NHS
Health Education England

Barts Health NHS Trust, Whipps Cross University Hospital

Geriatric Medicine

Risk-based Review (on-site visit)

Quality Review report

20 November 2018

Final report

Developing people for health and healthcare

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Quality Review details

Background to review	The risk-based review was planned in response to the General Medical Council National Training Survey (GMC NTS) 2018 results. In previous years there had been too few geriatric medicine trainees at Whipps Cross University Hospital to return GMC NTS results.
Training programme / learner group reviewed	Geriatric medicine
Number of learners and educators from each training programme	The review team met with eight core, foundation and general practice (GP) trainees currently working in geriatric medicine and two higher geriatric medicine trainees. The review team also met clinical and educational supervisors and the following representatives from the Trust: • Director of Medical Education • Medical Education Manager • Clinical Director and Educational Lead • College Tutor • Associate Director of Quality • Managing Director Education Academy • Medical Director.
Review summary and outcomes	The review team identified several areas of good practice, including good quality of supervision, responsiveness to trainee feedback, the individualised approach to higher training, improvements to staffing in the department and the development of a new frailty assessment unit. These areas are detailed at the end of the report. In addition, the review team noted the following areas requiring improvement: • the Acute Medical Rota was described as being onerous and trainees felt exhausted at the end of their on-call stints. There was also an unpredictable and often adverse impact of the rota on ward staffing • The Trust induction was described as disorganised, with IT and log in issues being the main area of difficulty. The departmental induction, including that provided informally by supervisors, was described as being more useful • There was a lack of clarity among trainees around which teaching sessions were bleep free and whether they should be allowed to attend teaching when on-call • The department did not offer specific training or supervision for trainees undertaking their quality improvement (QI) projects • The core, foundation and general practice (GP) trainees were unaware of the monthly departmental clinical governance meeting and therefore missed the opportunity to attend, contribute to or present at the meeting • Trainees reported regularly working extended hours beyond their scheduled duties. Although they were encouraged to submit exception

	reports at induction and at local faculty group meetings, no trainees had. Trainees had also not met with the Guardian of Safe Working Hours • The department staffing included five substantive and eight locum consultants. The review team heard that multiple attempts to recruit new consultant staff had been unsuccessful • The review team was not made aware of any departmental workforce strategy that included a multi-skilled and multi-professional workforce. At a junior doctor level there was a large proportion of locum staff with variable engagement with training and quality of service provision • The review team noted that there was no local professional development programme aimed specifically at maximising the training opportunities for foundation year two and GP trainees linked to the relevant curricula. • The department ran weekly training sessions on Mondays, but the trainees were unsure which sessions were relevant for which trainee groups • The review team heard that there were significant challenges around delayed patient discharges due to limited capacity in community-based health and social care services. This was impacting on the morale and training opportunities for junior trainees as well as compromising the care of patients • There was ample available time for training and supervision in consultants' job plans, but in practice there was a lack of any formalised time during the working week to give trainees feedback and complete assessments • The GP trainees required a more tailored programme of training activities relating to their curriculum, for example attending dementia clinics and working in the frailty unit.

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty Deputy Postgraduate Dean, North East London	**External Clinician**	Dr Mehool Patel Geriatric medicine Training Programme Director – South London
Foundation School Representative	Dr Keren Davies Director of North East Thames Foundation School	**Lay Member**	Jane Gregory Lay Representative
Observer	Paul Smollen Deputy Head of Quality, Patient Safety and Commissioning Team	HEE Representative	Tolu Oni Learning Environment Quality Coordinator Quality, Patient Safety & Commissioning Team Health Education England (London and Kent, Surrey and Sussex)
HEE Representative	Louise Brooker		

	Learning Environment Quality Coordinator Quality, Patient Safety & Commissioning Team Health Education England (London and Kent, Surrey and Sussex)		

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

The review team met with the Clinical Director and Educational Lead (CD), Director of Medical Education (DME) and Medical Education Manager (MEM) and discussed the department's response to the General Medical Council National Training Survey 2018 (GMC NTS) results. The DME advised that the number of red and pink outlier results had been unexpected. At the local faculty group (LFG) meeting on 23 July 2018, the CD reported that the results were discussed and the trainee representatives' feedback highlighted the same areas of concern and good practice as the GMC NTS results. The department conducted an internal trainee survey to gather more detailed feedback but no trainees responded. The Trust representatives outlined the current status of the department and the work which was underway to improve services and training.

