QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

West London Mental Health NHS Trust

Multi-professional Review (on-site visit)

Quality Review report

Date: 20 October 2016

Version (if required): Final report

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Quality Review details

Background to review	Significant concerns were raised following the release of the results of the 2016 GMC National Training Survey (NTS), and Health Education England North West London (HEE NWL) took the decision to undertake a multi-professional review of West London Mental Health NHS Trust (WLMHT). The Trust returned nine red outliers overall in the 2016 GMC National Training Survey (NTS), with six in core psychiatry training (CPT) alone (*overall satisfaction, reporting systems, adequate experience, access to educational resources, feedback and regional teaching*). Of particular concern was the Hammersmith and Fulham Mental Health Unit (H&F) site, with a total of 11 red outliers. The Trust received 15 pink outliers overall, particularly for 'clinical supervision' across CPT, child and adolescent psychiatry, GP programme psychiatry and general psychiatry. The recent GMC NTS returned four patient safety comments from trainees (three immediate and one non-immediate), which highlighted concerns about: • Incidents where ward nursing staff had not contacted emergency services or started CPR for patients with reduced consciousness; poor observations reporting out-of-hours (OOH) (child & adolescent); the standard of nursing staff; inadequate equipment; unsafe staff accommodation. (general psychiatry) • Poor care offered by nursing staff – trainees reported incidents where cardiac arrest was not recognised, and was treated as non-urgent in calls; trainees reported a situation where a patient marked at Glasgow Coma Scale 3 had not received any emergency procedure prior to doctor's attendance • poor access to vital equipment (General Psychiatry) Trainees raised concerns about the serious problems experienced when responding to medical emergencies on the psychiatric unit, particularly during on-call periods. Trainees stated that they raised their concerns extensively, but were unsatisfied with the responses they received. In its response to the 2016 NTS results, the Trust reported that it had undertaken a number of improvements, namely: • a nurse consultant in physical healthcare had been appointed, who visited each acute site across the Trust to deliver workplace-based staff training, develop educational resources and to develop policy in support of emergency and physical healthcare (linked to CQC Quality Improvement Strategy plan) • the nurse consultant was making weekly visits to H&F inpatient wards since January 2016 • Educational priorities had been identified, with all staff to be trained in NEWS by end of April 2016, and an additional training resource had been developed for resuscitation equipment • Situation, Background, Assessment, Recommendation, Decision (SBARD) training for Registered Nurses would be implemented from the end of April 2016 to improve the communication of clinical information to medical/paramedical staff in emergency situations • All wards at H&F were equipped with ECG machines (one repair and two replacements completed) with sealed lead acid batteries for their 24 hour

	maintenance • Ten new defibrillators delivered to Service Manager to enable their positioning on each ward and area (including patients' gym) so one should be no more than two minutes away • The Service Manager confirmed that 98.5 per cent of staff were up to date with annual mandatory training in basic life support, with particular emphasis on team working and simulation. HEE NWL was aware of intransigent issues around learner safety (including the provision of personal alarms), heavy workload and the quality of physical healthcare provision at the Trust. The CQC visited West London Mental Health NHS Trust in June 2015, and rated it as 'requires improvement'. The Trust was rated 'inadequate' across its forensic inpatient and secure wards. However, the Trust was rated 'good' for being caring and responsive and requires improvement for being safe, effective and well-led. West London Mental Health NHS Trust had last been visited by HEE on 13 January 2014, and all actions from that visit were closed. At the time of the review, the Trust had ten trainees in difficulty.
Training programme / learner group reviewed	Psychiatry, mental health nursing and occupational therapy.
Number of learners and educators from each training programme	The quality review team met trainees from GP Specialty Training (GP ST), Foundation years one and two, forensic psychiatry, general adult psychiatry, old age psychiatry and medical psychotherapy sub-specialties, across training grades Core Training (CT) 1 to 3 and Specialty Training (ST) 4 to 6. Also present were the Director of Medical Education (DME), Deputy DME, clinical and educational supervisors for child psychiatry, forensic psychiatry, general adult psychiatry, Foundation and GP ST trainees, medical psychotherapy and faculty and educational development leads from Broadmoor Hospital, Cassel Hospital, Ealing Hospital and H&F.
Review summary and outcomes	The quality review team thanked all who attended and the Trust's medical education team for its collaboration in arranging the Review. In advance of the onsite review, the review Lead and Trust Liaison Dean visited two Trust sites – H&F and the new Thames Lodge facility. The review team noted the exceptionally high quality of the facilities on offer at Thames Lodge, and was encouraged by the opportunities available to improve services well into the future. The Trust's performance in the GMC NTS and associated feedback was of serious concern for the Review team, yet the team acknowledged that the senior management team was engaging with the issues raised and was actively working to achieve resolution. However, the team remained concerned and was not yet reassured that intransigent issues had been sufficiently resolved and the panel was keen to work with the senior management team in its efforts to improve the quality of its medical education provision across all sites. In particular, the Review team was concerned about the lack of an established educational governance structure across the Trust, which had a marked impact on trainees and their experience of the training environment. Three immediate mandatory requirements were issued at the Review: • The review team discovered that there was frequently no continuity of

clinical responsibility for the on-call bleep during day shifts. This resulted in the bleep being left unattended. This was deemed to be unacceptable practice. The Trust was required to establish an immediate plan for appropriate clinical cover and responsibility at all times for the on-call bleep at the Hammersmith and Fulham site;

- Trainees reported that they were uncertain whether their personal alarms were working and that there was no regular testing of personal alarms. The Trust was required to undertake an immediate check of all personal alarms issued to trainees. The Trust was required to clarify whether there was a protocol/policy in place around alarm testing, and whether it had been implemented; and
- "WhatsApp" social media messaging application was being used by some trainees to handover patient issues. This was unacceptable and reflected a poor handover system at the Hammersmith and Fulham site. The Trust was required to stop this use of social media. The panel required the Trust to demonstrate a robust and secure system for handover at the Hammersmith and Fulham site, and required the Trust to review handover at all other sites.

The review team was also concerned about the impact that nursing shortages and overall quality of nursing was having on patient safety, physical healthcare, trainee workload and overall quality and experience of placements at the Trust. The national issue of shortages in the NHS workforce, particularly as it pertained to nursing and psychiatry was noted and taken into consideration in the preparation of this report into the panel's findings.

Areas that are working well

The Review team noted that the standard of clinical and educational supervision was praised by many trainees.

The Lakeside site offered areas of good practice, and its induction arrangements were described as good by a number of trainees.

