QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

The Royal Marsden NHS Foundation Trust
Paediatrics
Risk-based Review (on-site visit)

Quality Review report

Date: 19 July 2016
Version (if required): 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	The Royal Marsden NHS Foundation Trust is a specialist cancer hospital with two main sites: one in Fulham and another in Sutton. The latter is the location of the paediatric department, which does not have a paediatric intensive care unit (PICU). The paediatric department was last visited in May 2013 and at the time of the Risk-based Review in 2016, there were no outstanding items open on the Trust's action plan resulting from that visit. At the last visit, there was an apprehension regarding the complexity of the patients and whether this was appropriate to the specialty training year three (ST3) trainees. There were also issues concerning induction and service commitments in combination with gaps in the rota that limited the ability of trainees to access teaching and training sessions. In 2013, the visit team also found that trainees received good clinical supervision and support, but that this could vary considerably, depending on the consultant. The Risk-based Review was needed to ensure that these issues were not recurrent and intransigent. The General Medical Council National Training Survey (GMC NTS) for 2016 produced four red outliers in 'overall satisfaction', 'clinical supervision', 'adequate experience,' and 'access to educational resources'. This was double the number of red outliers from 2015. The GMC NTS 2016 also produced a pink outlier in 'feedback'. The London School of Paediatrics survey 2016 also produced very unfavourable results, which corroborated the GMC NTS findings. A patient safety concern was also raised through the GMC NTS regarding trainees consenting for procedures that they were not going to undertake, such as central lines and anaesthesia for magnetic resonance imaging (MRI) scans. The visit team felt it prudent to review the training environment and analyse why the department's results had deteriorated and ensure the patient safety concern had been resolved. The visit team also wanted to address the interaction of private patients with trainees and how this affected training and education, access to teaching, the cover and support trainees received out of hours (OOH) and the ease for trainees to attain sign-off on workplace-based assessments (WPBAs).
Number of trainees and trainers from each specialty	The visit team met with the senior management team which included: the chief operating officer, the chief nurse, the medical director, the director of medical education, the director for workforce and the chief finance officer. This was followed by a session with the college tutor and the lead nurse for the paediatric department, a session with the majority of the paediatric trainees and the last session comprised of meeting two other consultants and the college tutor.
Review summary and outcomes	The visit team would like to thank all those who attended and the post-graduate medical education team for their collaboration in organising the reviews. The visit team found that the training environment provided a very good case mix and rare pathologies that allowed sufficient exposure and training opportunities, especially for level three paediatric trainees. Unfortunately the apprehension surrounding the ST3 trainee role within the department remained. The visit team was concerned with the roles the ST3 trainees were undertaking without an adequate level of support and awareness from the department of their competence levels and limitations. The levels of clinical supervision were also variable across the consultant body; although all consultants were approachable and accessible via telephone, the physical, direct clinical supervision that was provided by the consultants varied greatly. This led the level one trainees to rely on the level three trainees for guidance and supervision. The visit team suggested that a policy should be created that set a

	standard for the level of direct clinical supervision that consultants should provide in and out of hours. The visit team was disappointed to find that the culture of education and training was lacking within the department. Excellent teaching and training opportunities, such as the twice weekly multi-disciplinary team (MDTs) meetings and consultant-led ward rounds were not optimised for learning and took on what was perceived as a 'business-like approach'. The visit team found that the responsibility of education and training was placed on the trainees and the majority of consultants were not as engaged in the process as is now expected. However, this was not the case for all consultants with Dr Chisholm, Dr Marshal and Dr Taj all being highlighted by the trainees for providing very good clinical supervision and proactively identifying training opportunities. The lack of a culture of education and training curtailed the optimisation of the training environment, but this was further impeded by the serious issues with the rota. The gaps on the rota, combined with a high workload ensured that trainees were not only working high volumes of night shifts, impacting on their day time training by the number of zero days they had to take, but were also unable to attend teaching or clinical sessions. The rota gaps also ensured the trainee representative had not attended any of the local faculty group meetings and had not been provided with or sign-posted to any of the information regarding the role of the trainee representative. The visit team found that there had been issues regarding the Trust induction because of the junior doctors' strikes, and although the local induction was diligently given by the department, the content and the information booklet could be edited to ensure trainees were better sign-posted to the opportunities available. The visit team was informed of robust governance systems in place for serious incidents and of levels of feedback. However, the visit team felt that more could be done to incorporate serious incidents in teaching and develop learning from this. The visit team noted excellent practice with the use of a psychologist who provided pastoral support and care for trainees after distressing cases and led on debriefing sessions. The visit team was pleased to find that the GMC NTS patient safety concern regarding consenting for central lines had ceased. However, trainees were still taking consent for general anaesthetic procedures that they were not going to be undertaking, such as magnetic resonance imaging scans (MRI) and metaiodobenzylguanidine scans (MIBGs). This practice needed to cease immediately and an Immediate Mandatory Requirement (IMR) was issued to the Trust on the day to ensure this would be resolved within five days of the review. Overall, the visit team found a department that had the potential to provide excellent training within a specialist environment. However, the lack of engagement from the consultant body and the rota gaps inhibited the full development of this training environment.