GMC theme one – Patient Safety

The geriatric medicine department included five wards, an acute stroke unit and a new frailty unit. Overall the department junior level rotas included three foundation year one trainees (F1s), 1 F2 trainee, four core medical trainees (CMTs), six general practice (GP) trainees and nine funded Trust-grade doctors. The PGME team advised that on weekdays there was one consultant assigned to each ward, working with two higher trainees (or Trust-grade equivalent) and two F1 trainees. The acute on-call rota included three F2, F3, CMT or GP trainees on the daytime rota to cover admissions. There was a consultant, a higher trainee (or Trust-grade equivalent), a CMT and a F1 assigned to the stroke unit and a consultant and two Trust-grade doctors assigned to the frailty unit. There were 13 consultants working within the department, eight of whom were long-term bank locums. It was reported that there had been multiple unsuccessful attempts at recruitment but that there was a fixed-term contract consultant interested in taking up substantive posts.

The review team heard that the ward-based consultants were permanently linked to their wards and held responsibility for clinical supervision and teaching on their respective wards. The CD reported that there were daily consultant-led ward rounds where all newly admitted patients and unwell patients were seen and discharge reviews were conducted. Twice each week consultants would review all patients on the wards. Consultant clinics were held after the morning round and the trainees covered the wards during this time. The CD advised that F1 trainees were usually paired with a higher trainee to provide support. The CD reported that consultants would conduct a second round including new admissions and unwell patients in the afternoon, either in person or by phone with the higher trainee. In addition, there were medical admissions rounds which the on-call consultants and trainees attended.

The review team heard that there was ongoing work to improve the geriatric medicine trainee rotas, including the acute medical on-call rota. There was a clinical fellow working in the department who was modelling alternative rota arrangements and considering potential improvements to the local teaching programme. Trainees had given feedback suggesting that the acute medical on-call shifts be consolidated into an acute medical 'block' in the rota. The DME reported that trainees had expressed confusion about who their clinical supervisors (CSs) were during on-calls, so this information had been added to the rota to ensure clarity. The CD advised that a meeting was planned to discuss trainees' ideas around rota improvements with a human resources representative, the medical consultant who oversaw the on-call rota and the clinical fellow. It was reported that, despite gaps in the trainee rotas, only three exception reports had been submitted in the three months prior to the review.

The departmental induction programme had been updated and the postgraduate medical education (PGME) team advised that an induction booklet had been drafted and would be finalised for use at the next induction in December 2018.

It was reported that the department had recently introduced a weekly morning report session where trainees could present patient cases from their on-call shifts to the consultants. This time provided an opportunity to complete workplace-based assessments (WBAs). The department aimed to ensure trainees were released from clinical duties during these sessions but the PGME team emphasised the need to balance this with maintaining safe staffing on the wards. There were separate training sessions for core, foundation and higher trainees. The review team noted that the annual review of competency progression (ARCP) records showed poor attendance by foundation trainees at local teaching sessions. The DME advised that it was now mandated that foundation trainees be released for this training and that the PGME team followed-up with trainees and their supervisors when trainees did not attend.

The review team enquired whether staffing issues and rota gaps ever compromised patient safety. The CD advised that they did not, due to the use of locum doctors and the redistribution of nursing staff as needed to ensure safe cover. If a consultant was on leave, the department would usually arrange for locum cover. It was reported that understaffing in the community services had more impact as this led to delayed discharges and prolonged hospital stays.