The Review Team acknowledged that the Trust is working hard to improve:

- training and education;
- engagement between education and the service (the Training Reference Groups)
- engagement between juniors and seniors (with particular reference to the establishment of junior/senior meetings at the Hammersmith and Fulham site)
- initiatives to improve physical health care management
- the redesign of posts to make them more suitable for training
- ensure incident reporting is accessible and understood

The review team noted that the initiative to shadow juniors was of great benefit and is an example of good governance practice that we wish to see formally implemented across the Trust's induction provision.

In addition, the Trust has worked to eradicate any culture of bullying and undermining and has sent a guide to trainees on bullying and how to access support, if required.

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

The Trust detailed that it managed a large training programme, with 130 trainees across four major sites with pockets of very good practice and areas of challenge, having undergone significant service reconfigurations.

The renegotiation of junior doctor contracts, suboptimal national recruitment outcomes and austerity were referred to as significant factors in difficulties faced in recent times. The Trust acknowledged that its focus on training had slipped in light of these challenges.

However, despite such difficulties, the Trust emphasised its high level of commitment to medical education and training. Both the DME and deputy meet with the Medical Director and Senior Medical Management Team on a regular basis and gave examples of how trainee and post specific issues had been resolved.

The Trust stated that it was aware of the on-going issues at the H&F site before the release of the 2016 GMC National Training Survey results, and had created an action plan to make improvements before the results were released. The Trust felt that it was becoming more proactive, and not merely reacting to the results of the Survey.

The quality review team heard that the Trust had worked with its Lead Provider to improve education and training, and had held regular medical educational committees to maintain open communication about the provision of services at the Trust.

The Quality Review team was keen to understand the Trust's management of concerns at the H&F site. The Trust advised that it had been heavily impacted by the closure of the emergency department (ED) at Hammersmith Hospital and *Shaping a Healthier Future*, more generally, which had redirected a lot of OOH work to the site. In addition, the Trust acknowledged that trainees were subject to a high workload, and found the balance between community and inpatient posts difficult to maintain, particularly when called back and forth between the two.

The Quality Review team also heard that the Trust was aware of an on-going problem with regard to the quality of the liaison nursing service OOH.

The Trust felt that the current organisation of training posts was linked to concerns around patient safety, workload, physical healthcare provision, nursing quality, and the inappropriate escalation of concerns; the Trust acknowledged that unforeseen rota gaps (particularly in the evening or night shifts) represent a major risk as locum agencies cannot always provide cover when the absence is at short notice.

Trainees stated that they were negatively affected by staff vacancies and the widely adopted cap on locum fees had caused problems in securing full rota cover. All such concerns had compounded the issue of an excessively high workload.

The Trust stated that in order to address these issues, it was actively engaging people to make changes. Concerns had been raised at tutors' committees and a recent Lead Provider visit, which offered the opportunity to troubleshoot and offer helpful guidance. The implementation of Training Reference Groups and the reconfiguration of core training posts offered the opportunity to explore issues and develop improvements. The Review team was informed that training posts had been reconfigured from split posts to either inpatient or community-based. The Trust explained that in collaboration with Clinical Directors, an explicit distribution of sessions and the type/number of cases in each had been embedded within new Training Job Descriptions.

Consultant responsibility had changed, and the previous challenge of trainees taking over merged clinics, thus needing to be in two places at once, had now been addressed as a result.

The Trust was keen to demonstrate that it had made progress with concerns raised about trainees' workload, e.g. actions arising from the Lead Provider visit, the implementation of a transition stage for OOH support and appropriate Crisis, Assessment and Treatment Team (CATT) cover. It was reported that there remained issues surrounding the morning handover process at the H&F site; while work had been done to improve this, the problems had not been resolved satisfactorily. At some sites, the CATT would see referred patients first and would then refer to the on-call trainee.

The Review Team was advised that H&F trainees received supervision for patient assessments.

With regard to triaging calls, the Review Team was informed that there were plans in place to move towards a system whereby the unit coordinator would screen calls, as trainees had reported concerns about the inability to

cover the ED and ward calls. The Trust stated that this initiative would be carried forward by Dr Fin Larkin, Interim Clinical Director for Access and Urgent Care Services. The Trust confirmed that at the time of the Review, the number of beds on wards was too large to be managed adequately.

The Trust stated that it had recruited medical psychotherapy consultants to ensure capacity in each site of the Trust, in addition to its delivery of a multi-professional MSC in Psychotherapeutic Approaches.

The Trust emphasised the responsive and effective role of its Occupational Health service in responding to Trainees' health needs.

Quality Review Team			
HEE Review Lead	Dr Bill Travers, Deputy Head of The School of Psychiatry	**GP Programme Representative**	Dr Andy Tate, Specialty Training Lead for General Practice
Trust Liaison Dean/County Dean	Dr Orla Lacey, Trust Liaison Dean, Health Education North West London	**Lead Provider Representative**	Dr John Lowe, Director of Education and Consultant Psychiatrist, Central and North West London NHS Foundation Trust
Foundation School Representative	Dr Anthea Parry, Deputy Director of the North West Thames Foundation School Dr Alex Bailey, Foundation Training Programme Director	**Trainee/Learner Representative**	Dr Flavia Napoletano, North East London NHS Foundation Trust
Lay Member	Jane Gregory Lay Representative	**Scribe**	Jennifer Quinn, Learning Environment Quality Coordinator, Health Education England North West London

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services.

1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.

Ref	Findings	Action required?

