QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Homerton University Hospital NHS Foundation Trust

Anaesthetics

Risk-based Review (on-site visit)

Quality Review report

18 January 2018

Final report

Developing people for health and healthcare

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Quality Review details

Background to review	Homerton University Hospital NHS Foundation Trust received the following outliers from the General Medicine Council National Training Survey (GMC NTS) 2017: • Core Anaesthetics received one red outlier (feedback), and eight pink outliers (overall satisfaction, clinical supervision, clinical supervision out of hours, induction, adequate experience, curriculum coverage, educational governance, educational supervision) • Anaesthetics received three pink outliers (feedback, induction and educational supervision). Health Education England (HEE) wanted to explore the reasons for the significant increase in the number of pink outliers for the above programme groups in comparison to the GMC NTS 2016.
Training programme / learner group reviewed	Anaesthetics
Number of learners and educators from each training programme	The quality review team met with the Chief Executive, Chief Operating Officer, Medical Director, Director of Medical Education, Medical Education Manager, Educational Supervisors for anaesthetics and intensive care unit, College Tutor, Clinical leads for anaesthetics and intensive care unit. The quality review team also met with the following trainees: • Core anaesthetics and ACCS trainees at level one and two x 4 • Higher trainees x 2
Review summary and outcomes	During the course of the on-site visit, the quality review team acknowledged that Homerton University Hospital NHS Foundation Trust had been proactive in improving the training environment and experience provided to its trainees. The quality review team was pleased to hear a number of areas that had been working well: • The quality review team wanted to commend the Trust on the buddy system that had been put in place in the intensive care unit (ICU), and hoped that this will continue. • The trainees spoke very highly of the anaesthetics training that they received. The trainees were highly complementary of the consultant body which they described as supportive, friendly and approachable. The quality review team was pleased to hear no reports of bullying and undermining. • The quality review team heard that the clinical environment had allowed the core trainees to complete their required units of training. However, the higher trainees reported experiences of difficulties in getting their anaesthetics competencies signed off. • The quality review team acknowledged that the Trust had been proactive in resolving the issues identified from the 2016 General Medical Council National Training Survey (GMC NTS) results. However, the quality review team also learnt of the areas that needed improvement:

	• The quality review team heard of numerous concerns in ICU including consultant staffing levels. In addition, trainees reported difficulties in achieving their anaesthetics training requirements as they were spending a disproportionate time covering the ICU, compounded by only allowing trainees to take leave during their non-service blocks. Trainees covering ICU on calls only did long days and nights on ICU leaving short days to achieve their anaesthetic training requirements. If they were not doing ICU on calls, they would do Obstetric on calls (which has the same intensity of service provision as ICU). The Head of School stated that a discussion with the postgraduate dean will be had to explore steps for a separate triggered external visit to the intensive care unit to try to resolve these issues. • The quality review team stated that there needed to be explicit recognition in the consultant job plans of time for educational roles separate from the general supporting professional activities (SPAs) time, as per the recommendations of 0.25 PAs per trainees for the educational supervisor role as well as some recognition for those individuals with overall responsibility for training e.g. College Tutors, 1PA/ 20 trainees • The quality review team stated that Trust needed to formalise its standard operating procedures (SOPs) for out-of-hours (OOH) cover for both ICU and anaesthetics, and to ensure that these where monitored with appropriate escalation when these were not followed. The team heard of three instances where there was little consultant involvement in cases despite trainees escalating concerns during OOH in the ICU. • The quality review team reported concerns about anaesthetic trainees who were covering ICU at the detriment of their general anaesthetic day time duties. Also, the quality review team learnt - and had concerns – about the number of consultants covering ICU. • The quality review team recommended that the Trust explore external support to improve team working between the anaesthetics and intensive care unit. The quality review team acknowledged that the Trust had been fully engaged in improving the quality of patient care, education and training in anaesthetics and intensive care unit. The Head of School stated that in order to offer further support to the Trust, there was going to be a discussion with the Postgraduate Dean about a separate visit to intensive care unit.

