King's College Hospital NHS Trust
(Princess Royal University Hospital)
Paediatrics
Risk-based Review (on-site visit)

Quality Review report

Date: 2 November 2016

Version (if required): Final Report

Quality Review details

Background to review	
	Health Education England undertook an urgent concern review focus group to paediatrics on 15 June 2016 following concerns raised at the Trust-wide review in May 2016 and other concerns HEE had been made aware of by trainees. The GMC NTS 2016 survey results were a substantial deterioration from the 2015 GMC NTS results with 10 red outliers for 'overall satisfaction', 'reporting systems', 'induction', 'adequate experience', 'supportive environment', 'workload', 'educational supervision', 'access to educational resources', 'feedback' and 'local teaching'. There were also two pink outliers within 'clinical supervision' and 'handover'. At the time of the urgent concern review in June 2016 the following areas were found which required improvement: Junior doctor rotas • The Trust was required to ensure that immediate steps were taken to ensure that the junior doctor rotas across the whole paediatric service were European Working Time Directive compliant. The Trust was also required to ensure that general practice (GP) trainees were allowed to attend the Wednesday half day release sessions by including this in their rotas. Handover • The Trust was required to take immediate steps to provide senior clinical oversight for both the morning and evening handover sessions. This was firstly to ensure it took place in a timely way and the principles of effective handover were adhered to, but also to ensure that feedback was delivered in a developmental and formative way, conducive to learning and reflection. Trainees had reported a consistently adversarial, belittling and undermining culture that was present during handover, especially in the mornings. Induction • The Trust was required to take immediate steps to ensure that a robust induction and training programme was put in place, and agreed with HEE, for new trainees joining the paediatric service at Princess Royal University Hospital. The programmes need to be tailored to the trainees' needs e.g. GP and Foundation year two (F2) trainees were likely to have different requirements to paediatric trainees. The visit team heard numerous examples of Foundation, General Practice and very junior paediatric trainees being expected to attend complex deliveries, and carry out baby checks and other associated tasks, without appropriate induction or training. This represented a serious patient safety issue for new trainees rotating into the department in the future. Educational Supervision • The Trust was required to conduct a review of educational supervision practice. Trainers needed to be supported to understand their obligations to provide effective educational supervision to trainees. All trainers needed to be provided with appropriate time in their job plan to carry out their educational role and effective monitoring mechanisms to ensure effective educational supervision needed to be put in place. As a minimum it was expected that each trainee should have a formal meeting with their Educational Supervisor three times in a placement and the first meeting (induction meeting) must take place within a month of the post starting. • The Trust was required to take immediate steps to ensure that an appropriate consultant-led educational programme was put in place for all trainees. The Trust was required to ensure that these sessions were often

	(but not exclusively) consultant delivered, protected and bleep free, and delivered in a manner which was conducive with good educational practice. • The Trust was required to ensure that appropriate steps were taken to provide educational and pastoral support to trainees in the paediatric department. Senior trainees were, at the time of the visit, responsible for the delivery of key educational interventions and tasks such as designing and managing buddying systems, rotas, training and educational advice. These tasks were either inappropriate for trainees to be conducting in totality, or inappropriate for them to be conducting without support and oversight. Clinical Supervision • Whilst clinical supervision was available to trainees when requested, there was a need to review the manner in which a consultant-led service was delivered in the department. There was a need for all the consultants to be visible in the clinical areas and accessible (not just two who were named by trainees as being ready and willing to get involved clinically) and for them to take the lead in intervening in clinical cases where their input was required. In addition, it was expected of them to proactively check on, recalibrate and review the workload of trainees throughout the day time. Reports of a trainee carrying three bleeps (Emergency Department, Neonatology and General paediatrics) during a busy day shift were not safe or sustainable. Trainees reported times when they had to make split-second decisions about which bleep to respond to as the consultants were not consistently present on the 'shop floor'. SI reporting • The Trust was required to take immediate steps to ensure that all clinical and serious incidents were a) reported via the Trust incident reporting system, b) reported to HEE in line with Responsible Officer Guidelines, c) dealt with from a pastoral perspective in line with expected practice. Expected practice was that trainees were provided with pastoral support, were debriefed as soon as is practicable, and certainly within hours/days of the incident. Trainees reported no support or opportunity to debrief having witnessed their first ever child death, or first death as the registrar in charge of the shift – and how terrible that made them feel. Trust leadership • The Trust was recommended to consider the immediate implementation of senior clinical oversight for the paediatric service at PRUH whilst steps were taken to improve the current situation.
Training programme / specialty reviewed	Paediatrics (foundation, general practice, core and higher)
Number and grade of trainees and trainers interviewed	The quality review team initially met with the college tutor and deputy clinical director of child health. The review team then met with two foundation trainees, two general practice trainees, four specialty training year one (ST1) trainees, one ST4 trainee and one ST6 trainee. Lastly, the review team met with four educational supervisors.
Review summary and outcomes	The quality review team heard the following areas that were working well. • The department had made vast improvements to the local teaching programme and the trainees had access to teaching every day. The