		Requirement Reference Number
1.1	**Trainee and Patient safety** The quality review team was deeply concerned to learn that in the event that the 9am to 5pm on-call trainee was working off-site in the community, the bleep was left unsupervised on top of a microwave in the doctors' mess, with no assigned clinical responsibility. Trainees expressed concern about the risk this posed to patient safety and frustration that they had reported this at every meeting for over a year, without resolution. It was reported that this issue had been escalated to the Clinical Lead. However, his attempt at resolution had been delayed because he was waiting for permission to allow off-site trainees to attend the H&F site. The Clinical Lead had raised the matter with Clinical Directors and had developed a contingency plan (the on call bleep being held by an identified consultant) while this was being resolved. Trainees working on the recovery ward at the H&F site reported that inadequate staffing levels presented major concerns for patient and trainee safety; the Review team heard that trainees frequently had to work there without any nursing staff in support and considered it a bonus to have a student nurse in attendance. This had been raised on a number of occasions as trainees did not feel safe. It was reported that one core trainee resigned after only one week due to safety concerns. Staff shortages and a part-time consultant left a F2 and a staff grade managing two sessions per week. This was raised with management, but again, trainees were yet to experience any change take place. Trainees stated that they witnessed consultants being assaulted and chased by patients on the acute medical admission ward. The quality review team learned that the lack of nursing staff often left trainees responsible for aggressive patients with only a healthcare assistant for support. On one occasion it was reported that security had to be called to the ward when a patient could not be restrained despite the attempts of over 20 members of staff. A foundation trainee at the Ealing site reported that they were left with responsibility for two sex offenders who had been incorrectly placed on the Horizon male assessment ward, due to a lack of space on the forensic ward. The trainee stated that they were uncomfortable working with sex offenders without security or protection. **Section 136 suite – H&F site** The Review team was very concerned to learn of inadequate security protocols at the H&F site's Section 136 suite. Trainees reported that the suite (adjacent to the Charing Cross Hospital ED and CATT hub) was not secure. Trainees reported that there was only one functioning entry/egress point, patients were able to exit and trainees frequently had to call the hospital's security team to assist. Two patients had managed to abscond within the last six months. It was also reported that there were blind spots within the Claybrook suite and that staff had to keep the door open in order to feel secure. The Review team visited both the Charing Cross and Claybrook site Section 136 suites, and was made aware of the concerns outlined above, including the fact that the Charing Cross suite had only one functioning entry/egress door. The Review team was concerned to learn of an occasion at the H&F site when a GP ST trainee was on-call and a Section 136 patient in the suite for admission had absconded and was found wandering around near the ED. The GP ST trainee was initially managing the patient, but was sent to the ED with a higher grade doctor. During their absence, a second Section 136 patient was admitted for assessment before the first patient was cleared for release, and the first patient was left unmonitored and able to exit the suite.	Yes – see P1.1a Yes – see P1.1b Yes – see P1.1b Yes – see P1.1c

	The quality review Team was advised that this had been escalated and that the Trust's interim Clinical Director was in charge of a review of the suite's security. Trainees felt that nurses located outside the suite were not as responsive as would be expected for high-risk situations such as those where patients had managed to abscond. Trainees advised that in the event a Section 136 patient or a patient requiring seclusion presented at the department when the on-call doctor was off-site without the bleep, they would have to run to the office and ask a senior clinician to attend. The quality review team was further concerned to learn that trainees would often only learn of the presence of a patient in the Section 136 suite by walking past. **Section 136 suite – Lakeside site** The Review team heard that in response to Section 136 cases at Lakeside, GP ST trainees were called by the unit coordinator and were supposed to negotiate with police officers who had brought the patient onsite. However, trainees reported that police officers had always departed by the time the trainee arrived. Trainees stated that they always felt able to deal with such situations and had received an appropriate level of support due to the efficient protocol in place at Lakeside. The trainees' overall role in Section 136 cases was to offer an initial physical assessment and review whether it was safe for the patient to be put on a ward to release the Section 136 suite for another patient. GP ST trainees reported that they had experienced delays in receiving support to deal with a 16 year old Section 136 patient; the psychiatry higher trainee would not come to review and the CAMHS higher trainee was too busy. On occasion, a patient had received an assessment under the Mental Health Act and the trainee was not satisfied that the patient would receive follow-up care. It was felt that this would not have happened were the patient older and therefore fell under the remit of adult mental health service provision. The Review team heard that there remained a distinct 'grey area' with the treatment of adolescents. The Review team was concerned at the discrepancy across sites of the implementation of the Trust's lone working policy policy on protecting trainees during periods of lone working, and the disparity at the Trust's sites of procedures to monitor trainees on occasions when they made home visits alone. Significant safety concerns were raised about the H&F site following a serious incident, following which a trainee was moved off site; this trainee reported that their safety alarm did not work at the time of the incident. Trainees were unclear of what the Trust had since done to improve security and trainee safety at the H&F site, and were concerned that there was no security team at the unit, due to the case complexity and danger presented by some patients on site. Lakeside trainees reported a similar issue with alarms – the assessment team was not given alarms when they started. When they finally received alarms, staff were unsure whether or not they worked, and had no idea what the response protocol would be in the event that they were pressed. F2 trainees were given alarms and received breakaway training at induction, yet GP ST trainees did not receive any local safety induction. With regard to the provision of cover in the H&F site emergency department, only one F1 trainee had to provide cover, in liaison psychiatry. Other trainees reported that the team structure was generally good, and they were aware of risk assessments, working mainly in pairs, but did not often have to attend the ED. Trainees stated that the small assessment room in the ED was not fit for purpose, with a small latch making it unsafe in the event that a quick exit was required, and was often used for storage by ED staff.	Yes – see P1.1d Yes – see P1.1e

	GP ST trainees advised that they worked in the ED when on-call, and only saw patients when working in a pair with a crisis nurse. There was an informal policy in operation where the respective pair would inform the ED team where they were. One F2 stated that they would not see a patient alone. **Broadmoor** trainees described the site as unsafe overnight during on-call shifts, and when they worked on seclusion units. During these shifts, trainees reported that it was a regular occurrence for them to be alone in the central hub, and had no idea whether it was safe to enter wards. Trainees were aware of a number of assaults committed against staff at that site. Two **Lakeside** trainees undertook home visits, but advised that they called colleagues both before and after visits if working alone. The Review team learnt that not all home visits were triaged in advance, and a number of trainees were hesitant to respond when asked by the quality review team whether they felt safe attending such visits. Trainees explained that arrangements for tracking home visits were different for each team; not all trainees know who was tracking them or how long they would have to be absent before the alarm would be raised, In addition, not all trainees knew the number on the bleep to call in the event of an emergency. Trainees working at the Ealing site stated that they had started driving to and from locations on the hospital estate as they did not feel safe, particularly when working at night and were the only person walking around the site with members of the community loitering on the estate. Trainees reported that they had raised this issue, and a named security escort was initially provided but subsequently stopped after one rotation. Escorting now took place only occasionally and often took over 30 minutes to arrive. Trainees reported that a hospital car was rumoured to have become available, but were unaware of how to access it. The Trust advised that a single-site security service dedicated to the St Bernard's site has been operational since the end of August 2016; this service can be accessed through the Trust contact centre, also based at the St Bernard's site. On the whole, trainees described feeling increasingly disconnected as they rotated through the programme. One trainee had moved three times across five rotations, which became more disruptive as the Trusts changed; each placement presented new challenges, but when passed to a new Trust, trainees felt that it was too disruptive to engagement and processes and contributed to the feeling that they were peripheral.	Yes – see P1.1f
1.2	**Serious incidents and professional duty of candour** Overall, the quality review team witnessed an inadequate system of serious incident reporting, in which trainees across the Trust received little to no feedback following a report being made, with particular reference to the H&F and Ealing sites. Trainees at Lakeside experienced a more positive approach, with regular ward meetings and monthly incident reviews taking place. The Trust made clear that it made significant effort to encourage incident reporting across the Trust, yet this was clearly not working coherently or constructively, in the absence of feedback being given to trainees or in one reported case, to families of patients whose care had undergone investigation. The Trust informed the quality review Review team that it had developed a new IR1 system that was scheduled to become operational at the end of October 2016. The new system would offer improved functionality for the dissemination of feedback and the Trust's Head of Governance intended to offer site-based training on the new system to trainees.	Yes – see P1.2
1.3	**Appropriate level of clinical supervision**	