GMC theme two – Educational governance and leadership

Due to the size of the Trust, there was a DME, MEM and medical director (MD) at each of the three main Trust sites. Each specialty had an educational lead (EL) and training programme directors (TPDs). The PGME team coordinated a monthly medical education committee meeting which all ELs and trainee representatives were invited to attend. Within most specialties, including geriatric medicine, there were LFG meetings which the PGME team usually attended. There was also a monthly junior doctor forum at each Trust site. The guardian of safe working hours (GoSWH) and safeguarding champion attended these meetings on a rotational basis and the GoSWH was due to attend the Whipps Cross University Hospital (WCUH) junior doctor meeting in January 2019. The geriatric medicine department held a monthly governance meeting which included representatives from medicine, nursing, therapy services, customer experience and Trust management. The DMEs participated in the hospital management board and had monthly meetings with the MD, so were able to escalate issues around training to the Trust executive.

GMC theme three – Supporting and empowering learners

As part of the improvements to the local teaching programme, the department planned to introduce human factors training, including simulation sessions and participation in the Trust-wide human factors conference.

The PGME team had worked to improve trainee attendance at local teaching sessions. The MEM reported that the usual reason given for non-attendance was high workload on the wards. However, the MEM noted that attendance had increased since the PGME team had begun to include supervisors in the email cascade list for information about training and to send reminders to the clinical areas to release trainees for upcoming teaching sessions. The review team was informed that if trainees missed a session, they were offered the option to attend a similar session at another Trust site.

GMC theme four – Supporting and empowering educators

The CD reported that all substantive consultants' job plans included time for supervision and teaching. The DME and CD were working with some of the locum consultants to enrol them on educational supervision training and that it had been agreed that supervision time would be included in their job plans once the training was complete. At the time of the review, three locum consultants had undergone the training.

GMC theme five – Developing and implementing curricula and assessments

The review team was informed that the department encouraged multidisciplinary working although formal multidisciplinary team meetings (MDTs) had been discontinued. Instead, there were daily board rounds for acute medicine and geriatric medicine, which included representatives from medicine, nursing, occupational therapy and a patient flow coordinator. The monthly ward meetings were also multidisciplinary.

The CD advised that one of the higher trainees had a particular interest in orthogeriatrics. As this service was primarily provided at the Royal London Hospital site, the PGME team had arranged for the trainee to work there for two days each week to gain experience in this subspecialty.

GMC theme six – Developing a sustainable workforce

At the time of the review, the department was working to re-write the consultant job descriptions. The CD explained that one new consultant was due to join the department but the Trust was aware that there was a national shortage of geriatric medicine consultants so was working to make posts more attractive to candidates.

The review team heard that there were no plans in place for recruitment of alternative non-medical roles in the department. The CD advised that there were advanced nurse practitioners working in the frailty unit and the team there was considering the development of a further senior nurse role. The review lead encouraged the Trust to seek advice from Health Education England about the potential to develop other roles such as physician associates. The Trust had successfully recruited nursing staff from overseas in recent years. The CD noted that it was more difficult to recruit nurses and occupational therapists to the WCUH site as it was not part of the Agenda for Change high cost area, so salaries were lower than those at some other hospitals in north east London.