trainees were very positive about the standard and mixture of teaching available.

- The departmental induction had improved. The GP and foundation trainees reported they had a day of neonatal training to ensure they were feeling confident and competent in this area.
- The new college tutor had made a significant impact and the trainees gave positive feedback on the appointment. The new college tutor was enthusiastic, proactive and engaged.
- The quality review team sensed a general feeling of the consultants being more engaged, proactive and demonstrating more leadership. At no point had trainees ever been in a situation with clinical concerns where they had not been supported.
- The higher trainees had good access to outpatient clinics and the quality review team welcomed the fact the trainees had their own clinic lists and ownership over their patients.
- Trainees reported all being able to access study leave and training days.

The quality review team highlighted the following areas for improvement.

- The morning and afternoon handover were reported to be unstructured, and poorly kept to time. Regularly consultants would interject with anecdotes or criticisms and there were discussions of management plans. This resulted in the handover in the morning running into the teaching sessions.
- The quality review team heard that the out of hours (weekday nights after 21h00 and weekends) workload was very heavy and the trainees felt under significant pressure to manage a number of different areas out of hours. The quality review team heard several examples of unsafe clinical practices due to there not enough staff being on shift at night and weekends which impacted on patient safety.
- The quality review team heard that the culture and moral issues were most acutely felt at consultant level. The consultant group had been through a difficult time and there had been improvements but there were still concerns surrounding morale and team working.
- All but one trainee reported having issues with IT log-ins and not having full access to the systems they required to complete their tasks. The quality review team heard that this had been escalated to every level with little improvement.

Educational overview and progress since last review – summary of meeting with College Tutor and Deputy Clinical Director of Child Health

The quality review team heard that the college tutor had stepped into the role following the urgent concern review in June 2016. The college tutor had worked on a variety of concerns raised in June 2016 to recreate an open learning environment as the department's ethos.

One of the key concerns following the last review for the department was handover and this now had established written ground rules for handover and there was an agenda to ensure handover was fit for purpose.

The college tutor had created a list of the core topics for the departmental teaching programme which was mainly aimed at foundation and general practice trainees whilst bearing in mind paediatrics trainees as they required similar teaching as they were new to core paediatric training. The consultants had all signed up to take part in teaching, and in addition external consultants from other specialties came to present topics. The trainees also had the opportunity to present and all trainees were asked to complete feedback forms following teaching.

The department had started a 'what I have learnt this week' board. Team goals were set each week by all staff members and trainees across both King's College Hospital NHS Foundation Trust sites using an educational programme called Slack (similar to WhatsApp). There was also an achievements board where anyone could write something positive about a colleague that week.

The quality review team was informed that the foundation year one trainee was currently taking a photo of the achievement board each week before it was cleaned to collate all the information and would be using this for their quality improvement project.

The college tutor was positive about the support the trainees had given him to start these new initiatives, and reported that the consultants were signing up to support these, some more than others.

The deputy clinical director of child health reported that some of the General Paediatric consultants from the Denmark Hill site were coming to the department for eight weeks a year to be consultant of the week. These consultants also supervised one trainee each and came across to meet these trainees. This was a part of the department's plans to work better as a cohesive group and to improve positive relations.

