid for seven days, they were not cross-correlated and the department did not inform the doctors about this. There was a potential patient safety concern when group and screen group and screen (G&S) samples were not processed by the haematology department as there was no feedback to clinicians.	Yes, see Ref. F1.1c below Yes, see Ref F1.1d
F1.2	**Serious incidents and professional duty of candour** **Ealing Hospital** The FTPDs informed the visit team there was always feedback from the reporting of serious incidents (SIs), although investigation often took a long time. The FDs at EH l reported that they were aware of the serious incidents reporting system, and filled out the Datix form as necessary. The visit team heard that the FDs received initial feedback on incidents they reported, but subsequently did not receive any feedback explaining how the incident had been resolved. The FDs at NWP Hospital did not report any problems with SIs.	
F1.3	**Appropriate level of clinical supervision** **Ealing Hospital** The visit team heard that there was good clinical supervision in emergency medicine (EM), geriatric medicine (care of the elderly), in many of the surgery firms, as well as in community psychiatry posts and in general practice posts. The visit team heard that these FDs knew at any given moment who to refer a patient to. However, supervision in cardiology, and urology was found to be poor, as was O&G with potential patient safety risks being identified. The visit team heard that there was a chronic understaffing in urology exacerbated by poor relationships with some of the consultant body in the team. The FDs in breast surgery reported that they had not seen one of the breast surgery consultants in the department for over a month after being in post. The visit team heard that all the patients were seen by the other consultant in post, and that a large proportion of the work fell on one consultant due to the absence of the other. **Northwick Park Hospital** The visit team heard that general surgery, vascular surgery and otolaryngology firms were well supervised and the consultants often provided cross-cover with the surgery departments. When not on site consultants were reportedly happy to speak with the FDs on the phone. The GP FDs informed the visit team that they had been allocated a supervisor at the start of the rotation and when they needed to escalate something there was always someone senior who was available. The FDs who were on the community rotation particularly on the short-term assessment, rehabilitation and reablement service (STARRS) rotation found themselves completing 'virtual wards rounds' on their own, although this was not common practice. The medicine F1s reported that there were times when they did not know who was covering the ward, in particular the Darwin wards, but this had improved with the streamlining of service. The visit team heard that the F1s on the acute medicine block felt supported the majority of the time in the jobs but there were times when they were not. However, the F1s conveyed that this was the reality of working of working in an acute Trust; they suspected, though, that a new F1 might initially struggle.	Yes, see Ref. F1.1b below

F1.4	**Responsibilities for patient care appropriate for stage of education and training** **Ealing Hospital** The FDs in the medicine and surgery firms reported that they often spent a large portion of their shifts taking bloods, particularly at weekends. The F1s in care of the elderly on department of medicine for older people (DMOP) stated that nurses would often help but to speed things up they often had to take bloods as well. The FDs in the surgery rotation reported that the surgery was often the least priority when it came to phlebotomy services, coupled with the fact that there was often a shortage of phlebotomists, so they would find themselves taking 30-40 bloods at some weekend shifts. **Northwick Park Hospital** The FDs interviewed reported that the provision of phlebotomy services at the Trust was haphazard. There was assistance from some of the nursing teams but this too was inconsistent and depended on each ward. The gastroenterology wards were reported to be consistent, whereas the James ward and some surgery wards (with the exception of vascular wards) were reported to be understaffed and the one phlebotomist who was on shift was often unable to complete all the requested bloods. The visit team was informed that when bloods were not done, it would create work for the next F2 doctor who would be on shift. The FDs on the old age psychiatry rotation reported having been asked to do coding for one hour each week, which they felt was an inappropriate duty for them as it was administrative-based.	Yes, see Ref. F1.4 below
F1.5	**Taking consent** There were no concerns reported with taking consent.	
F1.6	**Rotas** **Ealing Hospital** The visit team was informed that the urology department was very short-staffed and the locum higher trainee sometimes did not turn up for shifts. The visit team heard that this lack of staffing had affected the attendance of the protected educational sessions. The visit team discovered cardiology FDs were working long hours as the department was understaffed also. Similarly, it was reported by the F2 in O&G that the rota was designed for 14 doctors at F2 and higher trainee level but there were only eight covering the rota. The visit team heard that there was a variable provision of middle grade cover in respiratory medicine. A number of FDs working in the surgery firms stated they worked well beyond their rostered hours and were keen to see the introduction of diary card exercises. The visit team heard that diary card exercises had been carried out, (before the time of the visit) in the medicine firms and had been successful. The visit team heard that the surgery FDs had previously requested diary card exercise from the PGME department but they were sent to the human resources department (HR), which had appeared to be unwilling to carry out an exercise. The visit team heard that the T&O staffing levels were a major issue. The F2s informed the visit team that there used to be five full time higher trainees but at the time of the visit there were three on the rota and one locum higher trainee. When consultants were not available the higher trainee was required to cross-cover the two sites which would put a further strain on the FDs. **Northwick Park Hospital** The F2 doctors in T&O reported that the department was chronically understaffed and	Yes, see Ref 1.6 below