	Overall, trainees reported good clinical supervision at an appropriate level, with access and debriefs. A number of trainees reported that their supervisors went out of their way to help accommodate requests. CT1 trainees at Charing Cross Hospital reported that they received supervision once or twice a week and attended three to four clinics per week with 10 minutes supervision after each patient session. One trainee described their experience as increasingly stressful and was considering leaving the psychiatry training programme. The review team was concerned at reports that this trainee believed they were making decisions above their level of competence and did not have adequate opportunity to settle into the job. Most trainees present from the H&F site stated that they were unsupervised when they managed outpatient clinics for the first time. This was noted to be a long standing problem, Trust-wide; the review team heard that trainees were not supported, valued or listened to, a situation that had been on-going for several years – raising feedback was described as futile. A trainee at the Lakeside site reported that they saw patients alone, attended daily board rounds with the multi-disciplinary team and attended seeing patients both at home and on site. With regard to receiving a supervised induction, Lakeside trainees reported that at the start of their placement, they were supervised by a higher trainee or an experienced nurse. More recently, they had experienced periods of lone working, but were appropriately assisted, were further support required. Of particular concern to the review team was the lack of clarity on whether a formal cross-cover arrangement was in place in the event of supervisors' absence. In one case, a Lakeside trainee reported that their clinical supervisor (CS) was absent for their first five weeks of training, during which they spent the majority of their time in the office and received only one session of clinical supervision. This particular situation had now been rectified. By comparison, the DME stated that cover was always provided despite supervisor absence and trainees always knew who the named covering supervisor was. However, the review team remained unclear whether there were any formal cross-cover procedures in operation. **Foundation trainees** One F2 trainee reported that they were offered clinical supervision at the start of their placement, but had only four sessions since August 2016. Supervision was frequently given by a higher trainee, who was not officially a CS, but was described as 'extremely good'. Foundation trainees stated that they were always aware of who to call if further support was required. Clinical supervision at the **Lakeside** site was reported to be good, with dedicated once-weekly supervision and two staff grade doctors covering the 9am to 5pm shift. **Broadmoor** trainees received weekly one-hour clinical supervision. **Higher** trainees in general adult psychiatry raised concerns about supervision on shifts at West Middlesex University Hospital; in general, day shifts were reported to be 'excellently' supervised offering good feedback. In contrast, trainees reported that during their on call shifts (working one in eight full time, once every 14 days) they felt largely unsupervised. The review team heard that this placement left trainees feeling isolated and cut off from their other post and the consultants onsite were not expecting to supervise trainees from West London Mental Health NHS Trust. Trainees reported that they had complained about this for months but no action had been taken.	Yes – see P1.3a

	There is a discrepancy between what the trainees reported and the Trust expectation from consultant supervision; the Trust reported that the on call rota at Lakeside Mental Health Unit was fully supported by a on call consultant rota. More generally, trainees stated that they were trying to establish monthly supervision meetings, but with a number of external pressures there was little room to schedule this. **Forensic** and **Psychotherapy** trainees advised that they received a lot of supervision in their day jobs and that on-call supervision was good, and they felt very well-supported. Higher trainees were encouraged to attend a leadership and management course, but it was not known whether this opportunity was open to all training grades. Trainees working in community settings stated that it would be helpful to have meetings to discuss complex cases and cases that caused concern. Without that opportunity, there was little chance for trainees to understand team structures. The review team heard that despite the service reconfiguration at the H&F site, CATT team members would not see any patients alone, and requested a doctor to be present, which was in contrast to psychiatry liaison team members who worked more independently. It was reported that the local clinical commissioning group had removed funding, and the Trust was unable to sustain a 24 hour psychiatric liaison nursing service.	Yes – see P1.3b
1.4	**Responsibilities for patient care appropriate for stage of education and training** At the Ealing site, GP ST and F2 trainees reported that they were put on busy admission wards, which was felt to be a totally inappropriate allocation for their level of competency. In one case, a F2 trainee was the only doctor covering the recovery ward. Another Foundation trainee reported that they were not comfortable with monitoring protocols relating to high-risk patients; the quality review team heard that there was no induction on the monitoring of drugs and potential interactions.	Yes – see P1.4
1.5	**Rotas** Across the Trust, trainees said that the conflicting demands of managing referrals, ward cover and the workload in outpatients were difficult to balance with their training needs. The lack of administrative support placed a burden on trainees of every level, eating into their clinical time. Trainees reported significant rota gaps at **Broadmoor Hospital**, and the quality review team was very concerned to hear reports of trainees being compelled to cover gaps on night shifts with the use of emails that were described as ‘forceful’ and ‘pressuring’. It was reported that these gaps were often recognised well in advance, but there was no clear escalation policy and it seemed that replacements were only sought very close to the time; it was unclear whether the Trust had in place an advanced escalation policy. The review team was keen to understand the escalation policy for known rota gaps, and how this was kept under review. Trainees at that site stated that there appeared to be an informal policy in operation whereby trainees could be compelled to work certain shifts in the absence of a locum or any volunteer to cover, being told that they had to work these extra night shifts. This was not in trainees’ contracts, and the review team was advised that trainees had been put under significant pressure and were forced to replace gaps on such shifts.	Yes – see P1.5a