Quality Review Team			
HEE Review Lead	Dr Cleave Gass Head of the London Academy of Anaesthesia, Health Education England	**Deputy Postgraduate Dean**	Dr Indranil Chakravorty Deputy Postgraduate Dean, Health Education England
External Clinician	Dr Catherine Shaw Consultant Anaesthetist at Whittington Health NHS Trust	**External Clinician**	Dr Chris Sadler Consultant Anaesthetist at The Barts Health NHS Trust
Lay Member	Jane Gregory Lay representative	**Scribe**	Adora Depasupil Learning Environment Quality Coordinator, Health Education England, London and the South East

Observer	James Coeur-de-Lion Learning Environment Quality Coordinator, Health Education England, London and the South East		

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

The quality review team wanted to thank the Trust for accommodating the review and for the efforts made in facilitating the process.

The Director of Medical Education (DME) stated that the Trust had been through some organisational changes including the stepping down of a college tutor and that two senior intensive care unit (ICU) consultants had retired about three years prior to the review and the continued gaps in the rota due to national shortages of ICU consultants. The DME explained that there had been two internal incidents raised by the trainees which the Trust had investigated and the trainees were supported; however, these were not deemed as serious incidents. The quality review team heard that these two incidents involved a consultant support linked to service demands and pressures of the ICU not having enough consultant supervisors. HEE had also been made aware of one reported S.I. following an incident in ITU where a trainee had escalated concerns that there was no direct consultant attendance out of hours in the further management of a critically ill patient on the ICU. This was noted to be one of the three incidents which had been mentioned earlier. The Trust reported that consultant cover had been managed by the four substantive ICU consultants and by a locum consultant covering the fifth substantive post. The trust has advertised for a sixth consultant (since late 2017). The rota structure for ICU consultants had been changed to try and minimise the impact on continuity of care. Despite these changes the environment had continued to be stressful. The visiting team was also aware that at one point the unit had only one substantive consultant clinically present due to sick and annual leave over a period during the summer of 2017.

The DME stated that the Trust had already been aware of the three incidents prior to the 2017 General Medical Council National Training Survey (GMC NTS) results, and that the Trust had already started to put in efforts in order to address this. The quality review team heard that the DME and Head of Medical Education attended the local faculty group (LFG) meeting in October 2017, there had been approximately 15 trainees including trust doctors from different grades who had reported a positive culture in anaesthetics and ICU. Changes had been implemented to address the pink outliers resulting in some progress. For instance, the ICU clinical lead stated that in August 2017, when trainees were novices for anaesthetics the Trust had implemented a 'buddy-system' – where the trainees were each paired to work alongside a senior trainee for the first two to three months of their rotation.

The quality review team wanted to explore how the Trust had managed the training provided in the anaesthetics department. The college tutor stated that the novice anaesthetic trainees had been placed on a novice course based at The Royal London. The college tutor further stated that the trainees had been provided with a supplementary induction programme, including lectures and basic anaesthesia knowledge. The quality review team heard that the anaesthetic trainees had been provided with educational supervisors, that all trainees had been encouraged to work through their competencies within the first three months, and that their competencies needed to be signed off before the six-month period. The quality review team also heard that the trainees had been placed on the general on-call rota, but they had not worked independently, or worked beyond their set hours without a consultant to supervise them including at the weekends. The quality review team was pleased to hear that the college tutor and educational supervisors had been practising an 'open-door' policy to ensure the trainees felt that they could approach their supervisors whenever they needed advice or support.

The Trust reported that the annual delivery in obstetrics was approximately 5,700. The Trust stated that they had 16 clinical fellows, two of which were specialist doctors but worked on the same on the rota. The quality review team heard that the higher trainee body consisted of eight specialty trainees at specialty training year three (ST3) and above, three core trainees at ST2, two core trainees ST1 and six were CT2 from acute care common stem (ACCS) specialty training programme.

In regard to allocation of trainee per educational supervisor, the Trust reported that the majority of the consultants in anaesthetics and ICU were educational supervisors and were allocated no more than two trainees each. The quality review team heard that the college tutor was responsible for appraising the educational

supervisors. The DME further stated that the educational leads had been provided with study leave budget to support their educational responsibilities, and that everyone had been encouraged to take their study leave.

