

Lewisham and Greenwich NHS Trust

Medicine

Risk-based Review (on-site)



Quality Review report

13 November 2018

Final Report

Developing people
for health and
healthcare

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Quality Review details

Background to review	<p>Health Education England (HEE) felt that with the release of the 2018 General Medical Council (GMC) National Training Survey (NTS) results and an Educational Leads Conversation (ELC) which took place in September, a conversation with the trainees in General Practice (GP), Foundation Year 1 (FY1), Foundation Year 2 (FY2), Core Medical Trainees (CMTs) and Higher Trainees in Medicine was required.</p>
Training programme / learner group reviewed	<p>Medicine</p>
Number of learners and educators from each training programme	<p>The review team met with a number of trainees from Medicine including Foundation, Core Medical Trainees, Higher Trainees and General Practice trainees.</p> <ul style="list-style-type: none"> - GP trainees - Foundation year 1 Trainees - Foundation year 2 Trainees - Core Medical Trainees - Higher Trainees <p>As well as meeting with the trainees, the review team also met with a number of the senior management within the department including:</p> <ul style="list-style-type: none"> - Director of Medical Education - Medical Education Manager - Guardian of Safe Working Hours - Clinical Director - Training Programme Director - Educational Lead <p>The review team also met educational and clinical supervisors in medicine and geriatric medicine.</p>
Review summary and outcomes	<p>The quality review team would like to thank the Trust for accommodating the on-site visit and for ensuring that all sessions were well-attended. The quality review team was pleased to note the following areas that were working well:</p> <ul style="list-style-type: none"> - The acute medicine experience for all programmes was highly valued with appropriate workload intensity and supportive consultants - All trainees were released for regional training and were able to take appropriate study leave. - The opportunity for outpatient experience in ambulatory care for core medical trainees was felt to be very positive. - All consultants felt highly valued as supervisors with appropriate time in their job plans and felt supported by the Trust in their educational duties. <p>However, the quality review team also noted a number of areas for improvement:</p> <ul style="list-style-type: none"> - The Trust are to confirm the consultant responsibility for the assisted ventilation unit including daily consultant review of all patients, to be communicated to all trainees - The Trust are to ensure that all levels of trainees receive a departmental and local clinical induction - with sufficient support tailored to level of training and meet their supervisors in a timely manner.

- The Trust should ensure there is a clearly identified individual locally within appropriate specialty teams to monitor doctors' annual and study leave in conjunction with rotas and curricular training requirements.
- The Trust should ensure that the geriatric medicine doctors have a schedule available of named registrar and consultant cover with a clearly communicated process and pathway for escalation.

Quality Review Team

Deputy Head London School of Medicine and Medical Specialties	Catherine Bryant Deputy Head London School of Medicine and Medical Specialties Health Education England	Associate Director South Thames Foundation School	Mark Cottee Associate Director South Thames Foundation School Health Education England
Deputy Postgraduate Dean, Health Education England, South London	Jo Szram Deputy Postgraduate Dean Health Education England South London Health Education England	GP Associate Dean South London	Nikki Payne GP Associate Dean South London
Lay Member	Jane Gregory Lay Representative	HEE representative	Bindiya Dhanak Learning Environment Quality Co-ordinator Health Education England (London and the South East)
HEE representative	Ed Praeger Deputy Quality, Patient Safety and Commissioning Manager Health Education England (London and the South East)	Observer	Warren Lynch Quality Management Officer Joint Royal College of Physicians Training Board

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

The Clinical Director (CD) wanted to highlight to the review team that the Trust had recognised and implemented changes before the release of the 2018 General Medical Council's (GMC) National Training Survey (NTS) results. The CD informed the review team that joint work had been undertaken with the Core Medical Trainees (CMT) resulting in trainee-driven rota changes.

The Director of Medical Education (DME) informed the review team that the trainees were likely to report to the review team that the workload was very busy and heavy. The DME assured the review team that the department had tried to improve work-life balance and morale as much as possible. The DME informed the review team that the Trust had appointed 10 Physician Associates (PA) funded by the medicine re-design project. The CD informed the review team that every ward would now have a PA 9am-5pm each weekday and confirmed that nine posts had been recruited into with one extra post still due to be filled. The PAs will also contribute to the acute take rota 5-8pm. The CD informed the review team that three PAs had not passed their national exams but were still being supported by the Trust and would be appointed into lower banded posts to support the service while waiting to retake their exam in early 2019. It was reported to the review team that six qualified PAs started the previous week and had just completed a four-day induction.

