

**University College London Hospitals NHS
Foundation Trust (National Hospital for
Neurology and Neurosurgery)
Neurology
Risk-based Review (on-site visit)**



Quality Review report

26 January 2017

Final Report

**Developing people
for health and
healthcare**

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Quality Review details

Background to review	<p>The risk-based review (on-site visit) to the National Hospital for Neurology and Neurosurgery (NHNN) was undertaken by Health Education England (HEE) following poor feedback in the 2016 General Medical Council National Training Survey (GMC NTS). Neurology generated five red outliers for 'clinical supervision', 'induction', 'supportive environment', 'feedback' and 'regional teaching' as well one pink outlier for 'adequate experience'. In addition, one green outlier was generated for 'local teaching' in neurology. The quality review team was keen to explore the areas highlighted within the 2016 GMC NTS with regard to neurology training, both at higher specialty and core medical training (CMT) level.</p> <p>Moreover, the quality review team was keen to explore the opportunities available for trainees to attend outpatient clinics as well as trainee workload, handover and consultant on call arrangements.</p> <p>HEE had not previously reviewed neurology training at the NHNN site. Consequently, the quality review team was keen to review the training provided in neurology at the site, including the experience available to core medical trainees (CMT) and whether this was commensurate with their level of training.</p>
Training programme / learner group reviewed	<p>The quality review team met with 16 core and higher trainees in neurology, at the following grades:</p> <ul style="list-style-type: none"> • Core training year 1 • Core training year 2 • Specialty training year 4 • Specialty training year 5 • Specialty training year 6
Number of educators from each training programme	<p>The quality review team met with 13 educational and clinical supervisors in neurology.</p>
Review summary and outcomes	<p>The quality review team would like to thank the Trust for accommodating the risk-based review (on-site visit).</p> <p>During the course of the review, the quality review team identified areas that were working well with neurology training at the site, including:</p> <ul style="list-style-type: none"> • There was a rich neurological experience available at the site. • The leads for neurology training had clearly made serious attempts to improve training. • Following changes in practice, higher trainees were better able to attend regional teaching. This was noted as an improvement. • Trainees reported that they felt listened to and that they had seen that some of their suggestions had been acted upon. <p>In addition, the quality review team identified areas for improvement with neurology training at the site, including the following:</p> <ul style="list-style-type: none"> • The core trainee group interviewed was very disconsolate. They felt that they would not recommend this placement to a colleague, unless particularly wishing to train in neurology. • Core trainees noted that their working weeks were often very fragmented. There was a lack of continuity in patient caseload and a reduction in the learning possible from managing different patients on different days.

- Core trainees noted that they frequently had little or no exposure to consultants for whose patients they were responsible. There appeared to be a lack of contact between the senior clinical leadership and the core trainees.
- The firm Induction for core trainees was variable. It was poor for trainees when they started their placement out-of-sync with the standard changeover period. Also there was no clear induction when trainees changed firms to cover periods sufficiently long that learning and training would be possible.
- The number of ward rounds for higher trainees was excessive.
- Higher trainees undertook inappropriate duties, such as booking scans for consultants for patients they had not seen
- Higher trainees were concerned that the day-case unit was used as a way of seeing ad hoc urgent patients (who may be from quite far away from the immediate locality) who might be seriously unwell. However, there was insufficient support to manage these patients on the unit. The hospital does not have an emergency department for such admissions.
- Educational supervisors did not seem to be aware of their new duties regarding the new contract.
- The higher trainees appeared to be caught in the middle of working for multiple consultants with many ward rounds and burdened with sometimes overwhelming amounts of administration. In some instances, this made their roles unsustainable and confusing. However, this appeared to vary from sub-specialty to sub-specialty but the trainees would not be drawn on the specifics of which were of concern. The quality review team was concerned by the trainees' reticence to divulge further details on this.

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

The director of postgraduate medical education informed the quality review team that the governance structure for the Trust was organised on a Trust-wide basis rather than specific to each site. The governance structure meant that there was a route whereby trainees were able to feed any concerns to the Trust's director of workforce.