The Trust reported that the operating department practitioner (ODP) did not routinely attend ICU but was available if necessary. Additionally, the Trust stated that all ICU nurses were competent to assist if intubation was required to be in done ICU, and that a dedicated accident & emergency staff nurse was available if further support was needed. The Trust reported that the core trainees at level 2 were doing their obstetrics training on day time, not at night and that they were buddied up with a higher trainee. It was reported that there were consultants present for the main elective list, and one consultant for obstetrics at all times to ensure trainees were well supported and supervised. The quality review team heard that as two anaesthetists at night covered the labour ward, this meant that one of them was usually able to cover a critical patient elsewhere if necessary.

The quality review team was informed that 50% of the consultants on-call chose to stay in the hospital at night so they could respond almost immediately when required. The quality review team was informed that consultants had been allocated five days a week on labour ward and were expected to train the core trainees at CT2 for three months. The Trust stated that for the first six weeks the trainees were placed on elective lists to pick up competencies easily. The Trust further stated that one consultant stayed on the elective list, and the other on the emergency list and then switched around depending on the workload. The college tutor stated that the multi-disciplinary team handover on labour ward at 08:00 had been a positive change.

The Trust reported that at induction, all trainees had been informed that if the trainees had any concerns about bullying and harassment, that all educational supervisors were happy for the trainees to approach them and discuss their concerns. The DME reported that the main induction at the Trust was delivered every six months, and that a monthly induction for new starters where incident reporting was covered was also delivered. The DME explained that the trainees had been informed that the medical education team could also be approached by the trainees if they felt that they could not approach their department or if an issue had not been dealt with.

The quality review team heard that the Trust had appointed a guardian for safe working (GOSW). The clinical leads had received no reports, but commented that all reports would be sent to the trainees clinical and educational supervisors, as well as the GOSW. In addition, any exception reports relating to education or training were sent to the DME. The clinical leads reported that the trainees were placed on a rolling rota which the clinical leads monitored in terms of skill mix; for instance, to ensure that a core trainee had always been paired up with a higher trainee. The clinical leads also reported that the rota had allowed the trainees to enjoy a long weekend break in order to accommodate their personal lives and to replenish their energy.

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
A1.1	**Serious incidents and professional duty of candour** The quality review team heard of two serious incidents (SIs) that involved trainees. However, the trainees reported that the Trust had been proactive in ensuring that the teaching sessions also covered SIs. The quality review team heard that the Trust conducted a regular morbidity and mortality (M&M) meeting, and that all trainees had been encouraged to attend. The trainees reported that communication about SIs had been good and that the trainees had been receiving frequent e-mails to inform them of any SIs and recommendations. The Trust also reported that if trainees had been involved with any SIs, trainees were encouraged to reflect and the supervisor kept in regular contact with them whilst the SI was being investigated. The DME also reported that the Trust had been sending a monthly newsletter Trust-wide that covered SIs across all departments for shared learning purposes. Also, the quality review team heard that grand rounds were conducted on a regular basis.	
A1.2	**Appropriate level of clinical supervision** The higher trainees reported that they were able to obtain advice on the phone out of hours (OOH). However, the higher trainees reported that the management plans of patients changed on a day to day basis depending on the ICU Consultant and clinical supervision had to be more consistent, especially when a significant clinical decision had to be made such as escalation decisions and end of life care. However, the higher trainees acknowledged that there had been some improvement recently, prior to the quality review.	Yes, please see A1.2
A1.3	**Rotas** The core and ACCS trainees reported that the anaesthetics department worked on a one in eight rota, with one day on-call a week. It was reported that all consultants were supportive, especially if the novice trainees had not done anaesthetics before which had helped with developing their confidence. The trainees also reported that the consultants had been helpful in ensuring that the rota covered the necessary modules required by their curriculum. The core and ACCS trainees reported that the anaesthetics department had been a really good place to learn, especially if they were new to the specialty. The trainees reported that they were supernumerary, that the consultants stayed with the them until the cases had finished, and that all of anaesthetics consultants provided teaching on a list and they had the freedom to go home whenever they liked after 20:00 hours. However, the trainees stated that they would have liked to do more tasks during the on-call shifts. The core and ACCS trainees reported that the obstetrics theatre had been busy and so they had been placed on the rota during the day, but not the on-call rota. The trainees stated that there had been regular cover by higher trainees at night for obstetrics but that they also helped with the general theatre cases if needed. All trainees reported that they were informed to call the ICU consultants as first point of contact for any escalation or if they needed advice. In addition, one of the obstetric anaesthetic registrars is available if immediate assistance was required. The trainees reported that there was a formalised process in place for receiving feedback from the consultants and that they were presented with an opportunity for discussion, which meant that the trainees competencies had been signed off in a timely manner. Furthermore, the core and ACCS trainees reported that they were paired up as per the buddy system, for night and weekends for the first two months depending on their training placement duration, and that there were extra higher trainees who had been able to provide further support.	Yes, please see A1.3 below