When asked about clinical supervision, the DME informed the review team that since August 2016, the Trust had implemented a new medical model, whereby there was an acute consultant physician onsite 8am-8pm and there was always a named on-call consultant available on the phone at night for escalation.

The DME informed the review team that there had always been a trust induction alongside a departmental induction programme, which is held seven times a year. The DME ensured the review team that the departmental induction would be revised to ensure that the trainees were aware of their roles and responsibilities.

The CMT Programme Director (TPD) assured the review team that the consultants highly valued the trainees and it appeared the current trainees who started in August 2018 appeared more satisfied with their experience. The CD reported to the review team that the changes that had been implemented had not been triggered by the visit but because the department had wanted to make these improvements for the benefit of the trainees.

The Guardian of Safe Working Hours (GoSWH) reported to the review team that there were high levels of exception reporting in May 2018 due to rotas not being fully staffed and trainees staying late. The GoSWH stated that trainees were encouraged to exception report as part of the Trust induction. The GoSWH stated there were some days that trainees would stay late and, in these instances, were encouraged to exception report and keep a log of time worked so that time off in lieu (TOIL) could be taken. The GoSWH assured the review team that trainees were aware that they could speak to the consultants in their departments to determine how and when TOIL could be taken. The Medical Education Manager (MEM) indicated that the Trust policy was that if trainees were unable to take TOIL, they were paid for the hours they had worked.

The DME informed the review team that the Medical Director had given permission to the department to over-recruit to locally employed doctor posts, leading to a reduced number of rota gaps. The Trust had over-recruited by three to fill the gaps and cover leave. The DME noted that, provided that the funding was available, the department would like to keep them on.

When asked about trainees in difficulty, the TPD informed the review team that they had regular medicine local faculty group (LFG) meetings to discuss trainees in difficulty which were a good opportunity to share information in a confidential manner. The TPD expressed that support was given to Educational Supervisors (ESs) to have an open discussion about any active issues in the meeting, which the DME attended. The DME informed the review team that since 2009, educational appraisals and ES training occurred every three years in line with GMC standards. The Post Graduate Medical Education (PGME) department arranged internal courses and advertised external courses to support ES training.

The TPD informed the review team that there had been regular LFG meeting for core and higher medical training and a separate meeting was held for foundation training. There was no trainee representation at the medical education committee (MEC) as with approximately 450 trainees it is difficult to get trainee representation for all specialities. The TPD informed the review team that there was fair representation at other faculty meetings which fed through to the MEC. The TPD informed the review team that they had met with the CMT representatives in the Care of the Elderly (COTE) department to get feedback and as an opportunity to raise issues. The TPD stated that issues were then escalated to the DME and CD.

The review team was happy to hear that all trainees would recommend their post to others. The General Practice trainees (GPs) noted that the job is enjoyable although suggested that a four-month rotation would be adequate. The foundation trainees all said they would recommend the job and it was a good experience overall.

The review team was concerned to hear that some of trainees indicated to the review team that they would not be comfortable if their family or friends were to be treated at the hospital, especially in regards to elderly members of the family. This was because some of the trainees felt that patients received good medical care but observed that dignity was not always delivered as consistently. The GP trainees, Foundation year 1 (F1s), CMTs and higher trainees provided feedback that they felt patients were not given adequate levels of assistance in eating and drinking, toileting and call bells were often not answered for long periods of time. The Foundation Year 2 trainees (FY2s) did not express any concerns and said they would be happy for their relatives to be treated at the hospital and thought that staff showed compassion in the way they delivered care.

