QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Barts Health NHS Trust (St. Bartholomew's Hospital)

Clinical oncology

Risk-based Review (on-site visit)

Quality Review report

27 February 2018

Final Report

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Quality Review details

Background to review	The Risk-based Review (on-site visit) to clinical oncology at Barts Health NHS Trust (St. Bartholomew's Hospital) was organised in response to the poor results that were obtained in the 2017 General Medical Council National Training Survey (GMC NTS). Five red outliers were received in relation to: overall satisfaction, work load, adequate experience, educational governance and local teaching. A further six pink outliers were obtained for: clinical supervision out of hours, reporting systems, handover, induction, educational supervision and feedback. An Education Lead Conversation with the Head of School of Clinical Oncology, Postgraduate Dean and Deputy Postgraduate Dean took place in September 2017, during which the Trust explained that there had been long term absences at consultant level within the department which had likely contributed to the issues and poor results received. The Trust further reported that they had taken many steps to address the issues highlighted in the GMC NTS. Health Education England therefore felt it was necessary to organise a review, in order to ascertain the progress that had been made and determine whether the learning and training environment was suitable for trainees.
Training programme / learner group reviewed	Clinical oncology
Number of learners and educators from each training programme	The review team initially met with the Director of Medical Education, the Clinical Director, the College Tutor and the Educational Lead. The team then met with three of the higher trainees within the department and two of the educational and clinical supervisors.
Review summary and outcomes	Health Education England would like to thank the Trust for accommodating the Risk-based Review (on-site visit) and ensuring each session was well attended. During the course of the review, the team was informed of a number of areas that were working well in relation to clinical oncology training at St. Bartholomew's Hospital: - It was apparent that the department had worked extremely hard to improve the education and training environment. The review team heard that the changes that had been implemented in the department had had a positive effect and impact, especially in relation to the trainees' workload. - The trainees reported that the local teaching provided was of a high standard. The review team was informed that trainees attended three teaching sessions each week, one provided for medical and clinical oncology trainees that was consultant led, a case of the week teaching session and a physics teaching sessions. The trainees further stated that they had been invited to attend the radiology teaching sessions. - The review team ascertained that the local faculty group was working well in the department and that there was trainee representation at each meeting. However, the review team felt it would be beneficial if all trainees were invited and able to attend. - All the trainees the review team met with reported that they felt well supported by the consultants within the department and indicated that they had good working relationships with the consultant body. The review team was informed that trainees were always able to access clinical supervision and advice.

- All trainees stated that they would recommend the posts at St. Bartholomew's Hospital to colleagues and that they would be happy for their friends and family to be treated within the department.

However, the review team were also informed of some issues regarding the education and training provided, which are outlined below:

- It appeared that the governance structure that was in place regarding the on-call service and handover for the acute oncology service was not sufficiently robust, structured or formalised and therefore presented potential patient safety issues. The trainees reported that they and the core medical trainees were often not sure which consultant was on-call out of hours. They reported that the rota was not circulated to them on a weekly basis and that although it was available via the Trust's intranet, this often was not up to date and that switchboard often did not have the correct details of the on-call consultant, when they rang and asked to be put through. The review team therefore felt that the rota should be disseminated amongst all members of staff within the department, which showed who the consultant of the week was, which consultants were on-call and which higher trainees were on call, as this changed on a daily basis. The review team recommended this also included contact details.
- Subsequently, the review team felt that the handover system in place each morning was not sufficiently robust. The trainees described a system whereby they contacted each other via text or WhatsApp regarding any patient issues, which the review team did not feel met information governance standards. The trainees indicated that there was no standard operating procedure in place outlining the handover system and it appeared that the handover arrangements varied between trainees and teams within the department. The review team felt that in order to ensure the core medical trainees were aware of who to escalate to, a structured handover needed to be implemented between the consultant on-call, the consultant of the week, the core medical trainees and the higher trainees.
- The review team also recommended that a daily email was implemented which included a list of all patients on the ward, new emergency admissions and details regarding any advice that had been given over night. This would ensure that the on-call consultant was aware of any issues. The review team felt that implementing a 'higher trainee of the week' model might improve the handover system in place, but recognised that the trainees were opposed to such a model and therefore encouraged the trainees to be involved in devising a more robust and structured system going forwards.
- The trainees indicated that they received an unmanageable number of emails from the chemotherapy unit and the unit did not typically refer to the protocols and guidelines in place before contacting the higher trainees. The review team therefore recommended that an audit was undertaken to assess the amount of inappropriate emails the trainees received to determine if this is indeed the case. If so discussions would need to be had with the chemotherapy unit about what the threshold for emailing higher trainees should be.
- The review team felt the department should further explore multi-professional working within the department to reduce the trainees' workload in clinics, for example by implementing a nursing led telephone clinic.