	Consequently, trainees reported difficulties in attending any programmed teaching that fell on the day following these enforced night shifts, which clearly served a negative impact on their training experience. **Medical psychotherapy** trainees raised concerns about the pressure placed on them to do on-call shifts to fill gaps in the rota, which was described as 'overwhelming' and sometimes unmanageable alongside all other responsibilities. They often had to work night shifts after working during the day, and were then expected to go back to the day shift the following morning, taking trainees to above European Working Time Directive (EWTD) limits. In addition, trainees reported that they were unable to take advantage of the time off that was offered in lieu, due to the responsibility placed on them to uphold regular client appointments that could not be cancelled or covered by colleagues. The Trust explained that it engaged psychotherapy trainees in the general adult on call rota at Lakeside to ensure appropriate curriculum coverage for emergency psychiatry, which had previously been a major historic omission for most psychotherapy trainees. One medical psychotherapy trainees commented on how unsupported and disjointed the on-call work is in the Section 136 suites. It was reported that joint patient assessments with the Approved Mental Health Professional (AMHP) were not taking place so patient decisions could not be made. The AMHP may not be available for up to 72 hours, so patients could be waiting that long for a decision to be made about their detention. The quality review team heard that the trainees came up with a paper detailing suggestions for reduced participation by medical psychotherapy trainees, optimising how many patients were seen in a way that was able to meet training needs. They wanted the Trust to agree some adjustment to the frequency and pattern of their on-call shifts. This remained a problem under discussion at the Trust. The Trust advised that the trainees' proposed rota was not compliant, did not take into account trainees' statutory exemptions from on call and placed disproportionate burden on general adult psychiatry trainee; Psychotherapy trainees were given feedback and the Trust reported that it advised both trainers and trainees to ensure adherence with the Trust's European Working Time Directive compensatory rest protocol. The quality review team was informed that foundation trainees were not on the on-call rota and didn't have to hold the bleep. The balance between community and inpatient posts was mixed, with a limited number of trainees working only in community posts. General adult psychiatry was described as busy, with the rota gaps and lack of resources affecting the whole team. Trainees felt that working in the community was a quite solitary role that impacted on their training as there was little to no joint working.	Yes – see P1.5b
1.6	**Induction** The Review team was keen to ascertain what plans the Trust had in place to improve the quality of inductions that would be offered to new trainees rotating to the Trust in February 2017, particularly at the H&F site. The Trust was clear that information on trainee safety, personal alarms and key personnel at the Trust would be included. However, the Trust expressed frustration at the existing challenges of the disparity in the manner in which concerns had been raised; it was reported that trainees were talking among themselves about concerns but were not reporting back to the medical education faculty. The Trust's medical education manager explained that the Trust did as much as it could to induct trainees, taking a multi-team approach to its induction process – offering more local knowledge, which enabled those trainees to arrive on site and meet	Yes – see P1.6

	core trainee and higher trainees. In contrast, the Review team was concerned to learn that the inductions offered to GP Specialty Training (GP ST) and foundation trainees who were not familiar with psychiatry were not tailored to those trainees' needs, particularly to those who were attending on their first ever placement. In addition, trainees reported that they received no induction on the escalation pathway for patients presenting a decline in physical health; they had learned by experience. The Review team was advised that trainees were told to call an ambulance to send patients to the ED in the event that they were particularly worried about a patient. However, the Review team was not sufficiently reassured that the Trust was adequately orienting trainees new to psychiatry to the roles that were expected of them at the Trust, with particular reference to foundation trainees, for whom the induction was highlighted as being poorly designed for their needs. Furthermore, it remained unclear how those trainees fed back to the Trust any concerns about their placements. In response, the Director of Postgraduate Medical Education stated that foundation trainees were involved in all aspects of the academic reporting environment. The Trust acknowledged that foundation trainees had to miss the Trust induction due to scheduling clashes. However, the medical education manager stated that all trainees knew to get in touch should they have any concerns. Turning to the orientation offered to trainees new to psychiatry, the Deputy DME set out that in addition to shadowing, trainees attended supervision meetings and group supervision with all trainees, and that a lot of work to balance the workload distribution was undertaken to manage the large group of more junior trainees. With regard to offering a shadowing period of mentoring from higher trainees, the Trust advised that it had discussed this option but not yet implemented. However, there remained an opportunity to do that for trainees new to psychiatry, but it was unclear to the quality review team precisely how or when this would be enacted. The review team was informed that both the Medical Director and Director of Postgraduate Medical Education met trainees and would shadow on-call doctors to see where the issues lay; they also announced an intention to arrange a conference in the new year about managing pressures, to offer help with on-call triaging and prioritising. In respect of the specific areas covered at induction, the Review team was informed that the Trust envisaged an ideal situation covering a Trust induction, followed by a service induction. However, the Trust advised that it was reviewing its process and how this would be used for GP ST, CT1 and foundation trainees in their first week of post, including the level of supervision required. **Broadmoor** trainees reported a good induction with an informal trainee network in place. **The site-specific induction** at the H&F site was described as poor: scheduled presentations did not take place and were not rescheduled, and it was left to the juniors to initiate the preparation of a handbook for all new trainees. Trainees said that they feared that this would not be sustained in the long term.	
1.7	**Handover** The Review team was concerned at the lack of an adequate morning handover at the H&F site; at the time of the Review, trainees were using the WhatsApp messaging application as a back-up to handover patient information and any outstanding jobs following the end of a shift. Trainees advised that the management team knew about this practice informally, and the feeling among trainees was that they were allowed to continue doing this if it proved successful. However, this had not been discussed formally.	Yes – see P1.7

	It was reported that it was a rare occurrence for a face-to-face morning handover to take place at that site, and largely depended on the seriousness of any cases present. Gaps in the rota meant that there were more locum doctors covering night shifts, who did not wait for the handover and left 30 minutes early at 9am, before the junior doctor arrived onsite. By comparison, the medical education management team was surprised to learn that this was happening and stated that they believed a regular handover between the outgoing doctors was in place. The Review team enquired about exactly how the H&F site OOH liaison service handover and AM handover process worked in practice. The Trust advised that liaison ended at 10pm when the CATT nurse took over, and the morning handover was part of the normal CATT visit.	
1.8	**Access to simulation-based training opportunities** One core trainee stated that they had frequently raised the case for teams attending simulation training together, even if it were to be led by juniors. It was reported that there was a huge gulf between the different teams of nurses; trainees were clear that giving mental health nurses a quick course on writing NEWS charts or taking bloods was not the same as managing a set of acute patients, and any training offered should cover more than just emergencies. Trainees strongly believed that ward-based simulation would be of great benefit to all, and that nurses needed to be up-skilled in a sub and acute clinical sense.	Yes – see P1.8

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity.

2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.

2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.