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

G1.1	**Patient safety** Both groups of trainees advised that patient care was provided to a safe standard on the geriatric medicine wards at Whipps Cross University Hospital (WCUH). The core, foundation and general practice (GP) trainees (collectively referred to as junior trainees in this report) felt that a potential risk to patients was the length of time some patients remained in hospital after being declared medically fit for discharge. These delayed discharges were often due to limited capacity in community-based health and social care services. The trainees were concerned that longer hospital stays could increase the risk of patients contracting healthcare-acquired infections (HCAIs). The supervisors advised that there was ongoing work to build stronger links with community services through the frailty unit in order to address delays. This included plans to implement a dedicated phone line for GPs and community matrons to contact the frailty consultants and managers. The supervisors stated that the department was working with the integrated discharge team to become more proactive about discharge planning, for example by making earlier referrals to the occupational therapy team. The junior trainees were aware of one case where a patient had been 'lost' to the geriatric medicine team while waiting for discharge on an outlier ward. The patient had been moved to the outlier ward on a Friday after being declared fit for discharge but was missed from handover during the weekend and was not reviewed by the geriatric medicine team until the following Tuesday.	Yes, please see Other Actions
G1.2	**Responsibilities for patient care appropriate for stage of education and training** The higher trainees reported that the consultants spent a good deal of time on the wards and were easily accessible for supervision or for trainees to escalate concerns. However, the higher trainees felt that in some cases this prevented the junior trainees from working autonomously as some aspects of the service were mainly consultant-led. The supervisors advised that trainees were encouraged to seek supervision and advice if needed but were enabled to make decisions and deliver elements of care independently when appropriate. The supervisors emphasised the need to balance patient safety with allowing trainees to develop decision-making skills.	
G1.3	**Rotas** The review team heard that rota gaps were usually filled by locum doctors, many of whom worked at the hospital frequently and were familiar with Trust policies and ways of working. The trainees reported that some locum doctors lacked the skills or experience needed to work in the department, but that the rota coordinators were receptive to feedback in these cases. The foundation year one (F1) trainees felt that the rota was generally well-managed. F1 trainees did not participate in the medical on-call rota but were ward-based and therefore felt able to give good continuity of care to patients. The junior trainees reported that it was common for them to work past their scheduled finish times but that very few of them had submitted exception reports. The review team heard that trainees were encouraged to exception report by their supervisors and managers and that exception reporting was discussed at the Trust induction. When asked the reasons for working late, junior trainees advised that some tasks took them longer due to inexperience when they first started in post and that they felt reticent to exception report for this reason. However, the trainees also reported that on occasion ward rounds could become protracted and last until 16:00 or even 17:00 if the team was short-staffed and there were multiple new admissions. The review team was	

	informed that this was unusual, but that in these cases trainees needed to work late to complete the tasks assigned during the ward round. The trainees had not met with the Guardian of Safe Working Hours (GoSWH) but were aware that they would have the opportunity to do so at the departmental meeting in January 2019. The Trust had recently appointed three staff members to junior doctor support roles and it was anticipated that these staff would help to encourage and monitor exception reporting. The review lead enquired about the plans to change the on-call rota based on trainee feedback. The junior trainees were aware of this plan and agreed that mixing on-call and day shifts was difficult and left them feeling drained, as well as compromising the continuity of care. The review team heard that the resident on-call team included five junior trainees and a higher trainee and that this was a sufficient number to provide safe care. The junior trainees reported feeling well supported by higher trainees and nurses during on-call shifts.	Yes, please see G1.3a Yes, please see G1.3b
G1.4	**Induction** All trainees reported receiving a Trust induction and the majority had undergone departmental induction. The Trust induction was described as disorganised, particularly in terms of ensuring trainees had access to hospital information technology (IT) systems. When asked how the induction could be improved, the junior trainees suggested that information about rotas and on-call arrangements should be included and that IT logins should be set up in advance. The higher trainees advised that their educational supervisors (ESs) had given them additional, informal local inductions and that these had been very useful.	Yes, please see G1.4
G1.5	**Handover** The trainees stated that there were daily morning and evening handover sessions. The Trust had an electronic system for staff to update the handover list, which trainees found useful. The trainees reported that occasionally the electronic system was not used, which resulted in discharged patients being left on the list. On Friday evening there was a longer handover meeting where all geriatric medicine inpatients and admissions were handed over to the weekend team. The higher trainees advised that they were unable to attend ward handovers as these took place at the same time as the post-take handover.	
G1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The junior trainees reported that they mainly worked on the wards and felt that this was due to the demands of service provision, rather than being of benefit to their training. The review team heard that the consultants were supportive and that supervision was good but that ward work offered little teaching and that there were missed learning opportunities as junior trainees did not attend clinics. During on-calls, junior trainees reported that they were encouraged to do post-take reviews of each patient they clerked, which trainees found useful and interesting. When asked what could be improved, the junior trainees suggested that the programme should include more time to discuss learning from patient cases, experience in specialist clinics such as the vision and movement clinics, formalised time to work on supervised learning events with supervisors and more focus on teaching during ward rounds. The higher trainees felt that their programme was more flexible and tailored to their individual needs. The higher trainees advised that they were supernumerary when	Yes, please see G1.6a Yes, please see G1.6b