The quality review team heard from the training lead for neurology that following the 2016 GMC NTS results, the department sought feedback from trainees regarding potential improvements to be made. It was noted that this feedback had been reviewed and changes had been made to the neurology training at NHNN in the months prior to the risk-based review. The training lead for neurology stated that such improvements included:

- the removal of trainees from the University College London Hospitals NHS Foundation Trust (UCLH) stroke thrombolysis rota, and night shifts covered by research fellows.
- trainees to be on call from home after 9pm for general neurology.
- all trainees to attend regional teaching.
- implementation of a new core trainee level rota (designed in collaboration with trainees) which included a week of clinics to ensure trainees were able to meet competences in this area. This was due for implementation in February (after the next change over).
- common room to be created.
- development of a junior doctors' project group to include representation from the training programme director, core medical training lead, management team and trainees.

Furthermore, some of these changes were not due to be implemented until February 2017 so the current trainees may not have benefitted from such improvements.

At the time of the review, the department consisted of 106 consultants in neurology across ten specialist firms (as well as multiple sub-specialties) covering 18,000 inpatients and 28,000 new outpatients annually. The training lead for neurology advised that the training within neurology had an academic focus with 300 PhD students at University College London's Institute of Neurology. Furthermore, the majority of trainees in neurology were interested in undertaking research usually culminating in a PhD and the Trust was supportive of such

endeavours. Consequently, these academic activities impacted on neurology training in terms of trainees being out of programme (OOP) for a length of time. It was noted that as a result of this and the difficulty in appointing locums there were five vacant posts at the hospital when the 2016 GMC survey was carried out, which may have impacted on the responses. However, when the trainees were asked if as a result of this they felt that OOPs should be restricted they unanimously said “no”. The training lead for neurology highlighted some of the challenges faced by the neurology training at the Trust, which included the busy nature of the hospital with diverse patients having complex treatments, the number of ward rounds attended by higher trainees, relatively short attachments for trainees (maximum of 12 months and often split between three firms and sometimes subdivided into two month blocks.). Although this provided a rich experience from the point of view of exposure it consequently made the attachments very disjointed.

Regarding induction, the training lead for neurology advised that trainees received a Trust induction on the first day of their placement, a local half-day induction as well as a firm induction. It was noted that local faculty group (LFG) meetings and the junior doctor’s committee (which included consultant representation) were arenas where trainees could raise concerns regarding their training. It was noted that discussions regarding trainees in difficulty (TiD) were held following LFG meetings in a confidential meeting with only consultants present. Although the details of such a discussion was circulated to the visiting team as examples of the minutes, it was insisted that no such documentation was shared with trainees.

Quality Review Team

HEE Review Lead	Dr Karen Le Ball Head of the London Specialty School of Medicine	External Clinician	Dr Anthony Pereira Consultant Neurologist St George’s Hospital London
Trust Liaison Dean	Dr Andrew Deaner Trust Liaison Dean Health Education England North Central and East London	External Clinician	Professor Alasdair Coles Consultant Neurologist Addenbrooke’s Hospital Cambridge
Lead Provider Representative	Helen Jameson Director of Corporate Programmes UCL Partners	Trainee Representative	Dr Claudie Sellers Medical Education Fellow in Anaesthetics
Lay Member	Robert Hawker Lay Representative	Scribe	Kate Neilson Learning Environment Quality Coordinator Health Education England