2.1	**Effective, transparent and clearly understood educational governance systems and processes** Overall, the review team was concerned about the lack of an established educational governance structure across the Trust, which had a marked impact on trainees and their experience of the training environment. The visit team learned that opportunities for trainees to raise their views and any concerns were disparate across the Trust's geography, with only the H&F site offering a dedicated junior/senior meeting. Trainees at the Lakeside site experienced productive Medical Advisory Committee (MAC) meetings.	Yes – see P2.1

	The Review team was disappointed to hear that at the Ealing site, unless trainees directly approached managers, there were few platforms for trainees to provide feedback and to seek resolution of their concerns. In contrast, it was reported that forensic trainee reps were invited to attend the Trust's MAC meetings. Trainees at the H&F site reported very little management presence to solve problems; the problems were described as 'longstanding' and while the establishment of meetings was seen as a positive step, trainees were concerned about how things would move forward, as there had been insufficient evidence of positive change. With regard to mechanisms for trainees to feedback concerns to the Trust, the Review team was informed that foundation, core and higher trainees were invited to the newly-established junior/senior meetings at the H&F site, which were attended by senior clinicians and nursing staff at the H&F site. The Trust stated that it had become apparent that trainees did not always communicate with the most appropriate right people to report every day issues. H&F site trainees found the new junior/senior meetings useful, as they helped break down barriers between trainees and managers; they felt listened to and were keen for them to continue. The Review team heard that trainees were pleased at the effort made by the new medical director to visit each site and speak to trainees.	
2.2	**Impact of service design on learners** The current service reconfiguration across the Trust was having a negative impact on trainees' ability to manage their workload, which was very pressured and impeded trainees' ability to maintain a balance between service provision and their educational experience. The Review team heard that the workload at the H&F site was 'phenomenal' and trainees had to campaign for the establishment of separate roles covering either inpatient or community jobs, resulting in a minor reduction in trainee workload. The Trust stated that trainees at H&F were fully involved in prospective arrangements to establish inpatient and community based training posts through a Training Reference Group. However, the Trust acknowledged that in spite of work done by the Clinical Director to manage caseloads (including 'virtual clinics' with supervisors), the benefits in workload had yet to be fully realised. In addition, trainees advised that changes had been made to cover arrangements at Charing Cross Hospital; consequently, the liaison team worked until 10pm, so that the duty doctor role did not have to cover the emergency department. Prior to the liaison team extending its hours, junior trainees had to manage patient assessments within the hour, and in cases of any issues arising, had to put any ward duties second. In some instances, trainees described how some Section 136 patients were waiting for hours to be seen, as the juniors had been called to the emergency department. The change to the liaison team working hours meant that trainees could focus their work on the H&F unit.	Yes – see P2.2
2.3	**Organisation to ensure time in trainers' job plans** The DME stated that the clinical and educational supervisor roles were included in job planning and that appraisals were up to date.	

2.4	**Systems and processes to identify, support and manage learners when there are concerns** The review team was advised that the Trust had been very supportive when a medical psychotherapy trainee had been experiencing difficulty in managing their workload with cross-site cover over four service lines. The Trust subsequently reduced the number of sites covered by the trainee, who was reportedly well-supported in managing workload pressures. Unfortunately, with regard to the general matter of feeling well-supported when raising concerns, this was not an example experienced by many other trainees across all grades and specialties, who expressed frustration at not receiving responses to concerns raised.	

3. Supporting and empowering learners

HEE Quality Standards

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.

3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.

3.1	**Behaviour that undermines professional confidence, performance or self-esteem** While the quality review team did not hear any reports of bullying or intimidation taking place within the department, the DME stated that the Trust had worked to eradicate any such behaviour.	
3.2	**Academic opportunities** Trainees were frustrated at the lack of the opportunities to access research opportunities unless they were on the NIHR Academic Clinical Fellow training programme. A request was made to establish an interface between trainees and Trust senior medical education team to share a list of any available projects. The quality review team heard that the Trust's research and development team was not in a strong enough position to support trainees at the time of the review, and trainees had to work independently to try to undertake projects with little to no support available. The DME agreed that the department had 'dwindled', and stated that he had encouraged a number of trainees to concentrate on their core curriculum and consider research again when a higher trainee.	Yes – see P3.2
3.3	**Access to study leave** No trainee reported any difficulty in obtaining study leave.	

4. Supporting and empowering educators

HEE Quality Standards

4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.

4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.

4.1	**Access to appropriately funded professional development, training and an appraisal for educators** With regard to the suitability of the Trust's appraisal process, trainers advised that they had access to feedback and all individual posts had the opportunity to be reviewed by trainees via their comments in the free text box at ARCP submission. The Review team learned that the DME ran two surveys on learner quality and had acted on results to manage those individuals who were not meeting the required standards of supervision.	
4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The DME stated that clinical and educational supervisor roles were included in job planning and that appraisals were up to date.	
4.3	**Access to appropriately funded resources to meet the requirements of the training programme or curriculum** Trainers raised concerns about the lack of funding available to develop liaison psychiatry posts. The DME advised that discussions were held with the local clinical commissioning group (CCG) to protect vulnerable services; it was reported that the CCG gave little consideration to the Trust's quality data when reviewing services.	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.

5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.

5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.

5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.

5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** **Foundation** trainees raised a number of concerns about their psychiatry placements, as they felt that they were now lacking clinical experience in physical health, and had slipped behind their peers by being on the Ealing psychiatry placement as a F1 trainee. The Review team recognised that this remained an on-going concern for F1 trainees generally who started in psychiatry, and stated that the Foundation school was working to make placements more secure for trainees.	

	A F1 trainee working at the Ealing site expressed frustration at not being able to prescribe, which was stated as being detrimental to their training as a junior doctor. No legal supervision was available, as the trainee's supervising consultant did not prescribe at that site either. The Review team heard that it was the trainee's first job as a F1 doctor, and their learning curve was becoming increasingly steeper as a result. More generally, trainers reported that there were tensions between service provision and training – conversations were held about reducing time the spent by trainees undertaking nursing duties; trainers recognised the need to protect the training experience but initiatives like the Screening and Intervention Programme for Sensible Drinking made this more challenging.	
5.2	**An educational induction to make sure learners understand their curriculum and how their post or clinical placement fits within the programme** Trainees were keen to receive job plans in advance of rotating to the Trust and detailed information on what was expected of them as a trainee, as this had not been provided to date.	Yes – see P5.2
5.3	**Opportunities for interprofessional multidisciplinary working** The quality review team was disappointed to learn that the basic skill level among nursing staff remained at best variable across the Trust. Trainees stated that nurses worried about patients unnecessarily and were unable to perform basic checks, including ECGs, which trainees were routinely called to do. The quality review team was disappointed to learn that the Trust's initiatives to improve the quality of physical healthcare at the Trust were not showing improvements in practice. Core trainees were markedly frustrated when explaining that there remained serious concerns about the competency of nurses across the Trust. The quality review team was concerned to hear reports from trainees who attended calls from nurses to discover that no care had been offered to patients before the trainee had arrived, and in some cases, nursing staff were unable to carry out basic blood pressure or ECG checks. Worryingly, trainees reported that the drive to improve physical healthcare had actually increased their workload in terms of the process that had been implemented to monitor physical healthcare; paper recording was still in place, and trainees had not received any instruction about moving to the RiO electronic record system. All trainees were in agreement that they wanted to take refresher sessions in monitoring physical healthcare; it was reported that there was no such provision at Charing Cross Hospital. The quality review team heard that it was a regular occurrence at Charing Cross Hospital for a nurse to call a trainee to request attendance of a patient without providing information on the status of the patient's health; when pressed for further detail, the nurses often responded that it was not their duty to take patient case information as they were mental health nurses. The general sense among trainees was that nurses would contact the doctor and not know that they should carry out observations before calling; it was reported that this happened, on average, six times during an on-call shift. More often than not, trainees	Yes – see P5.3a Yes – see P5.3b