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
M1.1	<p>Patient safety</p> <p>A number of trainees highlighted to the review team concerns about medications not being given in a timely and safe manner including Parkinson's disease medication and insulin. This was reported to particularly be a problem on geriatric medicine wards with a high proportion of agency nurse use and was reported by the trainees that it was more concerning during the night shifts, when the proportion of agency staff on shift was highest.</p>	Yes, please see M1.1
M1.2	<p>Appropriate level of clinical supervision</p> <p>The Director of Medical Education (DME) informed the review team that there was an acute consultant physician onsite 8am-8pm and that there was always a consultant available on the phone at night for advice. The higher trainees informed the review team that there were two higher trainees on call for weekend days and one higher trainee on call for week days with one higher trainee on call at night.</p> <p>All trainees indicated to the review team that they felt part of the clinical team and that senior staff were approachable.</p> <p>The Foundation Year 2 trainees (FY2s) in acute medicine indicated to the review team that there were a number of specific consultants and a higher trainee that they could contact day to day if support was needed when on call. The review team were disappointed to hear from the Core Trainees Year 1 (CT1s) that there was no clear identified named consultant for the assisted ventilation unit (AVU). The CT1s indicated to the review team that it was not guaranteed that there would be a consultant present each day to review the patients.</p> <p>The General Practice (GP) and FY2 trainees indicated that there was a "Whatsapp" group which was helpful and responsive if they needed higher trainee level help on the geriatric medicine wards if their higher trainee was not present. The GP trainees and FY2s were not sure who the named higher trainee and consultant on call were for the geriatric wards if their higher trainee or consultant were away or on call. The GP trainees were not aware of the named consultant's contact number for their ward but did inform the review team that the consultant would come to the ward to speak to the team looking after the ward patients for a short period of time each day.</p>	<p>Yes, please see M1.2a</p> <p>Yes, please see M1.2b</p>
M1.3	Rotas	

	<p>The CD informed the panel that joint work had been done with the Core Medical Trainees (CMT) resulting in trainee-driven rota changes. The CMTs informed the review team that the workload was manageable at the Trust but was variable. The CMTs reported that there had been an increase in staffing with one additional CMT on nights and two higher trainees on call at the weekend. The Foundation Year 1 (FY1) trainees informed the review team that they had received a rota covering the whole of the forthcoming year.</p> <p>The FY2 trainees informed the review team that workload is manageable with ward work rated as fairly manageable overall. The FY2s based on geriatric wards informed the review team that weekend on-calls varied with regards to workload. The FY2s stated that there was a registrar on-call if needed and that a locum doctor had been hired to cover ward rounds to enable the FY2s to undertake referrals; however, the FY2s found it difficult to know if or when the locums had arrived.</p> <p>The CMTs reported to the review team that workload was average. The CMTs informed the review team that the staffing issues raised by previous cohorts had been improved by hiring locums to support the rota, especially on Alder ward. The CMTs commended the consultants and stated that the consultants had been very responsive to feedback. The CMTs working in geriatrics informed the review team that there was also a locum in the team but felt this appointment should be made permanent as there was a need for this level of staffing support long term.</p> <p>The CMTs reported to the review team that they had to arrange swaps between themselves if they needed to request annual or study leave or to attend a regional teaching day. The CMTs felt that this was difficult to organise and monitor on an individual basis especially as that there wasn't continuity with ward allocation. The CMTs noted to the review team that it would be helpful if there was a named person who could coordinated this.</p> <p>The higher trainees reported to the review team that the workload was manageable but could obviously vary during weekend shifts. The higher trainees felt that there was a robust and supportive hospital at night and critical care outreach team. The higher trainees also confirmed that there was an extra core trainee on nights and two higher trainees who worked at the weekend. The higher trainees all agreed that staffing numbers had increased and that this had improved the rota.</p> <p>The review team was pleased to hear that all trainees was released for teaching. The GP trainees informed the review team that teaching was good and consultants on post take ward rounds made an effort to teach on an informal basis. The trainees informed the review team that there was geriatric medicine teaching on Monday, acute medicine teaching on Tuesday, grand round on Wednesday and CMT teaching on Thursdays.</p>	Yes, please see M1.3
M1.4	<p>Induction</p> <p>The GP trainees informed the panel that they were told that they did not need to attend Trust induction as they had completed this previously during their VTS rotation, however the GP trainees stated to the panel that on reflection it would have been beneficial to attend the induction to gain the medical specialty-specific information regarding on call team structures, study leave and rotas. They did however attend the hour long CMT departmental induction.</p> <p>All FY1 trainees confirmed they had attended both the Trust and local departmental inductions. One of the F1 trainee explained to the review team that the local induction was limited as there were only two days of shadowing, they felt that it would have been more beneficial to have more shadowing days and suggested up to five days.</p> <p>The FY2s all confirmed they had attended the Trust induction on their first day. The FY2s also informed the review team that they had completed a number of online e-learning modules prior to induction which they felt were good preparation and had included specific information about working in medicine.</p> <p>All higher trainees confirmed they had received a Trust and departmental induction. The Rheumatology, Diabetics and Endocrinology trainees informed the review team that they received a good local induction. The Cardiology trainees informed the review</p>	Yes, please see M1.4