	staffing numbers allowed, which allowed them to pursue learning opportunities relating to the curriculum and to their subspecialty interests. The review team heard that the higher trainees were able to attend clinics and go to other Trust sites to gain experience not available at WCUH. The trainees had not worked on the frailty unit at the time of the review but believed that this opportunity would be open to them in future once the frailty pathway became more established. Junior trainees worked in the frailty unit and the admission avoidance team and the supervisors reported that these areas allowed a good amount of time for teaching as only one trainee was there each day. Overall the supervisors felt that the WCUH provided a good range of learning opportunities for trainees due to the broad range of patient cases. When asked about other learning opportunities that could be developed within the department, the supervisors agreed that the higher trainees could gain valuable experience in the frailty unit and the junior trainees would benefit from involvement with the community liaison services.	
G1.7	**Protected time for learning and organised educational sessions** There was a regular teaching session on Mondays, GP teaching on Tuesdays and an x-ray meeting on Fridays. The supervisors highlighted the x-ray meetings as an area for improvement, as attendance was often poor. The trainees reported that they were unsure which trainee group the Monday teaching session was intended for, as the subject matter and level was variable. Trainees were aware that the teaching programme was under review by the clinical fellow. The junior trainees were unsure whether teaching sessions were bleep-free or not. There was particular confusion around the GP teaching as trainees had been told during induction that the session was bleep-free but other colleagues had advised that if there was no-one to take the bleep from them, they should not attend the session while carrying the bleep. The F1 trainees found it easier to attend teaching as they were not included in the on-call rota, but F2 trainees sometimes missed sessions following on-call shifts. The higher trainees found departmental teaching variable and suggested that morbidity and mortality meetings were one area where teaching could be improved significantly, by discussing a few cases in depth rather than hearing brief details of all cases. The higher trainees had given this feedback to the clinical fellow and had suggested including non-clinical skills in the regular teaching programme, such as communication and how to deliver bad news. The supervisors reported that there was increasing need to release trainees for non-departmental meetings, resulting in some teaching sessions being moved. The supervisors suggested that the current rota arrangements sometimes made it difficult for trainees to find time to attend or prepare cases for meetings.	Yes, please see G1.7

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.**		
G2.1	**Effective, transparent and clearly understood educational governance systems and processes** The review team was informed that trainees were encouraged to submit Datix reports following clinical incidents or near misses, but that the Datix process was arduous and time-consuming to use and this deterred some trainees from reporting. Some junior trainees were unsure whether they had been taught how to complete a Datix report. When asked whether Datix reports and investigations were used to generate learning opportunities, trainees advised that this varied between wards. The review team heard that some wards incorporated discussion of clinical incidents into ward rounds or meetings but did not always relate these discussions to learning or quality improvement. The junior trainees advised that the local faculty group had been incorporated into the teaching sessions held each Monday, where they were able to raise any issues or concerns with consultants.	
G2.2	**Impact of service design on learners** The higher trainees suggested that the system for taking emergency department (ED) referrals required review. The review team heard that the trainees had been instructed not to decline or redirect inappropriate referrals but to accept all referrals and then refer the patient on to the correct ward or team if needed. The higher trainees believed this was because patient flow through the ED was seen as a priority, but felt that part of their training should be learning how to manage referrals and which to accept or decline. It was reported that the ED and geriatric medicine team at the Royal London Hospital site had a better system of referral management and that lessons could be learned from this. The higher trainees also reported that there was a lack of communication between geriatric medicine trainees and the radiology department, with referrals and case discussion being carried out on the IT system or between consultants. The trainees believed that they would benefit from participating in dialogue between the two departments and felt that this would be a good way to consolidate learning from the x-ray meetings. The review team was informed that there was no geriatric medicine-specific post take ward round. The higher trainees felt that this was a missed learning opportunity and that general medicine teaching was given higher priority than geriatric medicine. The supervisors noted that staffing levels had improved in recent years, but that the demands around record keeping and use of multiple IT systems had also increased which impacted on trainee workloads and the time taken to complete patient notes. The Trust had moved to a ‘paper light’ system in 2018 and all staff were working to adjust to this.	
G2.3	**Appropriate system for raising concerns about education and training within the organisation**	