	at time of the visit short of three F2 doctors. As a result, the visit team heard that this was impacting on the educational and training needs of the two F2s who were unable to attend set teaching or other educational sessions. The visit team heard that this had been escalated to the educational and clinical supervisors (ESs and CSs) and the medical education manager (MEM) but there had been difficulties sourcing locums from agencies, and there had been some miscommunication between the PGME department with regards to the urgency of the locum required for shifts, because by the time agencies were approached by the PGME department, it was too late to fill the gaps. The FDs in vascular surgery stated that the consultants started the board rounds at 7.30am with the gastroenterology teams, so they had no choice but to come in early and would sometimes finish at 8.30pm. Furthermore, the visit team heard that there were a number of weeks where the FDs in vascular stayed late as there was not enough cover, as there was only one junior doctor on the rota. The visit team heard that there was a lot of animosity in gastroenterology as everyone was working late.	
F1.7	**Induction** **Ealing Hospital** There were no issues reported with Trust induction but local induction seemed to vary in quality across different specialties. The visit team heard that FDs had received an induction in general surgery and in the care of the elderly firms, but the visit team heard that the cardiology induction had been provided by another FD ; when this FD was not available the FDs were required to learn things themselves. The FDs reported a lack of induction across many surgical specialties: The FDs in urology reported that there was no time set aside for their induction into the department. The visit team heard they only were able to have a meeting with the higher trainee three weeks into their rotation, as the higher trainee had been post nights prior to this. The visit team heard that F2s in respiratory medicine were not properly inducted into the management of non-invasive ventilation (NIV). The visit team heard that NIVs were usually placed by the nursing teams, or someone more senior, and the FDs admitted that they would not know what to do if they were in a position where they had to ventilate a patient. **Northwick Park Hospital** The FDs in otolaryngology reported that their local induction had been very thorough, as was the induction for the community, psychiatry and GP posts. There were a number of FDs who reported that they had missed their local induction due to local strikes that had taken place prior to the visit. Medicine was noted to be one of the firms but the visit team was pleased to hear that the consultant in stroke medicine had been able to provide a talk to those in this rotation. There was however no induction from care of the elderly medicine to stroke medicine. The FDs in vascular surgery stated that they felt as though they had been thrust into the department and no provisions had been made to explain the workings of the department to them, and there was no communication received from the consultant or the higher trainee There was an inadequate departmental induction in vascular surgery, and in the St Mark's Hospital posts. The visit team discovered that the Trust had placed two FDs in these posts when they should not have.	Yes, see Ref. F1.7 below Yes, see Ref. F1.7 below