Quality Review Team			
HEE Review Lead	Dr Suzannah Mawdsley	**External Clinician**	Dr Won-Ho Edward Park Clinical oncology consultant

	Head of School for Clinical Oncology		Imperial College Healthcare NHS Trust
Deputy Postgraduate Dean	Dr Indranil Chakravorty Deputy Postgraduate Dean, Health Education England North London	**Trainee Representative**	Dr Eleni Josephides Imperial College Healthcare NHS Trust
Lay Member	Ryan Jeffs Lay Representative	**Scribe**	Elizabeth Dailly Deputy Quality, Patient Safety and Commissioning Manager Health Education England London and the South East

Educational overview and progress since last visit

When discussing the changes that had been made in the department to improve the education and training provided, following the General Medical Council National Training Survey (GMC NTS) results received in 2017, the review team was informed that an internal action plan had been created and that they felt there had been a positive change and improvement within the department.

The Trust stated that the department did not have a full complement of consultants and the consultant rota was still short by two people. However, the review team was informed that the Trust was in the process of recruiting and that business cases had been submitted to recruit additional consultants.

Due to the rota gaps at consultant level, the Trust stated that some of the work in the department had been transferred to University College London Hospitals NHS Foundation Trust on a temporary basis, to ensure the workload in the department was not unmanageable, which they felt was beneficial for the trainees.

The Trust confirmed that the no exception reports had been submitted by any of the trainees within the department, but confirmed that all trainees were encouraged to do so and leave on time.

The review team was informed that prior to the review, the trainees had indicated that the acute oncology service at night had been extremely busy, which had been fed back to the consultant body via the Local Faculty Group (LFG). Following this, the trainees had undertaken an audit, which demonstrated that they were compliant and that the workload out of hours was manageable. The Clinical Director stated that the calls out of hours were managed by the advanced nurse practitioners, which had significantly reduced the trainees' workload and was working well.

The review team was informed that the Trust had met with the trainees to receive feedback on areas that needed to be improved and the Clinical Director reported that the educational lead and college tutor had worked hard to make a number of changes in the department to improve the quality of the education and training delivered. Following this the local teaching programme had been redesigned and that the trainees now received on a weekly basis: consultant led teaching the medical oncology trainees, a 'case of the week' teaching session, physics teaching and radiotherapy teaching. The educational lead and college tutor confirmed that the teaching sessions had been made more formal and that trainees were aware that they were obliged to attend. They further commented that the sessions were bleep-free for the majority of the trainees, as the 'higher trainee of the day' held the bleep for everyone else.

The educational lead further commented that they were undergoing a process to ensure that all trainees and supervisors had formalised time included in their job plans for radiotherapy planning sessions, during which the trainees sat with their consultants to go through all their planning and received feedback. The review team was informed that this was a work in progress and that at the time of the review, most teams had this time allocated in their rota, with plans to increase this for all teams.

The review team was informed that the department had undertaken an end of placement survey with the trainees to gain further feedback and assess what improvements had been made, which had been largely positive.

When discussing the upcoming reduction in the number of core medicine trainees (CMTs) that was due to take place in September 2018 and the impact this would have on the department, the Director of Medical Education

reported that a plan was being put in place at Trust Board level and that the CMTs leaving the department were due to be replaced with clinical fellows. The review team was informed that there were lots of clinical fellows based on the wards, which provided continuity of care for patients. Furthermore, the review team was informed that two physician associates were due to start within the clinical oncology department to provide further support on the wards and that the department was working with the renal department at the Royal London Hospital who already had a physician associate model in place.
The Trust stated that on a site basis, a task and review group had been introduced to consider how to change and further develop the multi-professional team. The review team was informed that this process was underway and that consideration was being given as to how to ensure they integrate with the rest of team and do not detract from training opportunities.
It was also heard that from March 2018 the department would only have five higher trainees as opposed to seven, which they had at the time of the review. When asked how the department would manage with the smaller number of trainees, the Trust stated that they had explored the possibility of implementing a 'higher trainee of the week' model with the trainees, but that the trainees had been opposed to this and instead wanted to keep the 'higher trainee of the day' model in place. The department felt it was possible to continue with the 'higher trainee of the day' model with only five trainees, due to the number of medical oncology trainees who shared the rota and the clinical fellow who was based upon the chemotherapy unit. The clinical director further commented that since the clinical fellow based on the chemotherapy unit had started within the department, they had received positive feedback from the higher trainees and CMTs. The review team was further informed that in light of the fewer number of higher trainees, the rota had been adjusted to ensure their workload was manageable and that they would be attending fewer clinics. The Trust stated that the consultants in the department had been informed of the upcoming changes and that they were aware that some of their clinics may not be covered by a higher trainee going forward.