	<p>team that no prior information was sent about local induction before starting but stated that induction was very helpful once completed, although they had to find an appropriate consultant to undertake an induction meeting rather than receiving a pre-scheduled induction programme.</p>	
M1.5	<p>Handover</p> <p>The GP trainees indicated to the review team that handover was generally good and structured, although quality was variable depending on who was running the handover. The GP trainees informed the review team that there was no official morning handover, it was usually an unofficial hand over to trainees by the on-call consultants, which was a potential problem when handing over ward cover patients.</p> <p>The FY2s agreed that there was no formal morning handover and that the list of patients did not provide details of the patient issues for review which made prioritising weekend reviews very difficult. They all agreed that the current handover list could be improved, such as with an SBAR structured summary.</p> <p>The CT1s noted that they felt that they had worked in previous Trusts which all had a more comprehensive handover process, specifically a formal and structured weekend handover often using a specific IT application and a Friday afternoon handover meeting. The CT1s felt anxious about leaving patients without formal handover as the current system only expects input of free text information into a cell and does not provide a prompt for each required detail; this meant some information could easily be forgotten. All CMTs agreed that a more structured system would be more beneficial.</p> <p>The DME indicated to the review team that handover had always been consistent in the evenings but admitted that it was not regular in the morning. The DME indicated that morning handovers had been implemented in July 2018 whereby the frailty consultant as well as the acute physician on-call meet at 8am in the bed bureau with trainees to ensure that there was adequate handover for all admitted patients. The Higher Trainees indicated to the review team that trainees were not involved in the meetings between consultants in the bed bureau and ward patients are handed over to their teams informally.</p>	<p>Yes, please see M1.5a</p> <p>Yes, please see M1.5b</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.

M2.1	<p>Impact of service design on learners</p> <p>The DME informed the panel that the Trust had appointed 10 Physician Associates (PA) funded by the medicine redesign project. The CD informed the panel that every site had a PA 9am-5pm each day and confirmed that nine posts had been recruited into with one extra post still due be filled. The CD informed the review panel that three PAs had not passed their national exams but were still being supported by the Trust and would be appointed into lower banded posts to support the service while waiting to</p>	
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	<p>retake their exam. It was reported to the review team that the six qualified PAs started last week and had just completed a four-day induction.</p> <p>The FY1s indicated to the review team that staffing issues affected the time they left work but due to the recent increase in staffing numbers this had improved.</p> <p>Most of the trainees who met with the review team knew how to exception report and felt encouraged to do so by consultants. The GP trainees indicated to the review team that the responses to exception reporting were quick but that it was difficult to arrange time off in lieu (TOIL) to make up the time. The MEM indicated that if trainees were unable to take TOIL that they were paid for the hours worked.</p> <p>The GP trainees informed the review team that they had not met with the Guardian of Safe Working Hours (GoSWH) and were not aware of any meetings with the GoSWH. The review team were concerned to hear that a number of the FY1s stated that they did not know how to exception report and did not know how to find out how to do this.</p> <p>All trainees felt that relationships between themselves and agency/bank nurses could be improved and that the agency/bank nurses didn't receive adequate handover on patient needs. All trainees felt that this resulted in additional workload for them. The CMTs had escalated this to consultants who had spoken to the ward matrons. The trainees felt that the Trust should try to recruit more permanent nurses as there was a clearly identified need for this in terms of patient care. All trainee groups commended the nurses employed by the Trust.</p>	Yes, please see M2.1
M2.2	<p>Appropriate system for raising concerns about education and training within the organisation</p> <p>The TPD informed the review team that there had been regular LFG meeting for core and higher medical training and a separate meeting was held for foundation training. There was no trainee representation at the medical education committee (MEC) as with approximately 450 trainees it is difficult to get trainee representation for all specialities. The TPD informed the review team that there was fair representation at other faculty meetings which fed through to the MEC. The TPD informed the review team that they had met with the CMT representatives in the Care of the Elderly (COTE) department to get feedback and as an opportunity to raise issues. The TPD stated that issues were then escalated to the DME and CD.</p> <p>The FY1s confirmed to the team they were aware of the foundation faculty meetings. One of the FY2s made it known to the review team that they were the trainee representative and were aware of how to escalate any issues and feedback.</p>	Yes, please see M2.2
M2.3	<p>Organisation to ensure access to a named clinical supervisor</p> <p>All trainees confirmed that they had been allocated a clinical supervisor and knew how to contact them if needed.</p>	
M2.4	<p>Organisation to ensure access to a named educational supervisor</p> <p>All trainees confirmed that they had been allocated an educational supervisor and knew how to contact them if needed.</p>	
<h3>3. Supporting and empowering learners</h3> <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>		
M3.1	Behaviour that undermines professional confidence, performance or self-esteem	