F1.8	**Handover** **Ealing Hospital** The visit team heard that there was a good handover system in the acute medicine take; there was consultant presence during handover and the teams were able to flag up any issues. However, the FDs reported this was less structured when the handover was given by Trust grade doctors. The cardiology F1s reported that they could be the only ones present during handover and there were times when other departments could reject patients they intended to hand over. The FDs reported that there was a formal system in place for handing over patients during the week, but it was less formal on weekends. The evening handover was reported to be variable but there were reliable systems in place, such as a Whatsapp group. The visit team heard that there was no specific handover for O&G. **Northwick Park Hospital** The visit team found that there was no continuity of junior medical handover on Friday evening between 5pm-9pm particularly in the Darwin, Dickens and 'short stay' wards. The visit team heard that there was a gap in the rota and nobody knew who to hand patients over to during this time. The visit team heard there was an inconsistent handover in respiratory medicine and heard of an occasion where patients had been lost. The visit team heard that F1s in medicine often had difficulties contacting the clinical fellow (CF) on shift as the CF was covering the EM department as well. The urology handover was reported to be lacking with the FDs stating that it was the junior doctors who went through the lists and the consultant who was covering would only accept patients after their scan images were back. The visit team heard that there was no cover in vascular from 6pm -8pm which meant handing over patients brought issues. The FD and the locum core-level doctor were both rostered to finish at 6pm.	Yes, see Ref F1.8 below Yes, see Ref F1.8 below
F1.9	**Protected time for learning and organised educational sessions** **Ealing Hospital** The visit team found that there was consistent teaching in the acute medical unit (AMU), with the FDs reporting that they benefitted from team presentations. The consultant presence in the teaching sessions was rated to be positive. The FDs also stated that there were opportunities to attend grand rounds and Schwartz rounds and these were reported to be excellent by those on the medicine rotations. The visit team found that there was no formal teaching in cardiology. **Northwick Park Hospital** There was great teaching in EM but the visit team heard this depended on where on the rota the zeros hours and night shifts fell. The FDs were able to be released from the department to attend their teaching sessions**.** The FDs in otolaryngology were encouraged to attend weekly Trust teaching and the paediatrics local teaching was reported to be very good; in addition, trainees had the ability to attend grand rounds. The F2s in medicine stated they attended back to back teaching on Tuesdays with the F1s but felt it would be more beneficial if the F2 teaching was more advanced as they had already attended many of the teaching sessions that were being given at the time of the visit as F1s. Furthermore, the F2s reported that the group was too large and they had no involvement in the teaching and would instead prefer the sessions to be smaller and more focused on their needs. The visit team heard that there was insufficient teaching in vascular surgery as few of the consultants were involved in teaching.	Yes, see Ref. F1.9 below Yes, see Ref. F1.9 below

GMC Theme 2) Educational governance and leadership

Standards

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

F2.1	**Effective, transparent and clearly understood educational governance systems and processes** **Ealing Hospital** The visit team heard that there was a local faculty group (LFG) to keep the FDs informed of the number of changes taking place at the Trust. In addition to the move of the paediatric emergency gynaecology and urology services to NWP Hospital, the visit team heard that there were plans to move the elective breast surgery services to NWP Hospital also. The visit team was informed that in addition to the regular LFGs FDs were informed of changes via email.	

GMC Theme 3) Supporting learners

Standards

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

F3.1	**Behaviour that undermines professional confidence, performance or self-esteem** **Ealing Hospital** On the whole, the F1 and F2 doctors interviewed reported that the Trust was supportive and that they found the majority of their consultants to be affable and approachable. The FDs in urology reported that although they themselves did not directly experience it there was unprofessional feuding between parts of the consultant team in the urology department where they had witnessed infighting in the department and shouting in the multidisciplinary (MDT) meetings. The visit team heard that F2 doctors who had been on the EM rotation had felt undermined by a senior consultant who had shouted at them on two occasions in the treatment area, in front of a number of staff, including medical and nursing teams. The FDs informed the visit team that they had received advice from a number of staff who had also been subjected to similar behavior from the same consultant, so they had been reluctant to report this formally because they had been advised that this would lead to negative repercussions for them in the short and long term. **Northwick Park Hospital** A number of F1s reported experiencing very difficult relationships with another FD who was on rotation in otolaryngology at the time of the visit. The visit team heard that there was a very negative atmosphere in the department which impacted the whole team. Other F1s reported being shouted at across the Trust corridors and witnessing instances where their colleagues were reduced to tears by the behaviour of the individual concerned. The visit team heard that measures had been put in place in otolaryngology to give	Yes, see Ref. F3.1