Quality Review Team			
Lead Visitor	Dr Atefa Hossain, Consultant Paediatrician	**Lead Provider Representative**	Dr Kumudini Gomez, Consultant Paediatrician
Trust Liaison Dean / County Dean	Dr Chandi Vellodi, Trust Liaison Dean	**Trainee Representative**	Dr Tatiana Hyde, Trainee Representative
Lay Member	Robert Hawker, Lay Representative	**Scribe**	Lizzie Cannon, Learning Environment Quality Coordinator

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
P1.1	**Patient safety** The visit team heard that the trainees were no longer consenting for surgical procedures that were undertaken by the surgeons. Although the surgeons were still not taking formal consent for these procedures either and it was left to the paediatric consultant or specialist doctors to undertake instead. The trainees stated that there were two discrete consent forms for bone marrow and lumber punctures, which they could consent for, as this was within their competencies. The visit team were assured that trainees did not consent for new chemotherapy treatment; this was the remit of the consultants. An IMR was issued because trainees were still providing the written consent for the scans requiring anaesthesia such as MRI and MIBGs, which they were not going to undertake, even though the visit team heard that the anaesthetist was there and took verbal consent from the patient's guardian/s. The trainees stated that they took consent for other procedures such as lumbar punctures. However, this was acceptable as the trainees then undertook these procedures. The visit team did not hear of any direct safety concerns from any of the attendees at the Risk-based Review for paediatrics. Even with the major rota gaps, all members of staff were contributing and working together to ensure patient safety; yet this was at the detriment to a work-life balance. The visit team was concerned that this was not sustainable.	Yes, see below P1.1
P1.2	**Serious incidents and professional duty of candour** The visit team was informed by the college tutor that the Trust had a robust serious incident reporting system that was well-managed by the risk assessment team. The paediatric department reviewed any serious untoward incidents and Datix reports at the monthly operational departmental meeting and these findings would then be shared with the rest of the department. If a trainee was involved then they would be debriefed immediately and these sessions would be led by a psychologist. The visit team heard that the DME was emailed all the serious incidents involving a trainee and would personally email the trainee. There were also arrangements to email the educational supervisor if the DME was away. The visit team was also informed that if the incident went to a panel, then another trainee was also on the panel to sense check the panels' decision and provide a trainee perspective. The trainees stated that the system was robust and feedback was efficient, with a monthly newsletter too. However, there was no impetus by the department to incorporate serious incidents into teaching or learning events.	Yes, see TWR report TWR1.1