The review team was informed that the department currently had a business case going through with the medical director's support to have two core trainees working at night. At the time of the review there was only one core trainee working at night.

The college tutor stated that the out of hours workload was a struggle for the whole team and that there were difficulties recruiting locum cover especially at higher trainee level.

The review team heard that the site currently had 6,200 deliveries a year. There was a move to develop the PRUH into a level two neonatal unit although this was probably a three-year plan; currently the department first needed to be safe and fully staffed at night.

The deputy clinical director of child health informed the review team that they recognised that the PRUH neonatal unit was overstretched and that they had submitted a business care for four neonatal consultants to work cross-site. However, this had been stopped due to the Trust's financial status.

The college tutor commented that some consultants had to work overnight as a middle grade trainee as there was a gap in the rota with no locum available. Even the consultants reported they had to make difficult decisions about prioritising patients when they acted down as the higher trainee and this was not an ideal way of working. The review team heard that at night the core trainee carried the delivery bleep, reviewed emergency department (ED) patients and sick patients on the ward.

The deputy clinical director of child health reported that the Trust was looking into medical training initiative (MTI) doctors who would do a year at each site of the Trust. The midwives had been upskilled to carry out baby checks, basic blood tests and other tasks.

The review team was informed that the postnatal babies were overseen by the higher trainee and they were happy to review patients on postnatal ward if the core trainee asked. If an issue was identified then a consultant provided input into that patient's care.

The August 2016 induction had included a neonatal life support session and in the trainee induction feedback forms rated this as the best session. The trainees did report back that they required further in-depth prescribing information, more hands-on prescribing experience and that there were information technology (IT) issues which the college tutor had fed back to the relevant departments.

The deputy clinical director of child health commented that the department had 8.6 whole time equivalents (WTE) consultants and within a year they would like to make this 10 WTE. In five years the department's vision was to have a level 2 neonatal unit with split rotas and evening consultant presence to review all children.

The college tutor informed the review team that the team had an external review by SLAM Partners to look at team functioning. They interviewed all consultants, nurses, managers and senior trainees and pulled together a package of feedback which had built on Simon Roth's external service review.

There was recognition that one problem within the department was in relation to governance, most especially disseminating and ensuring learning from events was established. The college tutor was looking at having a local governance lead to alter the cultural shift within the team to learning from their own governance and events.

There appeared to be managerial issues within the department which were not fully helping to support the department's changes as there was a lack of managerial carry through with actions. The review team understood that the Trust was going through a divisional restructure.

Quality Review Team			
HEE Review Lead	Dr Camilla Kingdon, Head of London Specialty School of Paediatrics	**External Clinician**	Dr Atefa Hossain, Consultant Paediatrician, St George's University Hospitals NHS Foundation Trust
GMC Representative	Hannah Watts, Education QA Programme Manager, General Medical Council	**Trainee Representative**	Dr Tatiana Hyde, Trainee Representative
Lay Member	Catherine Walker, Lay Representative	**Scribe**	Vicky Farrimond, 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 quality review team was informed that sometimes at the weekends the consultants did not carry out a ward round of patients on the special care baby unit (SCBU) and instead this was left to the higher trainee. The trainees reported that the consultant put together the plan on Friday and consultants came in if they had a chance although all new patients were reviewed by a consultant.	Yes, see action P1.1 below
P1.2	**Serious incidents and professional duty of candour** The review team discussed with the trainees a serious incident that Health Education England (HEE) had been informed of. The trainees reported that they spoke to the consultant following the incident to go through what happened and that the consultant was supportive. The trainees commented that they did not feel they had had a team debrief about the incident. The review team heard that the trainees reported being unsure how to write a written statement following the serious incident. The college tutor informed the review team that they discussed how to write statements at induction and that guidance was sent when the governance team requested statements.	Yes, action P1.2 from June 2016 Yes, action P3.1 from June 2016