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
CO1.1	**Appropriate level of clinical supervision**	

	All of the trainees the review team met with confirmed that they received an appropriate level of clinical supervision and could all escalate concerns when necessary. The trainees reported that when they were the 'higher trainee of the day' they carried the spinal cord compression bleep. However, the trainees indicated that the core medicine trainees (CMTs) within the department were also able to contact them via the compression bleep if a patient had become sick on the ward and they were unable to get hold of the particular higher trainee on the team who was responsible for the patient. The higher trainees indicated that previously, the CMTs had indicated that they had experienced difficulties accessing the correct higher trainee for each patient and therefore the higher trainees had tried to ensure that the lines of communication were clearer so the CMTs could escalate patients accordingly. The trainees reported that there was a good culture within the department and that if the CMTs were unable to get in contact with the specific higher trainee in their team, then any of the other higher trainees provided cover and clinical supervision.	
CO1.2	**Rotas** The review team was informed by the clinical and educational supervisors that during the previous year there had been substantial rota gaps at consultant level which had impacted on the ability of the department to ensure that trainees had adequate support and sufficient senior oversight. The trainees indicated that some jobs in the department were busier than others and therefore although the majority of trainees reported that typically they were able to leave on time, some commented that they routinely stayed up to an hour late each night. The trainees stated that they had not submitted exception reports in such cases, but reported that they had not felt discouraged to do so. The review team was informed that when they were on-call they were non-resident and took the calls at home. The trainees reported that this workload had lessened, as a system had been introduced whereby the advanced nurse practitioners in the department took the majority of the calls, which was working well. It appeared that the governance structure that was in place regarding the on-call and acute oncology service was not sufficiently robust, structured or formalised and therefore presented potential patient safety issues. The trainees reported that they and the core medical trainees were often not sure which consultant was on-call out of hours. They reported that the rota was not circulated to them on a weekly basis and that although it was available via the Trust's intranet, the rota often was not up to date and not everyone in the department was aware of how to access it. Furthermore, the trainees indicated that when they contacted switchboard to be put through to the consultant on-call, switchboard often did not have the correct details and sometimes put them through to another consultant who was not on call. The review team was informed by the educational and clinical supervisors that the rota was disseminated via email to the consultant body, but that the trainees were not included in the email trail. The review team therefore felt that the rota should be disseminated amongst all members of staff within the department, which showed who the consultant of the week was, which consultants were on-call and which higher trainees were on call, as this changed on a daily basis. The review team recommended this also included contact details. The review team explored the possibility of implementing a 'higher trainee of the week' model who would be based on the ward, with the trainees. However, the trainees explained that they were opposed to such a system as they felt the corresponding medical oncology work they would undertake would be extremely high and make their workload unmanageable. The review team questioned whether it would increase the trainees' acute oncology service (AOS) experience and whether this training need was being met under the current rota. The trainees reported that the AOS experience they	Yes, please see CO1.2