P1.3	**Appropriate level of clinical supervision** The visit team was concerned that consultant clinical supervision was not prioritised within the department and that this was demonstrated through the consultants not cancelling their clinics when they were attending for the week; where they were the designated consultant to provide clinical supervision to the trainees. The visit team heard that this was because the clinics were exceptionally overbooked and with the department needing an additional two consultants, it was felt the clinics could not be cancelled or covered. However, the trainees stated that the consultants were approachable and always accessible via the phone, although there was a variation between the consultants as to the level of direct clinical supervision which the trainees received. The visit team was disappointed to find a lack of awareness among some of the consultants regarding the necessary levels of supervision and support they should be directly providing to trainees at different levels of their training. Consultants should be aware of the competence levels and lack of experience a level one paediatric trainee possesses and should alter the level of supervision they provide to a level one trainee in comparison to a level three trainee. This was a salient issue regarding the ST3 trainees while working OOH, in light of the complex cases within the department this should be reviewed. The college tutor stated that the drug development fellows worked only at weekends and although they were not formally trained in clinical supervision, they were expected to provide clinical supervision to the trainees, as they were at a sub-consultant level. The college tutor did concede that the department should look at formally placing the drug development fellows on a clinical supervision course. The trainees stated that there were supposed to be speciality doctors on the wards, but the rota was so stretched that it was common for trainees to be the most senior doctor on the ward with one advanced nurse practitioner (ANP). This was also the case for ST3 trainees. The visit team heard from the college tutor that OOH there was a trainee within the department supported by an anaesthetic higher-training grade (or Trust-grade equivalent) and the consultant, who was non-resident and stayed at home, but was happy to receive phone calls and would attend the Sutton site if needed. The trainees confirmed that this was the case but that there was reluctance among some consultants to come in to support the trainees directly. Trainees reported that one consultant in particular was reluctant to provide direct clinical supervision while providing OOH on call supervision. The visit team heard that during the weekends, the consultants had to undertake consultant ward rounds at St George's University Hospital NHS Foundation Trust and then one at the Sutton site. The visit team heard that because of this consultant supervision was sparse on the weekends; this was supposed to be ameliorated by the presence of the clinical fellows who were close to consultant level. The trainees stated that the clinical fellows were very good, but would appreciate more consultant contact time, not just for supervision but also to access informal teaching and training opportunities.	Yes, see below P1.3
P1.4	**Responsibilities for patient care appropriate for stage of education and training** The visit team was concerned that the ST3 trainees, who were level one paediatric trainees were operating at a level three paediatric trainee level and that this was not only potentially unsafe, if unsupported, but also incredibly stressful for the trainees, which could undermine their professional confidence. The level three trainees the visit team met agreed that it was a very testing training post for an ST3, which had been made worse by the gaps in the rota and the lack of support and supervision that the level three trainees could provide. There were times when they felt they were operating outside of their competence, sometimes with little direct support from the consultants. However, the ST3 trainees stated that because the post was so challenging it provided	Yes, see below P1.4

	a good experience of preparing them to step up to a level two paediatric trainee. They also stated that because there were very few, if any, acute admissions at night, the workload OOH was light in comparison to the day time, which allowed them to lead clinically and manage the department. The visit team heard that the trainees did not undertake OOH duties until after three weeks of starting in the department. On the other hand, it was reported that there had been nights where the ST3 had been the most experienced doctor within the department OOH and the consultant support had been lacking; this had led to the ST3 trainees experiencing very stressful situations, which were outside of their level of competency.	
P1.5	**Rotas** The visit team was informed that the gaps within the rotas were severely impacting the ability of the department to provide education and training. Trainees' rotas were down by 2.4 whole time equivalent (WTE) posts but that the need for two new consultant posts had been identified and was being addressed and there were also nursing shortages within the department. The visit team was informed that the GMC ILTS requirements had slowed down the recruitment of overseas doctors being employed at the Trust, but that one MTI post would be filled by September 2016. The college tutor stated that the department had tried to fill the gaps in the trainee rota with locums OOH but that they had failed, not only to recruit any locums but also to have a single applicant. It was assumed that this was because of the location of the Sutton site, but also because locums would not be as comfortable working within a specialist, oncology environment. There were easier, general paediatric locum shifts available in central London, which were far more attractive. As a result, the department had utilised clinical fellows on night and also conceded that the trainees had undertaken a lot of night shifts. During the day time, the college tutor stated that the department filled the gaps with either locums, drug development fellows or advanced nurse practitioners (ANPs). The trainees stated that although they valued and appreciated the ANPs, there needed to be a review of the skill mix within the department, to optimise the influence of the ANPs. The visit team heard that there were limitations of the ANP role, with reduced prescribing; not being able to attend theatre and reduced clinical decision-making meant they were not an adequate replacement for a doctor. If placed with a level one trainee (ST3) then this placed a lot of pressure on the latter to make clinical decisions. The lead nurse for the department stated that the purpose of the ANPs were to complement the working of the doctors, not to replace them and that more emphasis needed to be placed on the ANPs' expertise and how this could benefit the trainees. The visit team heard from the college tutor that on the weekends the trainees worked short days from 8.30amto 3.30pm. The trainees confirmed this and reported that the clinical fellows were very supportive of the trainees leaving on time. The visit team heard that there were long-day shifts for the weekdays with pools of nights from Monday to Thursday and then Friday to Monday morning. The visit team heard that there was a set rota coordinator to manage the paediatric rota, but that one of the ST6 trainees was managing most of the gaps and making changes to ensure that shifts were adequately covered. The trainee stated that they had volunteered to do this and were happy to do so. However, it was very time-consuming. The visit team was concerned that once the trainees rotated, the rota organisation would deteriorate and the changes would not be as effectively communicated to trainees.	Yes, see below P1.5a Yes, see below P1.5b
P1.6	**Induction** The college tutor stated that the Trust induction alternated between the Fulham and Sutton sites for different years. However, the DME stated that they had ensured that there was a Trust induction specifically on the Sutton site. This was supposed to be held in the first week of the trainees' inception for two days and would be followed by three days of local induction where trainees would receive training in different protocols and guidelines. However, the trainees stated that because of the junior doctors' strikes the inductions were missed and were not caught up with properly. However, all trainees received their identification badges and computer logins in a timely fashion.	Yes, see below P1.6