	The core and ACCS trainees reported that they found requesting leave quite simple as they were supernumerary. As long as they gave enough notice, the trainees stated that the clinical lead had been flexible and had been accommodating of their leave requests. However, the core trainees also commented that in ICU, it was noticeable when there was a gap in the rota but if they gave enough notice they were still able to obtain leave approval. The quality review team heard that on the occasions when the trainees had to work late when undertaking cases, they were given the option to leave early during their next shift. The Deputy Postgraduate Dean recognised that these instances happen, but explained the importance of exception reporting and encouraged the core and ACCS trainees to complete them when they stayed late. The higher trainees reported that they sat down with the consultants and agreed their rota. However, the higher trainees reported that they would have liked to do more theatre time and obstetrics which had been scheduled on their short days. The quality review team heard that one day in a six-week period, the higher trainees had been pulled from their rota to help with the workload in ICU. The higher trainees confirmed that they were able to arrange a day back in theatres, and this was communicated through a WhatsApp group where trainees were able to swap shifts with their colleagues.	
A1.4	**Induction** All trainees confirmed that they received a departmental and Trust induction. The higher trainees stated that they attended a full day general induction, a separate anaesthetic induction or ICU induction, and received an ICU or anaesthetic induction after change over. The higher trainees reported that the general induction was very good but the OSCE session on blood transfusion could have been improved, as the trainees tried using the machine one by one so they had to wait around. Additionally, the higher trainees commented that the Trust had implemented paper-less records, which meant that they had started saving and recording patient records electronically. There were four hours' hands on electronic patient record (EPR) training on the general induction. The anaesthetics higher trainees reported that they would have found it beneficial if their local induction provided more time to learn the new software, especially as if a trainee was only placed in the department for three months it might be challenging to record everything on the system during their busy shifts as well as trying to learn how to use the system. Additional EPR training is already included in the ICU induction.	Yes, please see A1.4
A1.5	**Handover** The higher trainees reported that the majority of the ICU documentation remained paper-based, and some allowed for the electronic recording of patient records. For instance, the quality review team heard that in the hour of changeover, the higher trainees used an electronic handover sheet however that this was not scanned into patient notes. However, the decisions made and family discussions were recorded on the electronic system. Therefore, the trainees reported that although there had been a formal handover meeting in place, there was a risk of information being lost during the day to day handover. To minimise this, it was noted that there was a specific space in the patients written notes for documentation of plans made during the evening ICU consultant ward round.	Yes, please see A1.5
A1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The core and ACCS trainees reported that during a patient transfer, a consultant or a higher trainee usually accompanied them, but they were allowed to go on their own if they were deemed competent. For an out of hospital transfer, the core and ACCS trainees reported that they usually went with a higher trainee, but if the department was busy they went on their own, but they commented that they felt comfortable that they were able to call the consultants if they needed help. The trainees reported that this	

	had provided them with learning opportunities and had developed their confidence in their work.	
A1.7	**Adequate time and resources to complete assessments required by the curriculum** The higher trainees reported that although they had been pulled into ICU during busy times and to help with rota gaps, when they would have preferred to work in a different area of anaesthetics, they were highly complementary of the consultants' support to ensure they had passed their exams.	

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.