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
N1.1	<p>Patient safety</p> <p>The core trainees reported that they did not have any concerns regarding patient safety at the site as most of the patients they looked after were well, as often they had been admitted for investigation. The only acutely sick patients were those on the adult brain injury unit (ABIU) or the step down stroke ward.</p>	
N1.2	<p>Serious incidents and professional duty of candour</p> <p>The quality review team heard from the core trainees that none of them had reported a serious incident.</p> <p>The higher trainees who had submitted a serious incident report advised that they had not received feedback on these at the time of the review, although some had only been reported recently.</p>	Yes. See ref N1.2 below.
N1.3	<p>Appropriate level of clinical supervision</p> <p>The higher trainees informed the quality review team that whilst supervision at specialist clinics was usually good, hitherto supervision in general neurology clinics had been poor as in some instances, there had been none. However, the quality review team heard from the higher trainees that if clinics were to be used as a training opportunity, each patient should be reviewed in collaboration with the consultant, which did not always happen. The potential opportunity for undertaking supervised learning events (SLEs) was missed. The quality review team also heard that the intention was that these clinics would be 'wound down'.</p> <p>See section N1.5 below.</p>	Yes. See ref N1.3 below.
N1.4	<p>Responsibilities for patient care appropriate for stage of education and training</p> <p>The core trainees informed the quality review team that whilst the site provided exposure to specialist cases, they did not have much responsibility for patient management due to the levels of senior input. These trainees noted that their duties mainly included fitting cannulas, taking bloods and completing discharge summaries and that there was not much opportunity for additional responsibility. Furthermore, the core trainees advised the quality review team that they did not feel valued due to the fact that senior clinicians often did not read their patient assessments or provide feedback on them.</p> <p>The core trainees commented that their work could be done by a foundation year 1 (F1) trainee.</p> <p>Regarding the epilepsy placement at the Chalfont Centre, the core trainees informed the quality review team that although interesting, it was a very specialised environment and duties mainly included clerking and prescribing. There was little exposure to general medicine and as such, these trainees noted that it may not be a suitable learning environment for core trainees.</p> <p>The higher trainees reported that at times they were asked to complete administrative duties for patients under the care of consultants or research fellows (e.g. booking scans), which could be time-consuming and with no educational benefit. These higher trainees also advised the quality review team that they were expected to attend multiple ward rounds. They each worked with several consultants and each consultant would do their own individual ward rounds, which meant that they were</p>	<p>Yes. See ref N1.4a below.</p> <p>Yes. See ref N1.4b below.</p> <p>Yes. See ref N1.4c below.</p>

	often not able to complete duties following one ward round before the next ward round started.	
N1.5	<p>Rotas</p> <p>The core trainees reported that whilst their workload was manageable and that they were able to leave on time, shortages on the rota led to insufficient ward cover and as a result, they found it hard to attend clinics. Furthermore, cross-cover arrangements meant that these trainees often felt pulled in different directions and noted that this left little time to actually work with and develop a rapport with individual consultants. This affected their ability to request workplace-based assessments (WPBAs) and multiple consultant reports (MCRs). The quality review team also heard from the core trainees that they were rarely able to attend full ward rounds.</p> <p>The core trainees noted that the workload at night was light and involved clerking patients. These trainees advised that they usually knew which higher trainee was on call with them. It was noted that the core trainee on-call rota indicated who the responsible consultant and higher trainee were and that the switchboard could also advise of this. However, higher trainees were variable in the support they provided when on call. The core trainees informed the quality review team that when they were unable to contact a higher trainee in neurology, they could obtain advice from elsewhere (e.g. the anaesthesia team and medical intensive therapy unit).</p> <p>The quality review team heard from the higher trainees that regarding the on-call rota at the NHNN site, higher trainees worked onsite until 9pm. On the whole, they attended the hospital handover meeting and then were able to be on call from home after this time. These trainees advised that they also provided advice over the phone for the wider Trust but that they rarely had to leave NHNN to attend other sites.</p> <p>Regarding the higher trainee rota, it was noted that prior to the review, there had been five rota gaps which had made it difficult to manage.</p> <p>The higher trainees informed the quality review team that the name of the on-call consultant was not available on the higher trainee rota. Furthermore, whilst the rota coordinator had previously emailed the switchboard to inform them who the on-call consultant was, at the time of the review this practice had ceased. The higher trainees noted that this information was available on the shared drive but was often time consuming to find. In some cases, consultants contacted the higher trainee to inform them that they were the designated on-call consultant but that such practice was infrequent.</p>	<p>Yes. See ref N1.5a below.</p> <p>Yes. See ref N1.4c below.</p> <p>Yes. See ref N1.5b below.</p>
N1.6	<p>Induction</p> <p>The quality review team heard from the core trainees that arrangements regarding induction were variable. Whilst these trainees noted that they had received a Trust induction which was well structured, some did not receive a local or firm induction. This was especially the case for those trainees who started their placement out-of-sync with the usual placement start date. Those trainees who had received a local induction reported that it was not as structured as the Trust induction and that computer logins for the NHNN systems did not work on their first day of placement (although the UCLH logins did work) so they were not initially able to access the shared drive.</p> <p>The higher trainees informed the quality review team that regarding the firm induction, some firms provided this in the form of a conversation with a consultant and a related induction pack (including stroke, cognitive, epilepsy). However, provision was variable and some firms did not have such an induction. Also induction was usually not available for core trainees who were asked to cover a firm temporarily or those that joined the firm out of sync.</p>	<p>Yes. See ref N1.6 below.</p>
N1.7	<p>Handover</p> <p>The quality review team heard from the higher trainees that an email handover system was in place which was sent in the morning and evening. It was noted that this system worked well.</p>	