	The higher trainees reported that they had attended clinical governance meetings and felt able to participate in these meetings. The trainees were confident that senior staff listened to their feedback and reported that consultants, clinical directors, the postgraduate medical education (PGME) team and nursing teams engaged well with trainees. The junior trainees were not aware of the clinical governance meetings so had not attended.	Yes, please see G2.3
G2.4	**Organisation to ensure access to a named clinical supervisor** All trainees stated that they had named clinical supervisors (CSs) and that CSs ensured trainees knew how to contact them at all times. The higher trainees reported that consultants would proactively contact them at the start of each on-call shift and encouraged them to call regarding any concerns.	
G2.5	**Organisation to ensure access to a named educational supervisor** All trainees had met with their ESs. The higher trainees complimented the supervision they had received, particularly the time spent reviewing their individual training needs.	
G2.6	**Systems and processes to identify, support and manage learners when there are concerns** The supervisors were asked what action they would take to manage a trainee experiencing difficulty. It was reported that this was rare, but that supervisors would hold additional one-to-one supervision sessions with the trainee and escalate concerns through the ES or clinical lead. The supervisors did not mention the Trainees in Difficulty (TID) or Trainees Requiring Additional Support (TRAS) processes.	Yes, please see G2.6

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.

G3.1	**Access to study leave** Some trainees had been scheduled to work on regional teaching days and had been told to arrange their own cover for their shifts rather than being allocated study leave, despite the teaching dates being circulated in advance.	

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.

G4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The review team was informed that there was allocated time in supervisors' job plans for supervision and training activities. In practice, the supervisors found that there was sufficient time but that it was difficult to consistently deliver training due to the trainees' rotas.	

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.

G5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The junior trainees reported that contact with their ESs was largely informal and often occurred when they worked together on the wards, with few formally scheduled meetings. The trainees reported that consultants were approachable and friendly but that it was sometimes difficult to complete assessments and record supervised learning events (SLEs) due to a lack of allocated time for these activities. The supervisors advised that lack of suitable space to meet with trainees on or near the wards was also a barrier to holding more structured supervision meetings. There was a difference of opinion between trainees and supervisors around teaching methods. The junior trainees expressed a preference for more formalised, signposted teaching, either in teaching sessions or in practice, whereas supervisors felt that informal teaching through observation and experience was equally valuable. The GP trainees advised that in other specialties the higher trainees were often involved with teaching the junior trainees, but that this was less common in geriatric medicine. The junior trainees were asked about quality improvement projects. The foundation trainees reported that there had been little support for these until recently, when the Trust had appointed a new middle grade doctor who worked with junior trainees on these projects. The review team heard that core trainees received support for these projects through their supervisors and that quality improvement was part of the core teaching curriculum.	Yes, please see G5.1a Yes, please see G5.1b
G5.2	**Opportunities for interprofessional multidisciplinary working** All trainees reported that there was a strong culture of multidisciplinary working within the department. The junior trainees mentioned that the relationship between the medical and nursing teams was particularly good. The review team heard that levels of substantive staffing were higher in the nursing teams, which led to better continuity of care for patients and support for trainees. The higher trainees advised that the care	

	coordinators attended handover sessions and took on tasks such as following up referrals and scan results, which would otherwise have been delegated to the trainees. The review lead enquired whether the Trust had any plans to introduce further non-medical roles within the department, such as advanced nurse practitioners (ANPs), nurse consultants, physician associates and other allied health professional roles. It was noted that there was significant scope to develop ANP and nurse consultant roles within geriatric medicine. The consultants reported that the frailty unit had three ANPs and there was a proposal to recruit a fourth but that there were other areas where alternative workforce solutions could be considered.	Yes, please see G5.2

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.

G6.1	**Transition to employment** The review lead enquired what might make the department more attractive to candidates for substantive consultant roles. The higher trainees advised that there were good opportunities for substantive staff in the department and that it was a good place to work as management were receptive to feedback and open to making positive changes. The trainees suggested that candidates made negative assumptions about the department based on the number of locum consultants employed there.	