P1.3	**Rotas** The trainees reported that there had been a substantial improvement to the in-hours workloads and that there was more staff on the shop floor since September 2016 due to fewer rota gaps. Despite this, out of hours cover was still a problem. The trainees commented that on the weekend during the day there was one consultant, one higher trainee and two core trainees - one core trainee to cover the emergency department (ED) and ward and one core trainee to cover postnatal and neonatology. On the weekend during the night this cover was reduced to one higher trainee and one core trainee. Likewise, weekday nights had one core and one higher trainee to cover the hospital. The review team heard that the weekends and weeknights on-call required an extra core trainee, at the very least, to help relieve the onerous pressure of the workload. All the trainees reported that the weekends were physically and mentally exhausting for them due to the workload especially out of hours. The review team heard that on a core trainee's first night working in ED they were alone for six hours as the rest of the team were looking after other sick children which were prioritised. The trainees stated that occasions like this led to patient safety issues as there was no senior support available and they had to prioritise sick patients and hope they made the right decision. The trainees reported that they cross-covered the whole department out of hours which was too high a workload. The trainees covered special care baby unit (SCBU), postnatal, the ward and ED. The trainees reported that they reviewed all under one year old patients, all previously known to paediatrics patients and any clearly sick patient in ED. The out of hours workload was felt to be too much for the trainees to cover and the senior trainees reported struggling having to mentally switch between different clinical areas with different patient populations and needs, out of hours. The trainees reported that when they had locums covering the weekend shifts it was harder as decision-making was slower as the locums were often not aware of the department's systems and different ways of working. The review team heard of one occasion when there were three locums working a weekend (consultant, higher trainee and core trainee were all locums) with a trainee and this meant the trainee felt more isolated and alone. The review team heard that there were still some disparities within the consultant body in their willingness to pitch in and support the trainees with the heavy workload especially at weekends and out of hours. However, all trainees reported that at no point had they ever been in a situation with clinical concerns where they had not been supported. The review team was informed that some of the consultants had acted down and worked as trainees for some time on the weekends to help relieve the workload and the trainees appreciated this as they felt supported. The trainees stated that the department was trying to access more cover out of hours and had managed to occasionally have locum higher trainees covering the twilight shift. None of the higher trainees were on the twilight shift rota as they were insufficient in number to cover their own rota - there were five higher trainees on a seven man rota. The higher trainees reported that their current rota did not allow for a work life balance as they were only able to take from Monday lunchtimes to Thursday evenings off as annual leave. The core trainees reported that they had no rota gaps on their rota. The review team heard that the core trainees had a fixed rota with annual leave and there was no scope to change this which some trainees struggled with around family commitments. The trainees reported that they received their rota two weeks prior to starting at the Trust which was too late and childcare arrangements needed to be made with at least four weeks' notice. The review team heard that the core trainees were interested in a split rota where they undertook three months on general paediatrics and three months on neonatology as they knew the patients, were aware of how to work in that area and build on their competencies. The review team was informed that the department was looking at having two consultants present on the weekend morning to prioritise acute care and ward rounds	Yes, action P1.4 from June 2016 Yes, see action P1.1 below Yes, see P1.3a below Yes, action P1.3 from June 2016 Yes, see P1.3b below