	<p>All trainees informed the review team that they had not experienced any bullying or harassment in the workplace from any staff member. The FY2s and CMTs did report to the review team that they had received verbal abuse from distressed relatives of patients but reassured the review team that the consultants were very quick to respond and step in when needed. The FY1s noted to the review team that patient expectation was very different to doctors' expectations and some encounters were difficult as a result. The FY2s informed the review team that consultants were very supportive.</p>	
M3.2	<p>Access to study leave</p> <p>All trainees confirmed that they knew how to access study leave. The GP and FY1 trainees informed the review team that there were several different people that they had to submit various types of leave to and that it would be helpful if all leave was submitted to the same person to enable continuous monitoring to ensure safe staffing and equity of access.</p>	

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.

M4.1	<p>Access to appropriately funded professional development, training and an appraisal for educators</p> <p>The DME informed the team that since 2009, educational appraisals and educational supervisor training occurred every three years in line with GMC standards. The PGME department arranged internal courses and advertised external courses available for educational supervisor (ES) training.</p> <p>The ESs confirmed that they had access to internal training and felt this was useful and of good quality.</p>	
M4.2	<p>Sufficient time in educators' job plans to meet educational responsibilities</p> <p>All Educational Supervisors (ES) confirmed to the review team that they all had time allocated in their job plans to meet educational responsibilities. All ESs and CSs stated that they felt valued as trainers and said trainees were important to them and their own development.</p>	

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.

M5.1	<p>Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum</p> <p>The CT1s informed the review team that mandatory curricular procedures were mostly delivered through formal training (skills lab session). The CT1s indicated that the COTE department had a “post-take” shift which was a good opportunity for signing off procedures. The CT1s agreed that it was easy for them to clerk patients when they were on-call, especially when they had a FY1 trainee with them.</p> <p>The GP trainees indicated to the review team that whilst they were aware that clinics were not a mandatory requirement of their curriculum, it would be useful and would be educationally beneficial to them if they were able to attend some clinics or day case activity. The ESs indicated to the review team that the priority was to ensure that clinic requirements for CMTs were met and to achieve this they treated all juniors as supernumerary, whilst also giving GP trainees an option to attend.</p>	
M5.2	<p>Regular, useful meetings with clinical and educational supervisors</p> <p>The review team was pleased to hear that all trainees had met with their CS and ES, however it was noted that it took longer for some trainees than others for an initial meeting to be organised.</p> <p>The ESs indicated to the review team that trainees were met within the first few weeks of starting and that this process was easier if the same consultant was both the ES and CS. The ESs felt that the meetings gave them a good understanding of how the trainees were progressing and that they tried to keep an open door for any problems that may arise.</p> <p>The ESs informed the review team that all consultants now had office spaces which were beneficial for meetings with trainees.</p>	Yes, please see M5.2
M5.3	<p>Appropriate balance between providing services and accessing educational and training opportunities</p> <p>The GP trainees informed the review team that the proportion of routine workload and educational opportunities could be difficult to balance in a busy hospital. The GP trainees indicated that learning opportunities came from weekend on-calls and generally the day to day routine was more admin task-heavy. The GP trainees informed the review team that although weekend on-calls might be of more educational value, they did not want to be allocated weekend on-calls more than needed.</p>	

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.