	stated that nurses would call for assistance with minor problems. Trainees felt that a nurse's decision to contact a doctor for assistance should be part of a comprehensive *Situation, Background, Assessment and Recommendation* (*SBAR)* communication process, which was currently lacking. The quality review team was concerned to learn that trainees at the Ealing site were experiencing obstruction when contacting the acute medical team for assistance and advice. Trainees highlighted issues relating to the management of acute physical decline in new admissions. In one case, a trainee described a challenging situation whereby a patient newly arrived in the UK presented with self-reported diabetes and a supply of untraceable insulin. Without the GP history, the trainee felt it necessary to bleep the diabetes and endocrinology team at Ealing Hospital, but did not receive a response for approximately 36 hours. The patient subsequently developed diabetic ketoacidosis, ataxia and impaired mobility, yet the medical higher trainee was dismissive, stating that this patient did not present a justified admission. The delay in urgent response from other departments at Ealing Hospital was highlighted to the quality review team as an on-going challenge. Trainees were in agreement that other departments at Ealing Hospital seemed to know nothing about St Bernard's, and were confused as to why the psychiatry trainees were calling about basic medical conditions. The quality review team heard that communication breakdowns between psychiatry trainees and medical higher trainees were a regular occurrence; in old age psychiatry, trainees reported that on occasions where advice was sought from medical colleagues for something seen as more basic, such as prescribing queries, the medical team could be quite dismissive. A foundation trainee raised concerns that the frequent blocking by medical higher trainees to admit psychiatry patients presenting a rapid, serious deterioration in physical health was a serious patient safety risk. Trainees were clear that they did not feel experienced enough to make decisions without the input of other departments. It was reported that psychiatry higher trainees felt the same, so would also resort to calling the medical team instead. However, a number of trainees reported that they had always received what they felt was 'the right response' to requests for advice and assistance.	Yes – see P5.3c
5.4	**Appropriate balance between providing services and accessing educational and training opportunities** The Quality Review team was concerned to learn that trainees across all grades felt that their primary role was for service provision, as opposed to training. For a number of higher trainees, the excessive workload meant that training had to be sacrificed in the days following night shifts that were worked to cover gaps in the rotas.	Yes – see P2.2

6. Developing a Sustainable Workforce

HEE Quality Standards

6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.

6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.

6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.

6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.

6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

6.1	**Appropriate recruitment processes** Trainees across all grades and specialties reported that staff vacancies were an on-going cause for concern, with particular reference to the H&F site, where there was inadequate medical cover during the day (9am to 5pm). Furthermore, trainees stated that they were frequently called away to manage Section 136 cases. The quality review team was concerned to learn that at the H&F site, there was frequently just the bare minimum of one doctor covering during the day. Trainees explained that the named on-call person was responsible for covering both on-call and ward duties, with no safety net and no-one to cover clinical emergencies; ultimately, if the on-call doctor was called away, trainees faced no back-up system for on-call absences.	
6.2	**Learner retention** It was reported that the Trust experienced difficulty retaining nursing staff and was significantly understaffed. However, the Trust stated that its vacancy rates for mental health nurses was commensurate with other mental health trusts in the London region.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
N/A			

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**HEE Req. No.**
P1.1a	The Trust is required to establish an immediate plan for appropriate clinical cover and responsibility at all times for the on-call bleep at the Hammersmith and Fulham site.	The Trust is required to establish an immediate plan for appropriate clinical cover and responsibility at all times for the on-call bleep at the Hammersmith and Fulham site.	1
Immediate Mandatory Requirements (continued)			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**HEE Req. No.**
P1.1e	The Trust is required to undertake an immediate check of all personal alarms	The Trust is required to clarify whether there is a protocol/policy in place around	1

	issued to trainees.	alarm testing, detail exactly what said protocol is and whether it has been implemented.	
P1.7	The Trust is required to stop the use of social media to handover patient information in place of a formalised handover process.	The Trust must demonstrate a robust and secure system for handover at the Hammersmith and Fulham site, and must review handover protocols at all other sites. Compliance with this action should be monitored through LFG meetings, with the provision of minutes as evidence.	1

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**HEE Req. No.**
P1.1b	The Trust is required to review its arrangements for support available for staff when working with high-risk patients.	The Trust must provide the outcome of the review including any details regarding how the Trust plans to strengthen its current arrangements for supporting staff in high-risk situations.	1
P1.1c	The Trust is required to review the safety and security of all sites across the Trust, with particular reference to the Section 136 suite and small assessment room at the Hammersmith and Fulham Site, ensuring that the facilities meet the standards set by the Royal College of Psychiatrists.	The Trust's Section 136 suites do not all appear to be compliant with the Royal College of Psychiatrists 'The Section 136 care pathway' guidelines. The Review team is unaware of all details of the deficits in each suite. Therefore, an urgent, full review of each suite must be completed to ensure that they are all compliant with the guidelines, and provide a safe environment for both trainees and patients. A comprehensive report of remedial action taken to make the suites compliant must be submitted. Compliance with this action should also be monitored through LFG meetings, with the provision of minutes as evidence.	
P1.1d	The Trust is required to clarify its lone working policy and provide details of protocols in place to monitor trainees when working unsupervised in the community.	The Trust must provide a copy of its lone working policy and monitoring protocols.	1