	to ensure that all patients were seen by a consultant. Also discussions were taking place around increasing the consultant on-site cover until 9pm. The deputy clinical director of child health reported that the department was putting through a business case to have two core trainees working out of hours which was supported by the medical director. The review team heard that the department had become busier each year and Princess Royal University Hospital had 6,200 deliveries a year. Despite this the staffing levels within the department had not changed to reflect this and staffing levels were threatened.	
P1.4	**Induction** The trainees reported that they had a good induction which was informative and covered all the necessary areas such as what to do in an emergency in neonatology, opportunities for questions and conversations and ensuring trainees were confident and competent in each area. The trainees stated that the handbook given out prior to arriving at the Trust was very useful and they still referred to it. The trainees reported that none of them went to a delivery without being newborn life support (NLS) trained and no foundation or general practice (GP) trainee carried out baby checks without being supervised first. When trainees started on weekends and nights there was an extra core trainee added onto the rota to assist and show the trainee round the department. The review team was informed that the trainees were given a lecture on how to use the information technology (IT) systems without IT even being able to log into the IT system to show the trainees how to use it. The IT log-ins that were provided did not work on the wards, such as for organising investigations. The trainees reported that this had been fed back to the college tutor and had still not been fully resolved. All but one trainee still did not have access to every IT system they required. When locums worked the IT login situation was even worse.	Yes, see P1.4 below
	Handover The review team heard that of the three daily handovers only the evening handover at 9pm ran to time. It was reported that the morning and afternoon handover was not strict in timekeeping. The trainees felt the handover lost information as it took 45 minutes to discuss patients and patient management plans that were not necessary within handover. The trainees commented that there was a handover agenda which was followed to start with at each handover then discussion trailed off into management plans, anecdotes and other options for care. The trainees reported that two to three consultants attended handover, these usually being the neonatology consultant, consultant of the week and the evening consultant. The review team was informed that when handover ran over the trainees ended up going home late or missing some of their teaching sessions. The trainees reported that there was a jobs list attached to the back of the handover sheet such as chasing up results but since there were usually no names against these jobs; the list tended to get longer; at the time of the review it was over an A4 page. The trainees suggested that names should be placed next to each item and that they needed to ensure they did this when they added items.	Yes, action P1.6 from June 2016

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	**Impact of service design on learners** The review team heard that there had been quite a turnover of nurses on the children's ward with the nurses appearing tired and worn out due to the intense workload. The trainees reported that there was a concerted effort by the consultants to implement change and they were trying to support changes. The trainees stated that the consultants were under immense pressure and that the college tutor gave them their induction having just completed a middle grade on-call night shift. The review team heard that it was interesting to see the consultants from the Denmark Hill site working with them and the trainees wondered if it was possible for the Denmark Hill neonatologists to come and work on the special care baby unit (SCBU) for a week.	
P2.2	**Appropriate system for raising concerns about education and training within the organisation** The trainees reported that they had junior-junior meetings and recently they had started junior-senior meetings. The review team was informed there was no administration support available for the department's local faculty group and the college tutor had to also undertake this activity.	Yes, see P2.2 below
P2.3	**Systems to manage learners' progression** The trainees reported that they would not recommend this post to their friends due to the sheer work intensity out of hours which trainees described as 'crushing'. The trainees commented that the weekend on-calls made them incredibly tired and worn out. The core trainees did report that the higher trainees were supportive of them without fail during on-call night shifts and did not understand why all the consultants could not do the same.	
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	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees raised concerns regarding the behaviour of consultants within the handover. The visit team heard that trainees were still interrupted within their handover and had treatment of patients criticised. The review team heard that the handover following being on-call at night or on the weekend was still critical of the trainees. The trainees felt the criticism of their management of patients was not constructive and trainees came out of handover feeling victimised and upset. The review team heard that the way in which negative feedback or constructive criticism was provided needed to be improved. The trainees reported that following working a night-shift the negative feedback left them feeling low and unsupported. Further details on this behaviour were fed back to the Trust medical director and	Yes, action P3.2 from June 2016

	director of medical education following the review.	
P3.2	**Access to study leave** The trainees all reported being able to access study leave. The review team was informed that the trainees had not attended any Royal Society of Medicine days yet although if they asked for study leave for them they were able to attend.	
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	**Sufficient time in educators' job plans to meet educational responsibilities** The college tutor commented that the number of educational supervisors had been reduced to ensure that there was good quality educational supervision provided to trainees. The educational supervisors all had sufficient time within their job plans to carry out educational activity.	
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 trainees commented that they received local teaching every morning Monday to Friday which they all had access to. They reported that there was a list of 30 core topics which were to be covered once every four month rotation supplemented with monthly x-ray meetings, simulation training, morbidity and mortality meetings, perinatal meetings and case presentations.	
P5.2	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** The higher trainees reported that they attended a clinic on Monday, Tuesday and Wednesday where they had their own clinic list with set patients which was consultant supervised. The trainees stated they were not pulled out from clinic and were able to attend. The core trainees commented that they had been able to attend a couple of clinics including jaundice clinics.	