	Regarding hospital at night (H@N), the core and higher trainees advised the quality review team that there was a meeting between 8.30pm and 9pm to handover patients.	
N1.8	<p>Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience</p> <p>Regarding attendance at clinics, the core trainees reported that whilst there were three clinics with a dedicated room for use by core trainees, they were not always able to attend these due to insufficient ward cover. Consequently, these trainees noted that they would not be able to complete the 20 clinics as required by the curriculum. Some trainees were well short of achieving this number for this placement, which should have been in the realms of seven or eight for a four-month attachment.</p> <p>The quality review team heard from the trainers that clear guidance had been given to consultants as to the expectation from the core trainees in clinic but it sounded like they had limited opportunity to enact this. It was hoped that the new arrangements for clinics from February 2017 would help resolve this issue.</p>	Yes. See ref N1.8 below.
N1.9	<p>Protected time for learning and organised educational sessions</p> <p>The core trainees reported that the culture regarding education and training at the site was that teaching was done formally. In contrast, there was a lack of informal ward based clinical teaching and feedback. Moreover, these trainees noted that there was not a clear ethos that supported education at the site and that senior clinicians were variable in their commitment to education and training.</p> <p>The higher trainees informed the quality review team that there were good teaching opportunities available in the department but that the ability to attend these was often variable depending on the firm. Opportunities included the Gower's round and higher trainee teaching at 8.15am on Fridays. At the time of the review, changes had been made to facilitate higher trainee attendance at mandatory training days including bleeps being diverted to the on call higher trainee. Furthermore, clinics booked on Wednesdays had been reallocated to other days and higher trainees were not expected to attend ward rounds on Wednesdays to allow for study leave.</p>	
N1.10	<p>Adequate time and resources to complete assessments required by the curriculum</p> <p>See section N5.1 below.</p>	

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.