	There was unanimous agreement amongst the attendees that the induction booklet had become increasingly bulky and the salient issues were lost. The college tutor stated that it needed streamlining. The visit team would also like to see improved sign-posting to educational sessions, teaching and resource available at the Trust. The DME stated that the Sutton site had the larger library resources with the Institute for Cancer Research (ICR) library and the Marcus library on site. The college tutor stated that there were also good online resources and journals that the trainees could access. However, the trainees were not aware of the resources and stated that these had not been sign-posted in their induction. The trainees also stated that they would appreciate being informed at inception of the role and requirement of the trainee when preparing for the MDTs.	
P1.7	**Handover** The trainees stated that the handover processes were robust. The evening handover involved all the hospital at night team including the higher trainee (or equivalent Trust-grade) anaesthetist. The trainees stated that the consultants were present for the morning handover and afternoon handover; depending on the consultant they could also be present for the evening handover. The consultants stated that this was because there was limited time and as the afternoon handover could finish by 3pm, they did not see the relevance of attending the evening handover, so shortly after.	
P1.8	**Protected time for learning and organised educational sessions** The visit team found that there was a large disconnect between the consultants and trainees regarding training opportunities within the department. The college tutor stated that there was departmental teaching on Tuesday afternoons (3.30 -4.30pm), including a journal club and clinical governance. A solid tumour MDT took place on a Thursday afternoon. The college tutor was aware that for the former it had been difficult for trainees to attend because of the rota. For the latter, the trainees' working hours were extended to 6pm to ensure that the trainees felt that they could stay. The MDT involved radiologists and was seen by the consultants as an excellent opportunity for trainees to learn. The visit team also heard that there was a multi-professional MDT on Tuesday afternoons (2.30–3.30pm) which also involved a psychologist, and a quality clinical forum where trainees could present and have opportunities for case based discussions (CBD). The consultants perceived that trainees were either not aware of these opportunities or unaware that they were opportunities for teaching, and just needed sign-posting to trainees. However, the visit team learned that the trainees were aware of these sessions but not able to attend because of the number of zero days, due to nights or the high workload on the wards. When they were able to attend teaching they were frequently called out of the teaching session to attend to service demands. The trainees stated that attending formal teaching on Thursday mornings, which was not bleep free, was difficult to attend when in day care, where there was a lot of pressure to prepare the patients for theatre so that the theatre lists could run to time. This was made worse by the lack of staff in the day care unit with only one clinical fellow and one trainee, which meant that trainees had to miss teaching to clerk patients. The trainees stated that when on the ward; attending teaching was easier because the trainee would delay the ward round. However, if the trainee was carrying the phone, they had to answer it. The trainees recognised that the MDTs could be great learning opportunities but that they could very rarely attend as the time was not protected and when they did attend it was to read out and discuss case lists that they had prepared. The trainees stated that the MDT was service-focused as were the consultant led ward rounds, which left little time for learning. The visit team also heard that when trainees had tried to discuss cases in the MDT they had been interrupted or ignored, leading them to not feel like valued members of the discussion.	Yes, see below P1.8
P1.9	**Access to simulation-based training opportunities**	