Good Practice	
	N/A

Good Practice and Requirements

Good Practice	
The acute medicine experience for all programmes was highly valued with appropriate workload intensity and with supportive consultants.	
All trainees were released for regional training and were able to take appropriate study leave.	
The opportunity for outpatient experience in ambulatory care for core medical trainees was felt to be very positive.	
All consultants felt highly valued as supervisors, had appropriate time in their job plans and felt supported by the Trust in their educational duties.	

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.
M1.1	Trust is to ensure medications are given in a timely and safe manner including Parkinson's disease medication and insulin.	The Trust is to monitor adverse incidents and provide monthly summary reports.	R1.1
M1.2a	The Trust are to confirm the consultant responsibility for the assisted ventilation unit including daily consultant review of all patients, to be communicated to all trainees	The Trust is to provide evidence of a consultant rota indicating which consultant is responsible for the assisted ventilation unit implemented within one month.	R2.11
M1.2b	The Trust should ensure that the trainees in geriatric medicine have named higher trainee and consultant cover with clearly communicated processes for escalation.	The Trust is to provide evidence showing escalation processes and rota for named cover and evidence this has been communicated to all trainees. This documentation should be provided to the trainees within one month.	R1.8
M1.3	The Trust should ensure there is a clearly identified individual locally within the appropriate specialty teams to monitor doctors' annual and study leave in conjunction with rotas and required training.	The Trust is to provide evidence that there is a named individual with oversight of annual and study leave in conjunction with the rotas and required training. This information is to be clearly communicated with the trainees within one month.	R1.12

M1.4	The Trust are to ensure that all levels of trainees receive a departmental and local clinical induction, with sufficient support tailored to level of training.	The Trust is to provide evidence that all trainees have attended a local departmental and clinical induction. This can be confirmed through anonymised attendance register records. Trust is to provide evidence after next rotation and advise review team of date of this within one month.	R1.13
M1.5b	The Trust should ensure that there is a structured formal morning handover whereby trainees are also present.	The Trust is to provide evidence of a formal morning handover led by consultants with trainee attendance occurring daily, within one month.	R1.14
M2.1	The Trust are to ensure all trainees know how to exception report.	The Trust is to provide evidence that all trainees have been informed how to exception report. This can be confirmed by trainee feedback via trainee reps and medical education team.	R2.7
M5.2	The Trust should ensure that Educational Supervisor meetings with trainees happen in a timely manner.	The Trust is to provide evidence that all trainees have met with educational supervisors within three weeks of starting in post. This can be confirmed with a log showing start date and ES meeting date, by the medical education team, with any exceptions noted with reason and follow up. The date of the next trainee rotation requiring new ES meetings to be provided within one month.	R1.13

Recommendations

Rec. Ref No.	Recommendation	Recommended Actions	GMC Req. No.
M2.2	The Trust should ensure a trainee representative for each level of trainees at local faculty meetings, and a trainee representative at medical education committee.	The Trust is to provide a current list of trainee representatives for each programme group and LFG and MEC minutes to demonstrate trainee rep attendance and report. Please provide an update in one month.	R2.7
M1.5a	The Trust should explore a new system for handover where specific information regarding patient information would be prompted for when inputting.	The Trust should explore other methods and systems to use for handover, which may include the SBAR system for briefing, with appropriate training of F1s in the use of this tool, and provide an update to the review team.	R1.14

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

Requirement	Responsibility
Deputy Head of School of Medicine to confirm CMT placement information with workforce team and feed this back to CMT lead at the Trust.	Deputy Head of School

Signed

By the HEE Review Lead on behalf of the Quality Review Team:	Dr Catherine Bryant
Date:	21 January 2019

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.