	individual jobs to the F1s to ensure that there were no frictions, but this had not led to much improvement. Furthermore, the visit team heard the other F1s were concerned about the competence of this particular doctor and felt this might lead to potential patient safety concerns. The FDs reported cases of some bullying from sisters in surgery but stated they felt uncomfortable putting this in writing and pursuing it through HR. The FDs reported that higher trainees had had the same experiences but they had learnt to ignore it. The FDs stated that due to difficulties in relationships patient care could have been potentially affected.	
F3.2	**Academic opportunities** **Ealing Hospital** The FDs reported that they found it difficult to apply for audits, as there was a formal application process and if they succeeded there were difficulties attaining clinical notes. An FD reported that despite applying for an audit through formal channels, they had received late notification from the PGME regarding the decision.	
F3.3	**Regular, constructive and meaningful feedback** The FDs reported that they usually received feedback from their CS regarding their training at the beginning and at the end of their rotation.	
GMC Theme 4) Supporting educators		
Standards **S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.** **S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.**		
F4.1	**Sufficient time in educators' job plans to meet educational responsibilities** **Northwick Park Hospital** The visit team found that there was one FTPD who was on long-term sabbatical leave and one FTPD who was to be placed on secondment to another Trust. Considering the large numbers of FDs, the visit team felt that the remaining FTPD would need assistance.	Yes, see Ref. F4.1
GMC Theme 5) Developing and implementing curricula and assessments		
Standards **S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.** **S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good Medical Practice and to achieve the learning outcomes required by their curriculum.**		
F5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** **Ealing Hospital** The visit team hard that there was good experience in EM but that O&G and paediatric experience was less than ideal at the EH site. O&G was reported to be disappointing as there were no post-operative procedures for FDs to be exposed to. The visit team also heard that sonographers were in control of scanning sessions, so the FDs missed out on receiving experience here as well as well as there being occasions when FDs were being asked to type up ultrasound reports that sonographers had performed.	Yes, see Ref. F5.1

	The paediatic FDs reported that since the closure of the paediatric emergency department, experience in this area had been lacking. The F2s in surgery in reported that they had dedicated theatre time, occurring every fifth day, during which they could follow the patient's treatment pathway. However, they reported that they were unable to attend clinics, or were attending minimally when they had time. The visit team heard that there was no access to elective cases at the EH site. Some of the FDs who had been on the T&O rotations reported having only attended theatres once. There was a good variety of procedures to be learnt in the acute medical unit but practical procedures were found to be lacking in medicine. **Northwick Park Hospital** Surgical F1s (those in general surgery, vascular and otolaryngology) stated there were three F1s covering six consultants, due to the removal of some FDs, which meant there was not enough time for them to go to theatre. The FDs in vascular received teaching from the higher trainee but would have preferred more clinical teaching. The visit team heard the new community psychotherapy posts (community adult mental health CAMHS) needed to provide a broader experience to FDs. The FDs reported that they felt there was a great deal of politics in the department which hindered their learning experience as the psychotherapists would often express preference for the trainee psychotherapists, and they would not be exposed as to many cases as they would have liked. Furthermore, they felt there was no understanding of their role as FD by the psychiatrists with whom they worked and stated that they almost felt like medical students.	Yes, see Ref. F5.1

Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
F1.1a	**Ealing Hospital site** Radiology: Electronic requesting When urgent/important scans are declined, there is no robust mechanism for notifying the clinical teams. The Trust is required to place robust mechanism of notification to the clinical requesting team.	The Trust is required to provide plan of action within five days.	R1.9
F1.1c	**Ealing Hospital site** There is inadequate and inconsistent middle grade cover for urology on the Ealing site at weekends. A urology middle grade is meant to do daily weekend days ward rounds from Northwick Park. This frequently does not happen and poses a potential clinical safety concern. An immediate provision of a urology middle grade rota showing which middle-grade will attend the Ealing site for daily weekend ward rounds.	The Trust is required to provide plan of action within five days.	R1.1

F1.4	**Ealing Hospital site** Foundation doctors are being asked to carry out inappropriate duties. There is an inadequate provision for phlebotomy services on surgical wards especially at weekends.	The Trust is required to provide plan of action within five days.	R1.1