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**HEE Req. No.**

P1.2	The Trust is required to establish and implement a clear, robust system of incident reporting that offers timely and efficient feedback to trainees, including details of how the issue has been dealt with.	The Trust must provide a summary of feedback to trainees versus a log of incident forms submitted by trainees. The Trust must ensure that learning events from serious incidents are held and trainees are able to attend regularly. The Trust should also ensure that serious incident reporting is added as a standing item to the local faculty group (LFG) meeting's agenda and register of attendance taken and submitted as evidence.	1
P1.3a	The Trust is required to establish a formal system for arranging cross-cover of clinical supervision during periods of absence, offering, where possible, timely notification of cover to those trainees affected.	The Trust is required to provide evidence of a newly-strengthened system for arranging cross-cover of clinical supervision, demonstrating provisions for informing trainees of any changes in a timely and efficient manner.	1
P1.3b	The Trust is required to ensure that trainees are aware at all times of who their clinical supervisor is, and how they can be contacted, when necessary. The Trust must ensure that clinical supervisors are equally aware of trainees requiring supervision, with particular reference to the Lakeside Mental Health Unit.	The Trust must provide details of the on call rota clearly showing evidence of consultant support. Compliance with this action should also be monitored through LFG meetings, with the provision of minutes as evidence.	1
P1.4	The Trust is required to review its placement allocations to ensure that no trainee is inappropriately placed working above their level of competence, with particular relevance to GP, Foundation and core psychiatry trainees at CT1 level.	The Trust is required to provide job descriptions that state explicitly: 1. Trainee roles that are suitable for that particular training level. 2. The day-to-day supervision arrangements for trainees. 3. The specific types of clinical situations that will require senior input and how this will be obtained.	1
P1.5a	The Trust must clarify its policy on arranging cover for the on-call shift at Broadmoor Hospital. The Trust should make appropriate plans to fill any foreseeable rota gaps in a timely fashion. Trainees must not be subject to force or pressure to cover extra shifts extraneous to their rota and must ensure that no trainee is working unsafe shift patterns that disrupt their ability to attend teaching as a result.	The Trust must provide its HR policy for filling rota gaps. The Trust's clinical director must provide a plan of action for recruiting to current gaps. Rota gaps should also be added as a standing item on the LFG agenda, and appropriate and timely action should be taken following each meeting to address any issues in this area. Compliance with this action should be monitored through LFG meetings, with the provision of minutes as evidence.	1
P1.5b	The Trust is required to review the rota coordination in place across all sites, particularly as it pertains to medical psychotherapy trainees. The Trust is required to ensure that trainee rotas are	The Trust must submit copies of revised rotas clearly demonstrating that trainees are not working outside of the EWTD. The Trust is required to undertake a diary-card monitoring exercise to ensure that trainees	1

	compliant with the European Working Time Directive (EWTD).	are compliant with the European Working Time Directive (EWTD). Compliance with this action should be monitored through LFG meetings, with the provision of minutes as evidence.	
P1.6	The Trust is required to urgently review its induction process and provide a robust programme that caters to the needs of all trainees, particularly those new to psychiatry. Appropriate local inductions must be in place and must not be left to the goodwill of existing trainees to coordinate.	The Trust is required to ensure that the Trust-wide and local inductions are fit for purpose and tailored to all trainees' needs. **Evidence of this review and implementation appropriate, robust induction processes must be provided by 1 December 2016.**	1
P2.1	The Trust is required to implement quarterly sub-specialty LFG meetings across the Trust to ensure that trainees have a forum in which to feedback issues regarding their training to the consultant body and medical education team. LFG meetings should include clinical supervisors, educational supervisors, college tutor and representation of trainees at all grades. These meetings should be minuted including an action plan and a register taken.	The Trust must submit a schedule of LFG meetings for the next 12 months and register, minutes and action plan from the next four meetings.	2
P2.2	The Trust must ensure that the training experience is not compromised by service configuration and inappropriate rota coordination. The Trust is required to provide a review of trainee roles and a curriculum-mapping exercise confirming that placements fulfil trainee curriculum requirements including OOH shifts.	The Trust must provide the outcome of this Review and details of the plan it will implement in order to ameliorate the training experience and trainees' experience of working at the Trust. This should be corroborated with LFG minutes clearly demonstrating that trainees experience an appropriate balance between service provision and education, in an adequate training environment.	
P5.2	The Trust is required to clarify trainee roles and expectations in advance of commencing placements at the Trust. The Trust must ensure that all trainees receive such information (including rotas) at least six weeks in advance.	The Trust must submit copies of trainee job descriptions and rotas, in addition to evidence that this was sent to trainees at least six weeks in advance. Compliance with this action should be monitored through LFG meetings, with the provision of minutes as evidence.	5
P5.3a	The Trust must ensure that all nursing staff are adequately trained in the provision of basic health checks, employing the SBAR approach wherever appropriate. The Trust must clarify what steps it is taking to remedy the inadequacy of physical healthcare across the Trust and the burden this places on trainees.	The Trust is required to undertake an urgent review of the competence of all levels of nursing staff. This should include an implementation plan to ensure that all nurses: • meet the Nursing and Midwifery Council's minimum standards of competence • work to the Royal College of Nursing's core competence framework • have up-to-date BLS and NEWS courses	5

		The Trust is required to provide the outcome of the review including the implementation plan. Compliance with this action should be monitored through LFG meetings, with the provision of minutes as evidence.	
P5.3c	The Trust is required to ensure that any obstructive behaviour toward the psychiatry team from the acute medical team ceases immediately.	The Trust is required to provide a plan of how the relationship between the two departments shall be improved. Compliance with this action should also be monitored through LFG meetings, with the provision of minutes as evidence.	5

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**HEE Req. No.**
P1.1f	The Trust should offer a secure escorting service to trainees working across the Ealing site at night.	The Trust must provide evidence that this support is in place. Compliance with this action should be monitored through LFG meetings, with the provision of minutes as evidence.	1
P1.8	The Trust should consider offering joint ward-based simulation training opportunities to medical and non-medical learners.	The Trust should provide details of simulation training programmes and attendance registers. Compliance with this action should be monitored through LFG meetings, with the provision of minutes as evidence.	1
P3.2	The Trust should review the opportunities and support available to trainees wishing to pursue private academic research projects in the absence of an NIHR award.	Compliance with this action should be monitored through LFG meetings, with the provision of minutes as evidence.	3
P5.3b	It is recommended that the Trust review the need for a refresher course in monitoring physical healthcare for all trainees.	The Trust should provide plans of a refresher course for all trainees and submit LFG minutes demonstrating that trainees are receiving this course.	5

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
HEE to provide details of its Professional Support Unit to work with the Trust to strengthen educational governance.	Dr Orla Lacey

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Orla Lacey, Trust Liaison Dean

Date:	18 November 2016