	received at the time of the review was sufficient and met their curriculum needs. The trainees expressed further concerns that such a model would entail them also covering the Chemotherapy Unit and Radiotherapy Unit in addition to the ward. However, the review team explained that that was not necessarily the case and that it greatly depended on how the department structured the model.	
CO1.3	**Handover** The review team was informed that each Friday afternoon a handover took place, which was well structured and involved the consultant body, the CMTs and the higher trainee from each team. However, the weekend and morning handover currently in place did not appear to be sufficiently structured, robust and formalised. The trainees indicated that there was no standard operating procedure outlining the handover system and it appeared that the handover arrangements varied between trainees and teams within the department. The review team felt that in order to ensure the core medical trainees were aware of who to escalate to, a structured handover needed to be implemented between the consultant on-call, the consultant of the week, the core medical trainees and the higher trainees. The trainees indicated that when they were on-call over the weekend, they often text or emailed the other teams if there had been any issues with their patients and during the week, the higher trainee on-call would find the relevant higher trainee to handover any issues. The trainees described a system whereby they contacted each other via text or WhatsApp regarding any patient issues, which the review team did not feel met information governance standards. The higher trainees further reported that when on-call, some of the trainees then contacted the CMTs who had also been on-call, based on the wards, to find out if anything had happened overnight. The review team felt that the lack of robust system in place would not be suitable for more junior higher trainees starting within the department, as it was dependent on the individual trainees as opposed to being a formalised process. However, it should be noted that the trainees indicated that no patient safety incidents had taken place due to the lack of robust handover and reported that they were always aware of any issues regarding their patients. The trainees reported that when they were on-call, they predominantly took all external calls and provided advice. However, they indicated that the consultant on-call was not subsequently updated of what calls the trainees had taken and what advice they had provided; any relevant information was only passed onto the patients' specific team. However, the trainees noted that they all felt comfortable contacting the on-call consultant if they needed clinical supervision and advice. This was confirmed by the educational and clinical supervisors, who reported that if they had been on-call and had not been contacted by the higher trainee regarding any issues, they were not aware of what external calls the higher trainee had taken and what subsequent advice they had given. However, the review team was informed that no serious incidents had been reported and investigated relating to the higher trainees' decisions over night. The educational and clinical supervisors further explained that the consultant of the week undertook a handover with the CMT each morning, to review any new patients that had been admitted and any who were ill overnight. However, they reported that there was no dedicated handover between them and the higher trainee who had been on-call. Furthermore, the review team was informed that there was no structured handover between the consultant of the week and the consultant who had been on-call overnight, but that any relevant information was passed on if necessary. The review team therefore recommended that a daily email was implemented which included a list of all patients on the ward, new emergency admissions and details regarding any advice that had been given over night. This would ensure that the on-call consultant was aware of any issues and advice that had been given and that each team was aware of any issues with their patients and admissions. The review team felt that implementing a 'higher trainee of the week' model would improve the handover system in place, but recognised that the trainees were opposed to such a model and therefore encouraged the trainees to be involved in devising a more robust and structured system going forwards.	Yes, please see CO1.3a Yes, please see CO1.3b Yes, please see CO1.3a Yes, please see CO1.3c

	The trainees also explained that the advanced nurse practitioner who had been on-call sent an email to the on-call team and the specific teams the patients were under about any calls they had taken over night.	
CO1.4	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The review team was informed that the trainees often received multiple emails from the Chemotherapy Unit regarding whether patients were able to receive chemotherapy if their blood results were abnormal. The trainees reported that there were guidelines and protocols in place that staff on the unit could follow, but that often they directly contacted the trainees to determine whether patients could receive treatment, even when the results were not grossly abnormal and the guidelines clearly stated whether or not treatment was suitable. Subsequently, it was stated that this greatly increased the trainees' workload as a significant amount of their time was spent responding to such emails. The review team was informed that a clinical fellow was based within the chemotherapy unit, but that they were at a core trainee level and therefore did not make decisions about whether patients were able to receive chemotherapy.	Yes, please see CO1.4
CO1.5	**Protected time for learning and organised educational sessions** The trainees reported that there was time included in both theirs and their consultant's rota for radiotherapy planning each week, which they felt was extremely beneficial and educationally useful. The review team was informed that there were a number of local teaching sessions provided that trainees were able to attend, of which they were extremely complimentary. The trainees reported that there was a Monday morning session, that was consultant led delivered to both the clinical and medical oncology trainees, a Wednesday morning 'case of the week' teaching session and a Friday afternoon physics teaching. In addition to this, the trainees indicated that they had been invited to the radiology teaching which they had found extremely beneficial.	

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.

CO2.1	**Effective, transparent and clearly understood educational governance systems and processes** All trainees reported that they felt comfortable raising any issues they had with their educational supervisors and that they could speak to them in confidence.	