Requirements

Mandatory Requirements – 15 June 2016			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
P1.2	The Trust is to ensure that all clinical and serious incidents are reported via the Trust's incident reporting system, reported to HEE in line with Responsible Officer Guidelines and dealt with from a pastoral perspective in line with expected practice. The Trust is required to ensure that all trainees are actively encouraged to report all clinical and serious incidents.	The Trust is required to review all clinical and serious incidents reported that involve trainees and ensure that these are reported to HEE. The Trust should ensure that all trainees are provided appropriate pastoral support. This should also be monitored through the LFG and minutes submitted.	R1.1, R1.2, R1.3, R1.4
P1.3	The Trust is to review the manner in which the consultant led service is delivered in the department. Consultants should be visible and accessible to trainees.	The Trust is required to review the consultant rota to ensure there are always consultants present, visible and accessible to trainees. Where this is not possible the Trust should have a clear escalation policy and contact numbers of the on-call consultants. This should also be monitored through the LFG and minutes submitted.	R1.6, R1.7, R1.8
P1.4	The Trust is to ensure that the trainees' rotas across the whole paediatric service are EWTD compliant. The rotas should also include foundation and GP trainee mandatory teaching sessions.	The Trust is required to review the trainees' rotas across the whole paediatric service. The Trust should carry out an out-of-hours monitoring exercise to ensure the rota is EWTD compliant. The rota review should ensure that all mandatory teaching for foundation and GP trainees is included within the rota and they are released to attend. This should also be monitored through the LFG and minutes submitted.	R1.12
P1.6	The Trust is to ensure that there is consultant presence at morning and evening handover.	The Trust is required to ensure consultant presence at morning and evening handover. This is to ensure handover takes place in a timely fashion, principles of effective handover are adhered to and feedback is delivered in a developmental and formative way, conducive to learning and reflection. This should also be monitored through the LFG and minutes submitted.	R1.14
P3.1	The Trust is to ensure that all trainees within paediatrics receive appropriate educational and pastoral support.	The Trust is required to ensure that appropriate steps are taken to provide educational and pastoral support. These could be areas such as educational	R3.2

		interventions and takes such as designing and managing buddying systems, rotas, training and educational advice.	
P3.2	The Trust must ensure that bullying and undermining behaviour ceases as it is not conducive to a supportive learning environment and is not in keeping with the GMC's standards of good medical care and professional behaviours.	The Trust is required to provide evidence of an investigation into this type of behaviour (especially within handover) and the steps the Trust and department will take to ensure this does not happen. This should also be monitored through the LFG and minutes submitted.	R3.3

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
P1.1	The Trust is required to ensure there is sufficient medical staffing out of hours to ensure trainee and patient safety. At the very least this should involve increasing the out of hours team to three doctors, but ideally also provide an on-site consultant presence until 21h00.	The Trust is to provide evidence of a review medical staffing levels out of hours and produce a plan to increase the out of hours medical cover.	R1.7, R1.12
P1.3a	The Trust is to review the induction provided to locum staff prior to working within the department.	The Trust is required to provide evidence of the induction given to locum staff working within the department. The Trust is to ensure that they are provided with ID badges and working computer log ins.	R1.6
P 1.3b	The Trust is to review the coordination of the rota for all trainees and how the trainees receive the rotas.	The Trust is required to ensure that the rota provides a suitable work life balance for all trainees. The Trust is to ensure that annual leave requests submitted with suitable notice periods are met. The Trust is to ensure that all trainees receive a copy of the rota well in advance of starting at the Trust (ideally six weeks). This should also be monitored through the LFG and minutes submitted.	R1.12
P1.4	The Trust is to ensure that all trainees receive working IT log ins at induction.	The Trust is to ensure that all trainees IT log-ins work at the time of starting at the Trust. The Trust is to work with the department to ensure that all known issues are resolved in a timely manner to ensure trainees can access all relevant IT systems. This should also be monitored through the LFG and minutes submitted.	R1.19

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
P2.2	The Trust is to review the administrative	The Trust is to update on the	R2.7,

	support available to the department.	administrative support available to the department for activities such as LFGs.	R1.10

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

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Camilla Kingdon, Head of London Specialty School of Paediatrics
Date:	23 November 2016

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.