A2.1	**Impact of service design on learners** The quality review team learnt that some of the trainees described the atmosphere in theatres as better than the atmosphere in ICU. The anaesthetic and ICU departments had been described as divided, and the trainees commented that they were able to sense some tension between the ICU consultants. However, the trainees stated that this had had no impact on their training or the support provided to them, and described all of the consultants as professional at all times. The trainees reported awareness of consultant recruitment issues in ICU and stated that the consultants in ICU had been under a significant amount of pressure. The higher trainees described ICU as the most at risk area. The higher trainees stated that the buddy system had been implemented in ICU, where the core trainees had been paired up with a higher trainee at ST5 level and above. The quality review team heard that obstetrics during out of hours (OOH) had two registrars, which the trainees acknowledged as very helpful especially as obstetrics is a high risk unit. However, the quality review team and trainees commented that they were not aware of any obstetrics unit that had two registrars during OOH. The quality review team was informed of the standard operating procedure (SOP) for deciding which consultant (ICU or anaesthetic) should attend OOH under what circumstances e.g. paediatric emergencies. The quality review team learnt that ICU consultants were failing to attend OOH and release obstetric rota trainees back to the obstetric service. Additionally, it was reported that there was a lack of clarity on which consultants were responsible for patients in areas such as accident & emergency. The quality review team learnt that certain individuals had deviated from the SOP and had on some occasions used their discretion not to attend. Therefore, the quality review team stated that the Trust needed to revise and formalise its SOP and ensure that all staff followed this.	Yes, please see A2.1a Yes, please see A2.1b

A2.2	**Organisation to ensure access to a named educational supervisor** All trainees were highly complementary of their educational supervisors and the level of support they had received. All trainees confirmed that they were able to contact their educational supervisors whenever they needed help or advice.	
A2.3	**Systems and processes to identify, support and manage learners when there are concerns** The core and ACCS trainees reported that they were not sure of the formal systems or procedures for escalating concerns. However, they all reported that they always knew who to contact and were aware of who was on-call if they needed to escalate a clinical concern. In regard to dissemination of information, the core and ACCS trainees stated they receive regular e-mails especially about the departmental teaching sessions. The quality review team heard that trainees had had opportunities to discuss and learn from serious incidents (SIs), although they had not been involved in one at the time of the review. The quality review team also learnt that the anaesthetic department organised 10 clinical governance meetings per year. All of the trainees felt that the consultants in the department had all been supportive and approachable; and the trainees felt confident to speak to them if they had any concerns.	

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.

A3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The Trust reported that there were sufficient facilities and equipment such as offices, meeting rooms and computers for the trainees and their educational supervisors to use to facilitate private meetings, and work based assessments.	
A3.2	**Timely and accurate information about curriculum, assessment and clinical placements** The quality review team heard that one of the higher trainees hoped to work in obstetrics theatre on-call rota, but due to workforce issues with the intensive care unit, the trainee had been placed on the ICU rota. One higher trainee expressed some frustration that they were not placed on the obstetrics theatre list even though they asked in advance, but was pleased to pass their exams with the support of their educational supervisor. In regard to workplace assessments, the higher trainees were complementary of the support, and the quality of the ward rounds and team huddles which they found to be educational and supportive.	
A3.3	**Access to study leave** All trainees reported that they had good access to funded 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.

A4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The quality review heard that initially the DME appraised all of the educational supervisors, but via the medical education committee this was devolved to the educational leads/College Tutors in each area. The College Tutor/Lead educationally appraised the supervisors every 3 years and The DME appraised the educational leads. The DME reported that the appraisal for leads was aimed to be carried out annually, and had been included in the consultants' supporting professional activities (SPA) time which followed the recommended job planning.	
A4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The quality review team heard that the issue surrounding the lack of sufficient number of ICU consultants and issues with recruiting to the vacant posts had been raised by the department on numerous occasions. The consultants acknowledged that the ICU had not been compliant with the core standards at the time of the review, and although the intensity of workload is high, the unit had not expanded its beds or the consultant body. Therefore, the ICU consultants felt that they had not been supported by the Trust which consequently had led to the training issues identified in the 2017 GMC NTS results. The Head of School stated that the consultants job plans needed to be reviewed, and that supporting professional activities (SPA) needed to be clear in the job plans with an expectation of 0.25 educational programme activity per trainee	Yes, please see A4.2

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.