	The trainees reported that prior to the review they had had regular meetings with the Director of Medical Education, during which they could also raise and discuss any issues. Furthermore, the review team was informed that there was a Local Faculty Group (LFG) meeting which took place every two months, during which the trainee representative discussed any concerns and feedback the trainee body had. Despite this, it was noted that not all trainees were invited to attend the LFG meetings, just the trainee representative. However, the educational and clinical supervisors reported that following the review they would open up the meeting to ensure all trainees in the department were invited. The educational and clinical supervisors further commented that every couple of months, instead of providing the Monday morning teaching session, the consultants had a general catch up with the trainees, in which any issues were discussed.	Yes, please see CO2.1
CO2.2	**Impact of service design on learners** The review team was informed that the clinic undertaken at Whipps Cross University Hospital was often extremely busy and that up to 60 patients would be booked in to be seen by the consultant and higher trainee. Therefore, to reduce the number of patients arriving at the clinic, the trainees reported that they often spent the previous day undertaking telephone consultations with patients to reduce the clinic list, which then had a subsequent negative impact upon their ability to access training opportunities. The trainees indicated that previously, during the clinic the consultant typically saw the majority of patients who came in and that the trainees often undertook the telephone consultations, which meant they often missed the educational aspect of the clinic as they did not undertake the face-to-face patient consultations. However, the review team was informed that the trainees had fed this back to the consultant body and that following this they had not been required to undertake the telephone consultations during the clinic and reviewed patients in person. The trainees indicated that a specific telephone clinic was not organised and that instead the trainees went through the clinic list to identify patients that could be appropriately assessed by a telephone consultation to save them attending the hospital and to reduce the clinic list.	Yes, please see CO2.2
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.**		
CO3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The trainees confirmed that they felt well supported and that they had good working relationships with the consultant body.	
CO3.2	**Access to study leave** All trainees confirmed that they were able to obtain the necessary study leave to attend the relevant courses and regional teaching.	
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.**		
CO4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The educational and clinical supervisors reported that they had been supported by the Trust's Education Academy and in particularly the site's Director of Medical Education and the Associate Director of Quality, of whom they were particularly complimentary.	
CO4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The review team was informed that at the time of the on-site visit, the department was in the process of undertaking a review of the consultant bodies' job plans, to ensure that all educational supervisors had the correct supporting professional activity time included within their job plan.	

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.**		
CO5.1	**Regular, useful meetings with clinical and educational supervisors** All trainees confirmed that they were able to meet regularly with their educational and clinical supervisors to complete workplace based assessments and that they were easily accessible.	
CO5.2	**Appropriate balance between providing services and accessing educational and training opportunities** The trainees reported that they felt the balance between service provision and education and training was appropriate and suitable.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The trainees reported that they had been invited to the radiology teaching which they had found extremely beneficial			

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.**
CO1.2	The Trust to ensure that the rota detailing who the consultant of the week is, which consultant is on-call overnight, who the 'higher trainee of the day' is and which core medical trainees (CMTs) are on-call is disseminated to all staff within the department on a weekly basis. This rota should include the contact details for each member of staff	The Trust to submit example of the rota and communication that is disseminated on a weekly basis	R1.12
CO1.3a	The Trust to review the morning and weekend handover arrangements and ensure they are structured, robust and formalised The Trust to ensure that the new handover arrangements ensure that the on-call consultant is aware of any advice the higher trainees had provided whilst on-call	The Trust to confirm what changes have been made to the handover process and the new arrangements The Trust to submit the handover timetable and a register of attendance at handover	R1.14
CO1.3b	The Trust to create a standard operating procedure outlining the handover arrangements which is included in any new trainees' induction	The Trust to submit the standard operating procedure and confirm that this is included in trainees' induction materials	R1.14
CO1.3c	The Trust to introduce a daily email, which included a list of all patients on the ward, new emergency admissions and details regarding any advice that had been given over night	The Trust to submit examples of the daily email which has been implemented	R1.14
CO1.4	The Trust to audit the amount of inappropriate emails the trainees receive from staff in the chemotherapy unit and place an emphasis upon such staff consulting and following the appropriate guidelines in place before contacting the trainees	The Trust to submit the results of the audit and any changes that have subsequently been made within the department The Trust to submit feedback from the trainees, through Local Faculty Group (LFG) minutes, demonstrating that this issue has been adequately resolved and that the number of emails the trainees	R1.9

		receive from the chemotherapy unit is manageable	

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
CO2.1	The Trust to ensure all trainees are invited to the LFG meetings	The Trust to confirm that all trainees are now invited to the LFG meetings and provide a register of attendance	R2.1
CO2.2	The Trust to consider introducing a nurse led telephone clinic, to reduce the trainees' clinic workload and ensure they did not have to spend time before clinics undertaking telephone consultations to reduce clinic lists	The Trust to confirm the outcome of this review	R2.3

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 Suzannah Mawdsley
Date:	06 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.