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
F1.1b	**Ealing Hospital and Northwick Park Hospital** Trust to draft standard operating procedures for all wards/departments affected, outlining who is responsible for clinical supervision and how this will be ensured. Trust to conduct audit of FDs to test how often they are left without adequate supervision. FDs to be assigned a timetable covering their shift, which outlines who is responsible for their clinical supervision at all times, and the contact number for each. Trust to ensure that FDs are receiving adequate middle grade support, including daily ward rounds and cross cover arrangements for when team members are absent. Consultants must do daily post-take ward rounds.	The Trust is required to provide confirmation that clinical supervision has improved, including evidence of standard operating procedures and outcome of audit of FDs. The Trust is required to ensure that this is added as a standard item on the LFG agenda and provide minutes which should evidence that this issue is regularly being discussed, and appropriate action taken whenever there are deficiencies.	R2.11
F1.1d	There is a potential patient safety concern when G&S samples are not processed. There is no feedback to clinicians. The Trust is required to review the system for processing G&S samples. The system should be made more robust including ensuring that feedback is given to clinicians.	The Trust is required to provide outcome of review including any plans to strengthen this process.	R1.1
F1.6	**Ealing Hospital and Northwick Park Hospital** The Trust should make appropriate plans to fill any foreseeable rota gaps. Trust to revise rota(s) in view of the FD feedback discussed at this visit. Trust to diary card FDs. FD Reps to encourage and remind colleagues to participate in diary carding.	The Trust is required to provide the HR policy for filling rota gaps. Clinical director to provide plan of action for recruiting to current gaps. The Trust is required to provide outcome of diary card exercises.	R1.12
F1.7	The Trust is required to strengthen local induction in the following firms: **Ealing Hospital:** cardiology, urology and	The Trust is required to supply induction timetable, agenda, register and summary of feedback to FS.	R1.13

	respiratory medicine **Northwick Park Hospital:** stroke medicine and vascular surgery **All St Mark's Hospital foundation posts** Departmental induction must be provided for any FD starting any post at any time of year. The departmental inductions developed must be sustainable, of high quality and must include: • orientation and introductions • details of rotas and working patterns • clinical protocols		
F1.8	**Ealing Hospital and Northwick Park Hospital** Trust to ensure that handover is robust and consultant-led. Trust to create standard operating procedures for handover sessions. Trust to implement set times for handover.	The Trust is required to provide standard operating procedures document, handover templates, register of attendance at handover. The Trust is required to ensure that this is added as a standard item on the LFG agenda and provide minutes which should evidence that this issue is regularly being discussed, and appropriate action taken whenever there are deficiencies.	R1.14
F1.9	**Ealing Hospital and Northwick Park Hospital** The Trust should organise formal departmental teaching for FDs in **every specialty.** The Trust should review the content of the sessions offered as part of the F2 teaching programme at NWP. The programme needs to both cover the competences and be integrated in a clinical programme of teaching that fully engages the F2Ds. FDs to receive three hours of teaching per week. One hour is generic foundation teaching, the other two should be at departmental level.	The Trust is required to provide confirmation of departmental teaching arrangements, an audit of teaching received and a summary of FD feedback.	R1.16
F3.1	**Northwick Park Hospital** There is a foundation doctor currently working in the ENT team who is having such a negative impact on the other F1s in the team that they feel it is undermining behaviour and negatively impacting on their training. The Trust is required to ensure that an appropriate action is put in place with immediate effect, to support all the foundation doctor individuals concerned. Appropriate close clinical supervision, investigation and intervention may be necessary.	The Trust is required to provide the Trust's plans to address this issue and ensure non-prejudicial support for the individual foundation doctors concerned.	R3.3

F4.1	**Northwick Park Hospital** The PGME is required to organise adequate cover to ensure that the remaining FTPD is supported and can adequately carry out all responsibilities.	The Trust is required to provide a plan of how this additional support will be provided and this should be a standing item on the agenda of the LFG until all three FTPDs are back in post. This is to ensure on-going monitoring.	R1.7
F5.1	**Ealing Hospital and Northwick Park Hospital** LEP to undertake audit of opportunities to perform practical procedures. LEP to consider and implement measures to augment the experience offered by the current post, and submit report detailing what has been done and provide evidence that the issues highlighted have been rectified.	The Trust is required to provide detailed plan of action explaining how the Trust intends to address the deficiencies in this area, including timeframe involved.	R5.9

Signed	
By the Lead Visitor on behalf of the Visiting Team:	Dr Caroline Smith
Date:	23 August 2016