	The college tutor stated that the potential reason for the red outlier in 'access to educational resources' in the GMC NTS 2016 was because the simulation and educational facilities were located on the Fulham site and not the Sutton site. The lead nurse stated that there were annual simulation days at the Sutton site, held three times per year, but that the day-to-day simulation remained at the Fulham site.	Yes, see TWR report, TWR3.2
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.**		
P2.1	**Effective, transparent and clearly understood educational governance systems and processes** The DME stated that the majority of departments within the Trust now had well-established and attended local faculty groups (LFGs) with all trainees encouraged to attend. This was at odds with the situation within the paediatric department. The college tutor conceded that the department's LFG was held in an ad hoc fashion and was not formalised, but the trainee representative was invited to attend. The visit team heard that there was a consultant meeting held every week and once a month the trainee representative was invited to attend. The visit team was also told about a monthly operational group meeting that discussed the joint service between St George's University Hospital NHS Foundation Trust and the paediatric department at the Trust. Unfortunately, the visit team found that the trainee representative had not been able to attend any of the meetings because of the workload and rota issues. This lack of attendance had been compounded by the lack of information and direction that the department had given to the trainee representative, which clarified the role within the department. The trainees also stated that any trainee fora to discuss training issues were sporadic and due to rota and workload issues there was little opportunity to attend other conduits for feedback.	Yes, see below P2.1
P2.2	**Impact of service design on learners** The visit team heard that the workload had increased a lot and that this had not been helped by the need for two additional consultants. The college tutor informed the visit team that as part of the Trust's sustainability plan they had requested two more consultant appointments. The visit team heard that there was no distinction between private and NHS patients for paediatrics. The department rarely had private patients and when they did the department followed the Trust protocols to ensure that trainees were only benefitting educationally from those patients and not undertaking continuous routine care. The visit team was assured that the paediatric department did not have the same issues relating to training and education regarding private patients as within adult medicine and surgery.	
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.**		

P3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The visit team was very impressed to hear that a psychologist led the debrief meetings as soon as an event had occurred and that there were robust bereavement support services available for the trainees. Every Tuesday there were onsite sessions with a psychologist for trainees to access; this is excellent practice.	
P3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The visit team did not hear of any incidences of bullying and undermining behaviour within the paediatric department. However, the trainees did not always feel that they were valued or that their education and training needs were recognised.	
P3.3	**Access to study leave** The visit team was assured that the trainees were still able to take their annual leave and were provided with adequate study leave. The visit team found that trainees were indeed able to receive annual leave and the rota coordinator worked extremely hard to ensure that the rota was staffed to allow trainees to take study leave. However, the trainees were reticent about applying for study leave, knowing that this would leave their fellow colleagues stretched across the rota.	

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.

P4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The DME confirmed that the Trust was 100 per cent compliant with the GMC trainer compliance requirements and there was in-house training for educational and clinical supervisors to maintain this. The consultants confirmed this, and stated that the training was good. The senior management team stated that job planning was an on-going issue, but that in the future education would play a major role within the job plans of consultants and would be included in the regular appraisal process. The Trust had also recently appointed an appraisal lead, who reported to the medical director and worked with the DME to implement high quality appraisals. The college tutor stated that they received a separate educational appraisal for the college tutor role but that other educational supervisors did not. The consultants confirmed that they received 0.25 programmed activities (PAs) per trainee for educational supervision. However, the consultants did state that due to their workload and the service commitments, the job plan did not have an adequate allocation for all of the consultants' responsibilities; they regularly worked over their PAs.	

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.**		
P5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The visit team found that the gaps in the rota and the workload of the department were severely inhibiting the trainees' ability to access training opportunities. Trainees reported that, despite the posts offering good training opportunities, the culture within the department meant that trainees were not able to benefit from the training opportunities available. However, the trainees would recommend the training posts, although there were reservations regarding the ST3 training posts, in a specialist environment. The college tutor conceded that the gaps in the rota had meant that the trainees were not able to have the one-in-eight clinic weeks where trainees were able to attend a plethora of clinics and eventually see patients independently. The trainees confirmed that they had not been able to attend the clinic week because of the rota gaps and the service commitments within the department. The college tutor was aware that the trainees were finding it difficult to receive sign-off on WPBAs by consultants and that more needed to be done on the consultant ward rounds to ensure that trainees had opportunities to complete assessments. However, the consultants were not aware of these difficulties and perceived themselves to be very accommodating to trainees, but also stated that it was the trainees' responsibility to organise and identify training opportunities for WPBAs. They did concede though that while in clinics it was difficult to fit in time to discuss patients with trainees and sign assessments. The trainees stated that there were a few consultants who were proactive and supportive in helping trainees to achieve sign-off on WPBAs, but in general, it was difficult and sign-off was delayed. The trainees reflected the college tutor's sentiment regarding the consultant ward rounds stating that there were very few opportunities to discuss patients with consultants as the ward rounds were run in a business-like manner. The visit team also found that although the consultants were contactable via phone there was limited time where the consultant and trainee were directly together and as a result, the trainees stated that it was difficult to attain sign-off on observed procedures. Some trainees stated that the best method to ensure CBDs with consultants was to book a meeting with the consultant. The trainees also stated that when they were able to attend clinic it was a very good opportunity for WBPAs because it was the only time they had one on one consultant contact time.	Yes, see below P5.1
P5.2	**Regular, useful meetings with clinical and educational supervisors** The trainees confirmed that they had received the standard number of meetings with their education supervisor.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The accessibility of a psychologist to provide pastoral support to trainees is excellent.	Dr G Wares	Please complete the good practice case study.	September 2016

Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
P1.1	Trainees are consenting for general anaesthetics procedures such as MRIs and MIBGs that they are not undertaking. This is outside of the trainees remit. The Trust is required to ensure that this practice ceases immediately.	The Trust is required to ensure that within five days of the Risk-based Review that trainees are no longer consenting for general anaesthetics procedures such as MRIs and MIBGs that they are not undertaking. The Trust is required to provide evidence and confirmation that this practice has stopped.	R1.9

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
P1.3	The Trust is required to review the level of direct clinical supervision provided to trainees in and out of hours ensuring that trainees are provided with adequate levels of supervision to match their level of training and that clinical supervisors are trained appropriately. The Trust is required to formulate a standard protocol that outlines the expected levels of direct and indirect clinical supervision the consultants will provide and that this is then adhered to by all, to eliminate inconsistency amongst the consultant body.	The Trust is required to provide the outcome of the review, which details how direct clinical supervision will be provided to the different levels of trainees in and out of hours and the standard protocol for consultant clinical supervision, direct and indirect. This should be corroborated with minutes from the LFG meetings, which demonstrate that trainees feel adequately supervised and well supported in and out of hours (OOH) over a three month period. Please provide a list of all the trained clinical supervisors within the department responsible for clinical supervision including the drug development fellows.	R1.8
P1.4	The Trust is required to review the role of the ST3 trainee within the department and ensure that they are not undertaking roles that are beyond their competence levels. This review should also analyse the position of ST3 trainees providing cover OOH. This review should be shared with the London School of Paediatrics.	The Trust is required to provide the outcome of the review and provide LFG minutes of ST3 trainee feedback that demonstrates that they are happy with their role within the department and do not feel they are operating outside of their competencies.	R1.9
P1.5a	The Trust is required to review the skill-mix and staffing within the department and the models of working to ensure that the effect of rota gaps is ameliorated in the most effective way.	The Trust is required to provide the result of the review, an update on the recruitment to the department and the LFG minutes, which ensure that rota gaps are being addressed. Please provide results of a diary card exercise to demonstrate that trainees are not working outside of the European Working Time Directive.	R1.12
P1.6	The Trust is required to edit and streamline the induction booklet and ensure that this sign-posts trainees to educational	The Trust is required to provide the new induction booklet, the induction programme and LFG minutes which	R1.13

	resources and opportunities.	provide trainee feedback that their induction was satisfactory.	
P1.8	The Trust is required to ensure that the department increases the focus of education and training within the department and provides more protected educational and teaching sessions for trainees to access. This should include educational focus for consultant ward rounds, the MDTs, and ensure that teaching is bleep free and trainees are able to attend these opportunities regularly.	The quality of the training provided must be a standing item on the LFG agenda. The Trust is also required to provide LFG minutes which demonstrate that trainees are able to access teaching opportunities and that they are educationally valuable. The Trust is required to provide the attendance lists for teaching sessions and MDT meetings.	R1.15
P2.1	The Trust is required to ensure that there are regular LFGs (held every three months) with trainee and consultant attendance. The role of the trainee representative should be clarified and all new trainee representatives are aware of their responsibilities and have adequate time to meet these.	The Trust is required to provide the LFG minutes and attendance registers of the LFGs for the next four LFGs. These minutes should also include a plan of action for all issues raised and demonstrate solutions being implemented with trainee involvement.	R2.7
P5.1	The Trust is required to ensure that trainees receive adequate opportunities for WPBAs and that these are signed off in a timely manner.	The Trust is required to provide the minutes from the LFG which demonstrate that trainees are able to get adequate opportunities and timely sign-off on WPBAs.	R5.9

Recommendations

Req. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
P1.5b	It is recommended that the department ensures there is succession planning for the rota organisation for when the trainee responsible leaves.	It is recommended that the Trust provides an update on the rota coordination role and how this will be covered when trainees rotate.	R1.12

Other Actions (including actions to be taken by Health Education England)

Requirement	Responsibility
N/A	

Signed

By the Lead Visitor on behalf of the Visiting Team:	Dr Atefa Hossain, Consultant Paediatrician
Date:	19 August 2016