N2.1	<p>Impact of service design on learners</p> <p>The quality review team heard from the core and higher trainees that they would be happy for their friends and family to be treated at the site in the case of a serious neurological problem.</p>	
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	<p>The higher trainees informed the quality review team that they were often asked by secretaries and clinical nurse specialists (CNS) to review patients on the day unit. As these higher trainees may not have been involved with such patients' care previously, they noted that it would have been more appropriate to direct them to their local general practitioner (GP), their local emergency department (ED) or their own neurologist, as often they lived many miles away. Moreover, the higher trainees advised that the unit was not suitable for the assessment of these patients, who may present when acutely unwell and then require admission on an ad hoc basis.</p>	Yes. See ref N1.4b below.
N2.2	<p>Appropriate system for raising concerns about education and training within the organisation</p> <p>The core trainees informed the quality review team that they had the opportunity to attend monthly meetings with the college tutor and clinical leads and that this was a forum in which to raise any concerns they had around their training. At the time of the review, changes had been made to their rota in terms of minimising cross-cover responsibilities and implementing a clinic week to improve clinic attendance. As a result, these trainees noted that they were listened to but that they felt that the Trust was limited in what it could do to improve training.</p> <p>The higher trainees advised the quality review team that there were trainee representatives who attended the LFG meetings and coordinated trainee feedback. These trainees noted that senior staff were receptive to suggestions from trainees, and there did appear to be a commitment to exact an improvement. However, this desire may not have been universal within the consultant body.</p>	
N2.3	<p>Systems and processes to make sure learners have appropriate supervision</p> <p>See section N1.10 above.</p>	
N2.4	<p>Organisation to ensure access to a named educational supervisor</p> <p>The quality review team was informed by the core trainees that they all had an educational supervisor.</p>	
<p>3. Supporting and empowering learners</p> <p>HEE Quality Standards</p> <p>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.</p> <p>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.</p>		
N3.1	<p>Behaviour that undermines professional confidence, performance or self-esteem</p> <p>The quality review team heard from the higher trainees that whilst they had not experienced any explicit behaviour deemed as bullying or undermining at the site, the atmosphere of the Gower's Round could be intimidating. Moreover, it was noted by these trainees that the Gower's Round was not a forum in which they felt comfortable to ask questions so was not a constructive teaching opportunity.</p> <p>Whilst the quality review team was informed that improvements had been made to the Gower's round at the time of the review, the mood was still deemed to be old fashioned by the higher trainees.</p>	
N3.2	<p>Academic opportunities</p> <p>The quality review team was informed that trainees had the opportunity to complete PhD studies by taking time out of their programme and that they were encouraged to become involved in research projects and pursue further funding for higher research grants.</p>	
N3.3	<p>Access to study leave</p>	

	The quality review team heard from the core trainees that it could be difficult to obtain study leave, including for attendance at regional teaching. See section N1.10 above.	Yes. See ref N3.3 below.
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.		
N4.1	Access to appropriately funded professional development, training and an appraisal for educators There appeared to be confusion among the educational supervisors around the changes to their role in light of the new junior doctors' contract although some noted that they had received a letter about this. The quality review team advised that there was an e-module available from the HEE website about the changes to the role of educational supervisor.	
N4.2	Sufficient time in educators' job plans to meet educational responsibilities The quality review team heard from the educational supervisors that they all received an allocation of 0.25 programmed activities (PA) for their educational supervision duties.	
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.		
N5.1	Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum The quality review team heard that the fact that there were 106 consultants in the department meant that it was difficult for core trainees to build relationships with them, which in turn made it hard to completed SLEs and WPBAs due to a lack of continuity in clinical supervision. Shortages on the rota exacerbated this issue as trainees were required to provide cover across firms. However, these trainees noted that at the time of the review plans had been implemented to improve the rota allocation for core trainees. The educational supervisors advised that it was often difficult to sign off assessments for trainees due to the limited time they had working with them. An example of this, was not knowing a trainee for long enough to be able to complete an MCR. However, it was noted that at the time of the review there was an increasing awareness of the need to meet with trainees regularly in order to complete their e-Portfolio. The	Yes. See ref N1.8 below.

educational supervisors advised that the college tutor had flagged this concern at recent LFG meetings (the last meeting was on 12 January 2017).	
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Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
N/A			

Immediate Mandatory Requirements			
Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
	N/A		

Mandatory Requirements			
Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
N1.2	The Trust is required to review and strengthen the engagement of the trainees in the serious incident process. The Trust to ensure that all trainees who submit Datix reports receive feedback, including details of how the issue has been dealt with.	Trust to provide summary of feedback to trainees versus a log of Datix forms submitted by trainees. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where feedback from Datix reports is discussed.	R1.3
N1.3	The Trust should conduct a survey of trainees to ascertain how often they are left without adequate supervision in clinics.	Trust to submit results of the survey, including detailed plan of action to remedy any deficiencies. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where attendance at clinics is discussed.	R1.8
N1.4a	The Trust is required to change the culture surrounding the core trainees to make them feel more valued and align their training needs with their day-to-day work. Learning should be individualised and tailored to trainees' needs, interests and objectives. Consultants must provide feedback to core trainees on their work.	Trust to submit a report detailing how they plan to improve the culture for core trainees and tailor their learning to individual trainees' needs. This report should include information about how consultants plan to provide feedback to core trainees. Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where adequate experience for core trainees is discussed.	R1.15