Good Practice and Requirements

Good Practice
The trainees advised that they were happy to recommend their posts to colleagues and happy for their friends and relatives to be treated at the hospital.
The review team heard that the department was responsive to trainee feedback and worked proactively to understand their concerns.
The trainees praised some of the consultants in the department for being particularly supportive and approachable.
The junior trainees advised that consultant supervision was good and that they were not expected to perform tasks beyond their remit or competency level.

The higher trainees reported that the department adopted a flexible approach to their training needs. This included allowing the higher trainees supernumerary status on the ward rotas where possible, individualising training plans to accommodate trainees' needs and arranging for trainees to spend time at other Trust sites to gain sub-specialty experience.
The review team noted that staffing levels within the department had improved and that there was a good culture around supervision and multidisciplinary team working.
The frailty unit was recognised as an innovation which contributed positively to patient care and establishing links with community-based services.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	None		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
G1.3a	The Trust should ensure that trainees are encouraged to exception report and that the new junior doctor support team actively monitor reporting rates.	Please provide evidence of communication to trainees encouraging exception reporting and information on the numbers of exception reports for the next three months.	R2.2
G1.4	The Trust should arrange all necessary IT system access and login details prior to the start of trainees' rotations.	Please provide feedback from trainees after the February 2019 rotation date confirming that IT access and login information are provided at induction. This can be in the form of LFG minutes, trainee survey data or induction feedback forms.	R1.13
G1.6a	The Trust should create a local professional development programme detailing the available training opportunities for foundation trainees in the department, linked to the relevant curricula.	Please provide copies of the development programme by the end of March 2019.	R2.4
G1.6b	The Trust should create a local professional development programme detailing the available training opportunities for GP trainees in the department, linked to the relevant curricula. The Trust is advised to appoint a departmental lead for GP training.	Please provide copies of the development programme by the end of March 2019 and inform HEE when a GP lead has been appointed.	R2.4
G1.7	The Trust should ensure that teaching sessions are bleep free and that trainees are able to hand over bleeps to attend teaching.	Please provide trainee feedback confirming that teaching sessions are bleep free and that trainees are able to hand over bleeps for the duration of their teaching sessions. This could be in the form of LFG or other departmental meeting minutes.	R1.16
G2.3	The Trust should inform the junior trainees about the remit and timing of the clinical governance meetings and encourage them to attend.	Please provide copies of communication to trainees about the clinical governance meetings by the end of January 2019.	R2.1

G2.6	The Trust should ensure that all supervisors are aware of the appropriate process for managing and escalating concerns about trainees experiencing difficulty.	Please provide evidence that all CSs and ESs in the department have undergone training on use of the TRAS process by the end of March 2019.	R2.16
G5.1a	Each ES should have 0.25PA per trainee allocated in their job plan for supervision activities, allowing scheduled weekly time with their trainees to review progress, discuss any concerns and ensure that curricular requirements are met.	Please provide confirmation that all supervisors have 0.25PA per trainee included in their job plans. Please provide evidence of trainee feedback confirming that trainees have weekly sessions with ESs and are able to complete SLEs and supervision paperwork. This can be in the form of LFG or other meeting minutes or trainee survey data.	R2.10

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
G1.3b	The Trust is advised to continue the ongoing work around geriatric medicine trainee participation in the acute medical on-call rota.	The Trust is advised to consult with trainees in developing any new rota arrangement.	R1.12
G5.1b	The Trust should provide more focused support to trainees carrying out QI projects.	The department is advised to appoint a QI lead to guide trainees in accessing appropriate training and offer ideas and supervision to undertake meaningful projects relevant to the departmental activities.	R1.22
G5.2	The Trust is advised to develop a medium to long-term departmental workforce strategy, including ways to increase substantive staffing levels and introduce additional roles such as advanced nurse practitioners (ANPs), nurse consultants, allied health professionals and physician associates.	The Trust should liaise with HEE for assistance in developing this strategy.	R5.9

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
The review team acknowledged that delayed patient discharges and lack of capacity in community services presented a challenge which impacted on trainees, the wider geriatric medicine team, patients and the service as a whole. HEE plans to escalate this issue to other regulators at the north east London Quality Surveillance Group.	HEE

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Indranil Chakravorty Deputy Postgraduate Dean, North East London

Date:	18 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.