A5.1	**Appropriate balance between providing services and accessing educational and training opportunities** The higher trainees stated that they felt they had been placed on ICU for service provision as opposed to providing an educational benefit, and did not see a career path in ICU. The higher trainees explained that when needed, the consultants had given them practice sessions to help with their assessments. However, the trainees acknowledged that the service had been very busy and had too few consultants. The	

	quality review team heard that ICU was a 10-bed unit, with four beds open for escalation. Prior to the review, the higher trainees reported that they had 12 ICU patients with only one consultant managing the ward round; therefore, the trainees felt that there was no time for medical education. However, the higher trainees reported that the department had set teaching sessions every Friday which were led by trainees, but the consultants had input on the discussion. The Trust explained that higher trainees would have been placed on the ICU rota on long days and night as these trainees would have been signed off for obstetrics already. However, the head of school highlighted that the way the trainees had to take their leave had an impact on their theatre rota, which meant that the trainees had not been able to maximise their training potential. The Trust explained that due to the issues in ICU, the appointed applicants tend to accept the job but stated that they would not want to work in ICU. Furthermore, the quality review team heard that there had been a dispute around the two higher trainees allocated to obstetrics on-call and whether they were allowed to help in ICU which may have contributed to a perceived lack of clinical supervision OOH which was received as a pink outlier from the GMC NTS.	

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.

A6.1	**Appropriate recruitment processes** It was ascertained that the main cause of issues in ICU had been due to recruitment and retention challenges at consultant level. Therefore, HEE suggested that the Trust looked at recruiting to other roles such as physician's associates, advanced critical care practitioners, and clinical fellows in order to provide further support to the trainees in anaesthetics. On the other hand, the quality review team was pleased to hear that the ICU nursing staff received praises from the trainees and similarly, the educational leads described the nurses as well embedded in the department.	Yes, please see A6.1
A6.2	**Learner retention** The trainees were happy to recommend Homerton University Hospital NHS Foundation Trust as a place of training for main theatres and obstetrics, but not for ICU. The trainees explained that the Trust had been an enjoyable place to work in but in relation to medical learning at the time of the review, the higher trainees described it as quite limited. Finally, the quality review team heard that a higher trainee had considered working in the Trust as a consultant in the future, but not in ICU.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The quality review team wanted to commend the Trust on the buddy system that had been put in place in anaesthetics and intensive care unit (ICU),			

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

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
A1.2	The Trust to ensure trainees always know who is providing their clinical supervision when working in the Intensive Care Unit. Trainees to be assigned a timetable covering their shift, which outlines who is responsible for their clinical supervision at all times, and the contact number for each.	Trust to submit details of trainee timetables which should clearly indicate who is responsible for their clinical supervision at all times, including contact numbers.	R1.8
A1.5	The Trust to review the handover system in place in the ICU to ensure that any written notes made are included in the patients' electronic records.	The Trust to confirm the outcome of the review and submit trainee feedback, in the form of Local Faculty Group (LFG) meeting minutes, confirming that this issue has been adequately resolved.	R1.14
A2.1b	The Trust to revise and formalise the standard operating procedure (SOP) to provide guidance on flexible ways of covering OOH care which does not detract from any of the clinical areas, whilst the Trust seeks a more permanent solution for ICU cover.	The Trust to submit a copy of the SOP and the communication used to disseminate it to all staff. The Trust to submit trainee feedback, through LFG minutes demonstrating that this issue has been appropriately addressed.	R2.3
A4.2	The Trust to review the consultants' job plans and ensure that the requisite supporting professional activity (SPA) time is included.	The Trust to confirm this review has taken place and that all consultants have the necessary SPA time for their educational responsibilities.	R4.2

Recommendations

Rec. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
A1.3	The Trust to review the rota to ensure that the specialty trainees on general modules were not rostered in ICU in daytime hours during the week, providing this does not impact on patient safety or the overall trainee experience	The Trust to provide a review copy of the trainee rota.	R1.12
A1.4	The Trust to consider whether it is suitable for the trainees' Trust induction to include a session on the new electronic patient record system.	The Trust to confirm the outcome of this review and whether a session on the electronic patient record has been included in the Trust induction.	R1.13
A6.1	The Trust to consider looking at recruiting to alternative roles in the ICU.	The Trust to confirm the outcome of the review.	R1.7
A2.1a	The quality review team recommended that the Trust explore external support to improve team working between the anaesthetics and intensive care unit	The Trust to confirm the outcome of the review.	

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
The Head of School to discuss with the Post Graduate Dean mechanisms for instituting an external review of the ICU	HoS

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Cleave Gass
Date:	15 March 2018

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.