N1.4b	<p>The Trust must ensure that the burden of administrative duties be lessened for the higher trainees, as follows:</p> <ul style="list-style-type: none"> Higher trainees should not have to book investigations on the behalf of consultants The number of emails they receive burdening them with more admin should be monitored The amount of extra work they are given by other members of the team (e.g. specialist nurses asking for them to arrange tests or see patients) should be monitored and reduced <p>Trust to conduct audits on the type of inappropriate duties undertaken and how often/for how long.</p>	<p>Trust to submit the audit of inappropriate duties undertaken and submit a plan of action of how they plan to rectify the situation.</p> <p>Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where inappropriate duties is discussed.</p>	R1.15
N1.4c	<p>The Trust is required to ensure that core trainees are able to attend at least one full ward round a week.</p> <p>The number of consultant ward rounds should be lessened to permit higher trainees to complete them. This could be achieved by having an attending system or having a weekly teaching ward round where all patients are seen.</p>	<p>Trust to submit communications sent to trainees advising of the ward cover arrangements to allow them to attend ward rounds.</p> <p>Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where attendance at ward rounds for core trainees is discussed.</p>	R1.12
N1.5a	<p>The Trust is required to reduce the number of consultants that individual (core and higher) trainees work with, in order to enable better continuity of roles and allow trainees to develop relationships with consultants.</p> <p>Moreover, the amount of cross-cover by core trainees should be reduced.</p>	<p>Trust to submit copies of the updated rotas over a four-week period.</p> <p>Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where this is discussed.</p>	R1.12
N1.5b	<p>The Trust is required to ensure that the higher trainees' on-call rota clearly states who the responsible consultant is and that the switchboard also receives this information.</p>	<p>Trust to submit copies of the updated rotas over a four-week period.</p> <p>Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where this is discussed.</p>	R1.12
N1.6	<p>The Trust must ensure that a local induction is provided for any trainee starting any post at any time of year. The departmental induction must be sustainable, of high quality and must include:</p> <ul style="list-style-type: none"> orientation and introductions details of rotas and working patterns clinical protocols 	<p>Trust to confirm, via a survey of trainees, that each trainee has received an induction and that this was considered fit for purpose.</p> <p>Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where induction is discussed.</p>	R1.13

	<ul style="list-style-type: none"> working computer logins. 		
N1.8	The Trust is required to revise the rotas to ensure that core trainees attend regular clinics. Core trainees must also obtain feedback via SLEs.	<p>The Trust to submit copies of the revised rotas for core trainees, which clearly indicates access to clinic lists.</p> <p>Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where access to clinics is discussed.</p>	R1.12
N3.3	The Trust must ensure that core trainees obtain sign off for their study leave in a timely manner.	<p>The Trust to submit copies of correspondence to trainees that clearly states the process for sign off of study leave, including who is responsible for this and the timeframe.</p> <p>Compliance with this action should be monitored through LFG meetings. The Trust to submit minutes from LFG meetings over a three month period, at which there is trainee representation, where study leave is discussed.</p>	R3.12

Recommendations

Rec. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
	N/A		

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

Requirement	Responsibility
With internal medicine training (IMT) on the horizon all core medical training rotations in London will be reviewed and mapped to the new curriculum, which may have an impact on where trainees are placed in the future.	Dr Karen Le Ball

Signed

By the HEE Review Lead on behalf of the Quality Review Team:	Dr Karen Le Ball Head of the London Specialty School of Medicine
Date:	28 February 2017

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.